



'I've become so healthy that I can't live anymore': exploring 'health as balance' discourses and the construction of health and identity among young urban South African adults

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Abstract

Social science research on health in South Africa tends to focus on illness and how to address health problems. Qualitative empirical research focussing on lay understandings and experiences of healthiness, or health discourses, in South Africa is fairly limited. This article addresses this gap by critically exploring how young South African adults used discourses of balance to make sense of what it means to be a healthy person and highlights the implications of these discourses for identity. Foucault's concepts of 'technologies of the self' and 'techniques of discipline' are discussed as a theoretical grounding for this paper. Data were collected from 20 in-depth semi-structured interviews, and analysed using Foucauldian discourse analysis. This paper will specifically explore a key discourse identified through the analysis: 'health as balance' and 2 interrelated sub-discourses which fall within it. Through this discourse, healthiness was constructed as requiring a broad focus on improving all aspects of one's life ('health as holistic') and the avoidance of any behaviours or emotions which could be classified as extreme ('health as moderation'). Constant, careful management of the self, or 'calibration', functions to both perpetuate a cycle of 'anxiety and control' and to obscure ways in which health discourses can be harmful or problematic.

Keywords Health · Balance · Self-control · Identity · Neoliberalism · South Africa · Discourse analysis

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Introduction

The health of South Africans is an issue of great significance to politicians, those involved in health promotion efforts, as well as to ordinary citizens. South African health research often tends to focus on illness and how best to manage national health problems such as HIV, TB, cardiovascular disease, obesity (Maredza et al. 2016; Mchiza et al. 2016; Nojilana et al. 2016; Otang-Mbeng et al. 2017), and most recently, the Coronavirus pandemic. Less research has focused on how South Africans make sense of the concept of health and the discourses they draw on to shape how ‘healthiness’ is understood and experienced. These topics have implications for a range of health-related endeavours including health promoting interventions and the communication of health information. Discourses of health also play a significant role in the constitution of identity. This has both personal and political implications. First, these discourses shape how individuals may feel about themselves and others, and in turn, influence how they behave. Second, the reproduction of specific health discourses may, either purposefully or inadvertently, support or undermine broader societal structures.

The broader project on which this paper is based, sought to answer the questions: how do young South African adults discursively construct health and what implications do these constructions have for the constitution of identity? This paper explores one of the dominant groups of discourses (*health as balance*) which were drawn on by participants when making sense of what health means. By unpacking and interrogating underlying assumptions about what it means to be healthy, and why it is important, this paper aims to contribute to existing public health and health promotion literature by providing a critical perspective on the impacts of health discourse both personally for individuals, and more broadly in terms of how dominant discourses support or are upheld by existing social structures. This research is intended to encourage critical reflection on how health is implicitly constructed within public health research and health promotion endeavours.

Theoretical framing

In this article, discourses of balance and health will be discussed and the identity implications they have for individual subjects will be explored. We will be adopting a view of the self as constantly constructed and reconstructed within the boundaries of social norms, rather than as pre-existing and fixed. Burr (1995) highlights the role of social interactions with others in the identity construction process, especially the importance of linguistic interactions or conversations. Foucault’s notions of ‘subjectification’, ‘technologies of discipline’ and ‘technologies of the self’ will be outlined below, as these concepts were used to frame the authors’ understanding of how discourses play a role in the construction of the self as well as how these processes of self-constitution are influenced by power.

Foucault describes three modes by which individuals become subjects, one of which (called 'subjectification' by Rabinow 1984) seems particularly relevant for this analysis (Rose 1998). Subjectification refers to the active process of forming oneself into a certain kind of subject. This is done through constituting the subject, recognising the self as a subject, and relating to the self as such. This paper aims to draw on this understanding of the constitution of subjects to explore the various ways in which individuals take up dominant discourses to construct for themselves certain subject positions.

Another aspect of Foucault's work which is relevant to this article is his notion of 'technologies'. At different points in Foucault's work, he refers to different 'technologies', such as technologies of power, technologies of government and technologies of the self. Usually these technologies allow for the production of (amongst others) things, meanings, behaviours, or practices. Two of these technologies are of particular relevance to this paper: technologies of power (specifically techniques of discipline) and technologies of the self.

In *Discipline and Punish* (1977), Foucault discusses disciplinary techniques, an example of technologies of power, and examines the way that discipline, as a form of self-regulation, is encouraged by institutions and permeates modern societies. He discusses how individuals internalise pressures from external institutions and then sustain the power relation by regulating their behaviour in order to conform to societal norms. These disciplinary pressures function in a way that makes it unnecessary for institutions to coerce individuals into conforming, as these systems of control are internalised and enacted on the self. The individual thus plays both the role of the oppressor and the oppressed. These disciplinary practices are experienced as natural and originating from within the self rather than as being externally imposed (Mills 2003). This process is not linear, so individuals are not passive recipients of cultural, social and economic norms. Instead, they interact with these ideas and adopt certain practices while rejecting others (Fox 2016).

Technologies of the self also involve the production of certain practices but instead of being centred around avoiding punishment, these practices tend to be more aspirational, aimed at producing more ideal subjects. Foucault (1988) defines technologies of the self as those which, 'permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves to attain a certain state of happiness, purity, wisdom, perfection, or immortality' (p. 18). For example, a person's decision to purchase organic foods could be viewed as an effort to work on and improve the self in an attempt to embody perfect health. Certain discourses construct ideal ways of being, and set out the guidelines or rules to abide by to achieve these ideals (Wright et al. 2006).

By drawing on these concepts, this paper is able to highlight connections between discourse, social norms and ideals, and the construction of subjectivities. In addition, it uses these theoretical framings to explore how individuals play an active role in constituting their own identities and in reproducing and resisting different discourses.

Background literature

This section discusses a few key empirical studies which have explored the construction of identity through health-related practices and discourses. These studies were selected based on their particular focus on health improvement practices, specifically in relation to balance, and the construction of identity. The authors selected a limited number of studies where the findings were particularly relevant to those in the current paper, allowing them to be described in more detail. Previous empirical research relating to healthiness and the construction of identity has often focused on the performative aspects of food consumption. Performativity involves the repeated actions and rituals which have come to represent certain kinds of selves (Butler 1999). As Manton (1999 as cited in Taylor, 2010) and Poole (2012) argue, food consumption enables individuals to demonstrate their membership to specific groups or evidence certain personality traits and, similarly, as Barthes (1957/2009) and Bailey (2007) point out, this also enables individuals to distance themselves from groups with which they do not wish to be identified.

Cairns and Johnston (2015) explore the process of constituting ideal identities through healthy food consumption among middle class women exposed to the contradictory pressures of neoliberal capitalist societies. Neoliberal subjects are supposed to exhibit characteristics such as self-control and discipline while at the same time express their freedom through consumption (Cairns & Johnston 2015). Cairns and Johnston (2015) argue that the women in their study navigated this tension through the use of what they term the 'do diet'. This refers to the practice of consuming primarily healthy food options. This way, they were able to engage in what is presented as empowering consumption while at the same time demonstrating their self-control by carefully selecting foods believed to enhance one's health and avoiding those which are seen to be health-harming (Cairns & Johnston 2015). This practice of healthy food consumption, however, required constant and spontaneous 'calibration' in order to avoid extremes of either consumption or self-control (Cairns & Johnston 2015). If the individual engaged in *too much* consumption or was *too* self-disciplined with their food consumption choices, this could have negative identity implications and could place them in categories such as: self-indulgent, ignorant or fat, or a health fanatic, rigid or obsessive. 'The do-diet celebrates healthy food choices, while emphasizing the need for continual bodily discipline, allowing the seemingly contradictory neoliberal logics of continual consumption and corporeal control to co-exist' (Cairns & Johnston 2015, p. 170). Similarly, Luna (2019) in her research with American runners, found that participants constructed a 'narrative of balance' where they drew on ideas about the hard work required to maintain their physical fitness while at the same time emphasizing the 'ease of hard work' suggesting that this disciplined pursuit of physical fitness came easily to them or was fun. This meant that they were able to avoid negative 'health fanatic' associations while still constructing their associated privilege as deserved.

Less research is focused on identity and health in a broader sense (beyond food and exercise choices), however, Robertson's (2006) article discussing men's lay understanding of health more generally also noted an emphasis on a balanced

approach to health which avoided various ‘excesses’. He explains how gender plays an important role in how men talk about their health. To construct themselves as masculine, the men in his study were obliged to assign a low degree of importance to their health. This is related, in some ways, to the gendered social pressure placed on men to be ‘risk takers’ in order to constitute themselves as masculine. Robertson (2006) refers to this as the ‘don’t care/should care’ dichotomy where men are obliged to take care of their health in accordance with the expectation to be good citizens, however, their hegemonic masculine identity is put at risk if they appear to be too invested in their health.

Methods

This study aimed to explore the discourses young South African adults from urban areas used to construct ‘health’ and the implications these discourses had for identity and broader structures. Data were collected through in-depth, semi-structured interviews with 20 (10 women and 10 men) South African young adults who ranged in age from 18 to 35. Participants were recruited using purposive and snowball sampling. This research was interested in exploring the concept of health and the discourses which are used to shape how healthiness is understood and experienced and thus individuals who had an interest in personal health improvement were approached. This involved contacting fitness centres (for example gyms and yoga centres), and those involved in other areas of health improvement such as medical students and a wellness blogger. From these participants, snowball sampling was used to provide access to additional participants who were involved in various kinds of health improvement practices (running, surfing, ‘alternative’ as opposed to Western healing practices, community gyms, and various food-related health improvement strategies).

The sample consisted of participants who identified themselves as either ‘white’, ‘coloured’, ‘indian’ and ‘black’. The majority (13) of the participants identified as ‘white’ and would be considered to be from middle-class social groupings. All participants were from urban areas in South Africa (Durban, Johannesburg and Cape Town). All had received at least a secondary school education and many had, or were currently pursuing, tertiary qualifications. In addition, all the participants sampled described themselves as ‘healthy’ at the time of the interview, which shaped the kinds of health-related topics they identified as most pressing. This sample featured individuals who had access to certain privileges in relation to the majority of the South African population (such as relatively ‘good’ physical health and access to education), however, a portion of the sample were currently living in low-income communities and did not necessarily have access to the same health improvement resources as those in higher-income settings. While researching individuals from marginalised groups is essential to adequately understand social problems, studying those who appear to be benefitting in some ways from the status quo is also important, as it allows an exploration of how systems of inequality are reproduced and why discourses which function to perpetuate these inequalities may seem appealing.

This group of participants provided insight into how those with some (but limited) resources *and* those who were more financially secure constructed the ‘healthy self’. While the participants share some similarities, the group is too diverse to be representative of any specific subsection of the population. In general, discourse analytic research is less interested in producing generalizable findings. As Fiske (1994) explains, ‘no utterance is representative of other utterances, though of course it shares structural features with them; a discourse analyst studies utterances in order to understand how the potential of the linguistic system can be activated when it intersects at its moment of use with a social system’ (p. 195). What this paper aims to provide, therefore, is an exploration of some of the processes through which individuals can make use of available discourses (in this case, ‘health as balance’ discourses) to construct identity and to reproduce/resist broader social ideals.

All interviews were conducted in English by the first author between 2015 and 2017 and took place in locations of the participants’ choosing, including coffee shops, university classrooms, fitness centres and the researcher or participants’ homes. A social constructionist theoretical approach was taken and the transcribed interviews were analysed using a Foucauldian method of discourse analysis based on Willig’s 6 step guidelines. A Foucauldian discourse analytic approach was selected as this method focuses on an exploration of the links between discourse, social structures and subjectivity. By examining the discourses used to construct health, and the broader social systems which uphold or are reproduced by these discourses, we are better able to make sense of the consequences of the health messages we take for granted. It is important to examine the intersections between discourse, social structures and subjectivity to develop strategies to communicate about health in ways that are less likely to have negative, unintended consequences and also to facilitate the exploration of innovative approaches to challenging health inequities through discursive choices.

Willig’s (2013) approach to discourse analysis involves identifying the discursive object to be discussed, which in the case of this study was ‘health’. All mentions, or notable omissions, of the discursive object are then considered in relation to how they fit into wider discourses present in society. The ways in which they function to allow for certain subject positions to be taken up, certain subjective experiences and certain opportunities for action, are also explored. This article will focus on one of the groups of discourses identified through the analysis: ‘health as balance’. This paper will discuss how these discourses were used by participants to construct health and the implications this had for the constitution of identity. The use of ‘health as balance’ discourses are considered in relation to how they serve participants, as well as how they can simultaneously be problematic. ‘Health as balance’ discourses are also situated within broader discourses in order to show how their use interacts with political and economic structures beyond the individual. The intention is to provide a nuanced critique of how health is constructed by these participants, to better understand why certain ways of framing health are appealing, and how they both resist and are rooted in broader systems of inequality.

Ethical clearance for conducting the study was obtained from the Rhodes University Institutional Review Board. Informed consent was obtained from each

participant and all identifying factors have been changed in the discussion to ensure confidentiality.

Results

An underlying idealization of the notion of *balance* in relation to health was prevalent throughout the data. Participants were not asked directly about balance unless they first raised the idea. ‘Health as balance’ discourses were most commonly used in response to questions including “What do you think health means?” and “How do you try to stay healthy?” ‘Health as balance’ discourses were used to construct health in two main ways. First, health was constructed as a careful moderation of behaviours and emotions to avoid either of the health extremes (too unhealthy or too healthy) and maintain one’s amiability (‘health as moderation’). Second, health was constructed as achieving a balance between all facets of one’s life. Emotional, mental, spiritual and physical aspects all needed to be given sufficient attention and work (‘health as holistic’). In other words, healthiness was constructed as involving a holistic approach to self-improvement. These two ‘health as balance’ discourses will be discussed below.

Health as moderation

Through the ‘Health as moderation’ discourse, health was constructed as the effective management of one’s behaviour and emotions to avoid what were perceived to be excesses or extremes and to maintain amiability. Participants drew on this discourse to construct two undesirable health extremes and then to construct a health ideal that was situated between these extremes. This ‘middle ground’ was viewed as socially and morally preferable.

Too healthy

The first constructed extreme was the ‘health fanatic’: someone overly concerned with health and associated practices. The quotes below illustrate some of the problematic aspects of this kind of subject.

April: *I got to a point where I was like panicked ‘cause I suddenly had to eat food that I didn’t know what was in it and that’s when I realised I’ve become so healthy that I can’t live anymore, like I can’t live in the real world.*

Richard: *...the trend is ja the dominant one is that guys who are in top shape or girls who are in top shape are jerks ja, that’s the trend.*

George: *I do have a friend... You look at her, she’s very healthy, she does look like somebody who takes very good care of herself. But I noticed that when we were in the train. At one point, she actually took a picture of someone who was behind me... and she sent it via whatsapp to me like: “look at that person*

who's behind you" and behind me was a lady who was actually, she had, you know she was a bit overweight- chubby. So that kind of gave me an impression that she's very healthy and stuff but see now, it's starting to have a negative impact on other people, you know? And it's also starting to change the way she looks at other people.... So I think being too healthy, (sighs) it can come with some problems as well.

The above quotes address the social component to health practices. George points out that people could be put off by his 'very healthy' friend's critical attitude towards others and Richard expresses an observation that, in general, men and women who are very fit are often 'jerks'. The expectation to maintain a certain level of healthiness and to bear the signifiers of this health (an acceptable weight and a certain degree of attractiveness) exists alongside the social expectation to be sociable, easy-going, to participate in social customs and, 'to live in the real world'. These two expectations sometimes contradict one another and the restrictions or disciplinary techniques (Foucault 1977) required to maintain an acceptable level of health, may prohibit individuals from engaging fully in certain social events, for example those where the consumption of 'unhealthy' foods is expected. Maggie describes individuals like this who are 'like "oh no that's not healthy I can't eat that"' as being 'very unapproachable'. Through 'health as moderation' discourses, participants constructed this undesirable super healthy 'health fanatic' who was obsessive, rigid, judgemental, and antisocial.

Too unhealthy

The second undesirable health extreme was the subject who was *too unhealthy*. Participants were seldom highly critical of people with health problems but would often emphasise the importance of working towards improved health. In a more extreme case, people who were too unhealthy were described as 'inherently lazy'. Not being healthy enough was also described as leading to a range of unpleasant experiences including feeling physically unwell, contracting diseases, emotional pain and low self-esteem, or living in a way that felt inadequate.

Maggie: with unhealthiness brings it brings sadness, it brings this kind of like guilt and loathing, self-loathing, which added on to the fact that for example, will add on like loss. Like it's not good for you. Like loss and self-loathing- not a good combination at all.

Maggie describes some of the consequences if one's health and body 'aren't in balance'. She talks about physical sickness and the impact on one's self-concept. She describes feelings of 'self-loathing' and 'guilt'. These kinds of emotions are usually the result of being ashamed of one's behaviour, or of who one is. Maggie's association between these kinds of emotions and unhealthy behaviours or states, functions to moralise health. Within this construction poor health is not only a physical problem it also implies that someone has done something wrong and shameful. This idea, that healthiness is essential for self-acceptance, means that experiencing a sense of self-acceptance becomes temporary at best and at worst, impossible. We

see here how social norms around acceptable health behaviours are internalised and then experienced as originating from within the self. External judgement is unnecessary as the subject disciplines herself and regulates her own behaviour by evaluating herself and experiencing emotional distress if her behaviours are not in accordance with accepted ideals.

Just right

In opposition to these two undesirable health extremes, participants constructed an ideal healthy subject situated between these. To access this ideally healthy subject position, participants were required to adopt technologies of the self to successfully resist the pressure to be ‘perfectly’ healthy and the temptation to become too lax with one’s health enhancing practices. In the following interaction, Maggie illustrates how she strikes the balance between the healthy and unhealthy extremes. She expresses a disapproval of an obsessive attitude towards health and favours one which is more light-hearted and carefree. However, she also suggests that a failure to live up to health standards does need to be addressed and corrected.

Maggie: I think, well, in my group of friends we eat healthy, and we’ll have the occasional cake and cupcake ... which is great and that’s good ‘cause you can’t ‘live’. But then there are the other friends who, when they eat something bad then they, “Oh I shouldn’t have eaten that, I feel bad, I feel guilty, it’s bad for my body” you know like that kind of thing. I have one friend...who because she’s eaten like that meal or that bad meal she won’t eat anything after that for the whole day or so. Really bad to skip meals at all in my opinion. I have others who are like “ah I shouldn’t have eaten that oh well” (laughs) you know what I mean? That’s like the one friend that I have.

Interviewer: Like the damage is done?

Maggie: Exactly. Well not so ‘wow’ but like it’s already done so it’s in the past - exactly. So I’m not like, going to starve myself for the next four hours because of this one cheat you know. I’ll go to gym tomorrow and try work it off - it’s kind of like a balance.

In the beginning of this interaction Maggie describes eating something like a cupcake which is generally not considered a health promoting food as ‘great’ and ‘good’ because enjoying food like that is part of ‘living’. This suggests that too intense a focus on healthiness and perfect health rule following, is not ideal as it is restrictive and boring. She also resists the interviewer’s conceptualisation of eating a cake or cupcake as ‘damage’ thereby carefully avoiding the condemnation of occasionally indulging in so-called unhealthy foods. She then also critiques the corrective behaviour of her friend who ‘skips meals’ if she has eaten something ‘unhealthy’ as she argues that such behaviour is ‘very bad’. So it seems that unhealthy behaviours when engaged in for the sake of ‘living’ and enjoyment are acceptable, but when they are engaged in as a response to feelings of guilt they become unhealthy.

Despite Maggie's criticism of obsessive corrective health behaviours in response to simply enjoying oneself, she does describe a behaviour like eating a cupcake as a 'cheat'. This is a very common term used in diet culture and illustrates the negative connotation given to the consumption of 'unhealthy', especially high calorie, foods which could lead to weight gain. The word cheat also suggests a purposefulness in relation to this behaviour. In this context, eating a cupcake is not a momentary lapse in self-discipline or a failure to comply with health standards. Instead it is a choice to 'live'. We see here how discourses legitimating the value of self-control are upheld even within 'health as balance' discourses despite participants' intentions to resist the restrictiveness of these discourses. She then goes on to say that she would not do anything as radical and unhealthy as 'starve myself' as a result of the consumption of the illicit food, but she would need to go to the gym the next day and 'work it off'. So although she describes the incident of eating the cupcake as 'in the past' it stays with her for at least a day until she has corrected for and undone her 'cheat'. Through the 'health as moderation' discourse, certain practices are constructed as enabling the production of an ideally healthy, balanced self. In this example these technologies of the self involve a limited and controlled indulgence in behaviours which would generally be categorised as 'unhealthy' while also displaying the ability to engage in health enhancing practices such as exercising and limiting 'negative' emotional reactions such as anxiety or guilt. Through the use of these discourses Maggie can construct for herself a subject position of managed contradictions: the free, happy, self-confident self who can enjoy her life without restriction; the self-controlled, disciplined self who makes rational choices and takes responsibility for her decisions; and the emotionally restrained self, who will not overreact to a small mistake but will instead behave calmly and reasonably. However, as a result of these competing discourses, a situation arises where one is prohibited from reacting emotionally to the experience of living with tremendous pressure to become a self who embodies seemingly inconsistent traits.

The following section explores an alternate way in which the notion of balance was used to structure understandings of health.

Health as holistic

This discourse constructs healthiness as carefully maintaining a balance between all the facets of one's life. Here it was emphasised that physical health should not be prioritized at the expense of mental health and that it is important to make an effort to maintain one's wellbeing more broadly, rather than focusing exclusively on one component of health.

Adele: Health means your overall wellbeing... not just your physical...I think to be healthy is a holistic thing so you can be physically healthy but it doesn't mean that you're mentally or spiritually healthy... So it's a daily process I think, keeping yourself healthy.

Participants' phrases such as: 'health is a balance in your approach to nutrition and exercise as well as emotional aspects in your life', 'Health means your overall

wellbeing not just your physical but also possibly your mental and spiritual' and 'it's a daily process' illustrate how all aspects of one's life should be carefully, constantly and 'holistically' managed to ensure a balance is achieved. When viewed this way, discourses of balance become a different manifestation of discourses that promote self-control. These discourses insist that the individual is exclusively responsible for monitoring their body and their behaviour and effectively disciplining themselves to ensure that they are abiding by the requirements expected of 'healthy citizens'. This, and the idea that it is necessary to maintain perfect self-control in order to be healthy, was often exactly what participants were challenging when drawing on 'health as balance' discourses. However, the powerful moral value of discourses valorising self-control, made it difficult for participants to completely reject these notions. Within 'health as holistic' discourses, we see their more subtle reproduction. Some of the difficulties experienced as a result of this internalisation of the responsibility for health within 'health as holistic' discourses are discussed below.

George: Well hectic schedules for starters like uh being a student and all. Like for instance, there's this...assignment that I have to do...and I also have to write a review... and I also have to study a reading for an assignment tomorrow, and study for a test, and I have to do this [place] thing as well. So that'll take up most of my day so I have to do most of what I'd do now in the night. So ja you can imagine that and trying to squeeze it all in between eating healthy and exercising and having a meaningful conversation with a classmate or a friend or a call. So ja it's trying to find a balance... ja, I think that's what makes it difficult, that's the difficult part, balancing things out.

Many of the participants made use of 'health as balance' discourses to invoke a sense of flexibility and ease. In the above quote, however, we see the participant struggling with the dedication and commitment required to live a balanced, healthy lifestyle. In this way trying to achieve a balance between all the necessary aspects of health, in line with 'health as holistic' discourses may lead to stress and anxiety. However, stress is often considered harmful to health, as shown by Amelia's quote below, and is yet another thing that should be managed in order to achieve balance.

Amelia: I think stress is very unhealthy, it upsets your balance a lot.

If the pursuit of a balanced, healthy lifestyle is experienced as difficult and sometimes stressful then an inescapable cycle of 'anxiety and control' (Crawford 2006) is likely to occur. The responsibility for ideal health is internalized and when this becomes challenging or impossible, a sense of anxiety may result. Because stress is viewed as a threat to one's health the responsibility for managing this is also internalized and so the cycle continues.

Adele: I'm not very good at it actually [managing stress], but I would say that probably exercising is the best way for me to control it, and just maybe socialising with friends, getting out of certain environments that maybe are stressful.

In the above quote we see Adele internalising the responsibility for managing her stress through techniques of discipline, for example, 'exercising'. However,

Adele also says that, ‘exercise is important but sometimes that creates more stress because you creating time to go to the gym that you don’t have ...’. This illustrates the cycle of ‘anxiety and control’ which Crawford (2006) predicts: the pressure placed on individuals to live a holistically, healthy life and how unattainable this goal has become. In other words, through participants’ attempts to resist and dismantle the unrealistic ideal of perfect healthiness, balance has been elevated to an ideal that appears to be equally unattainable.

Discussion

Balance was one of the most frequently referred to ideas across all of the interviews. Balance was seen both as an ideal to aspire towards, and itself a signifier of health. John Stuart Mill’s (1834 as cited in Phillips, 2011) states that, ‘there seems to be something singularly captivating in the word balance, as if, because anything is called a balance, it must, for that reason, be necessarily good’. Phillips (2011) discusses the idealisation of balance and how the notion of balance is used in a range of contexts to reassuringly refer to someone or something, creating a sense of order. Being, having or using balance, according to Phillips (2011), is almost always used to denote a positive state. One notable exception he cites is in art, where balance is not uncritically desired. The moral security of balance may be related to the kind of political and social views which are seen to be unbalanced—often the ‘isms’ (fascism, sexism, racism, etc.). The notion of balance Phillips (2011) describes, which is most relevant to the current research, is the understanding of balance as the avoidance of excess. Also relevant is the often mutual exclusivity of balance and passion. Phillips (2011) notes how challenging it is to maintain a sense of balance in relation to the things we really care about. The participants in this research constantly reiterated the importance and value of health while insisting that the avenue through which one should achieve a healthy ideal, was by ensuring one’s approach was always balanced. The effect of this tension between passion and balance meant that participants needed to ensure that their emotional reactions were always carefully managed. There were certain emotions which were discursively constructed as undesirable and to be avoided, especially anxiety, stress, guilt or shame. This reluctance to express these kinds of ‘negative’ emotions may be related to the challenge of maintaining a balanced approach to health when one is experiencing strong emotions. This is illustrated by the growing prevalence of ‘keep calm’ culture where individuals are expected to moderate their emotions and avoid panic, anger and stress for the sake of their health. This is associated with the popularity of mindfulness and meditation practices and applications aimed at assisting individuals with managing their stress (Cederström & Spicer 2015).

Gill and Orgad’s (2015) conceptualisation of ‘confidence cult(ure)’ is also relevant to this discussion. They argue that, in a post-feminist context, insecurity is seen to be ‘problematic, indeed toxic’ (Gill & Orgad 2015, p. 330) and a lack of self-confidence has come to be viewed as unattractive. Expressing emotions that indicate some sort of dissatisfaction with oneself (e.g. guilt or shame) may be interpreted as a kind of insecurity or lack of confidence in oneself. According to Gill and Orgad

(2015), individuals (particularly women) are now expected to take responsibility for their self-esteem and, at the very least, act confident at all times if they want to be worthy of love and success. 'Health as balance' discourses function to reinforce this idealisation of emotional restraint and perpetuate confidence culture by constructing emotions like guilt and shame as unhealthy.

In addition to the emotions mentioned above, participants also needed to avoid too much enthusiasm or zeal in relation to pursuing health improvement. This temperance of emotions may be related to dominant gender norms. While both men and women in the study appeared to be attempting to reduce any strong emotional expressions about their experiences of trying to stay healthy, the gendered norms which align with this tendency are different, and this specific kind of emotional temperance did seem slightly more prevalent among the men in the study. Men are prohibited from expressing too much enthusiasm or investment in the pursuit of health ideals, as this would contradict acceptable notions of masculinity linked to stoicism and emotional restraint (Norman 2011; Robertson 2006) as well as the social pressure to be 'risk takers' (Robertson 2006). Women on the other hand may attempt to distance themselves from historical critiques of femininity as overly emotional, too sensitive and caring too much (Barret and Bliss-Moreau 2009) to access socially preferred feminine identities. Within *d* discourses, this careful emotional regulation functioned both as a technique of discipline (allowing for the avoidance of the negative consequences of a subject who is guilty, anxious and insecure) and a technology of the self (producing a calm, laid-back, socially engaged subject). Through this discourse, individuals could abide by the socially necessitated pursuit of health without compromising their personality ideals and also ensuring that they complied with socially rewarded gender norms. We also see the interaction and mutual reinforcement of health and gender discourses: the 'health as moderation' discourse functions here to reproduce dominant gender ideals.

While engaging in this kind of active self-management of one's emotional reactions appeared, on the surface, to serve the participants by ensuring that they could enact socially approved subject positions, politically this may be problematic. If strong feelings are repressed and silenced through the constant self-management of emotions, resistance to oppressive discourses is made much more difficult and the status quo is allowed to persist.

The discourses discussed in the results section (particularly 'health as moderation') highlighted the importance of carefully moderating one's behaviours in order to avoid either of the undesirable health extremes. Cairns and Johnston's (2015) concept of 'calibration' may be useful when trying to understand the way 'health as balance' discourses are experienced. They make use of this term when discussing middle class women's relationships to food and define it as, 'a practice wherein women actively manage their relationship to the extremes of self-control and consumer indulgence in an effort to perform acceptable middle-class femininities' (p. 154). Individuals made sure to carefully 'position themselves as conscientious, but not fanatical' (Cairns & Johnston 2015 p. 157) to avoid being pathologised as 'health-obsessed' but also to avoid the opposite extreme of overindulgent or abject. The desire to distance oneself from the 'health fanatic' categorisation is especially relevant to the current study. According to Cairns and Johnson (2015) the

'health-fanatic' is associated with 'overly perfect' (p. 157) performances of healthy femininity, the feminine subject who 'is too informed, and too controlling in her eating habits' (Cairns & Johnston 2015 p. 157). The careful management of identity required to avoid the two extremes, illustrates the sharp borders of acceptable performances of health and demonstrates the connection between discourse and subjectivity (Cairns & Johnston 2015).

Although Cairn's and Johnson's paper focuses on middle-class femininities in a Western context, in this study 'health as balance' discourses were used in a similar way by both men and women from varying income backgrounds and in relation to both food and exercise. This notion of 'calibration' could still be applicable here and may illustrate the increasing reach of discourses which require a constant policing and moderating of behaviours and subjectivities. Although men and women, as well as those from different income groups, seemed to be calibrating their relationship to health, this kind of calibrating may perform different social functions for those located in different economic contexts or exposed to divergent gendered norms. 'Health as balance' discourses allowed for the alternate problematising and legitimating of discourses which require individuals to maintain perfect self-control. They enabled the participants to avoid some of the negative aspects of discourses which promote perfect self-control (the constitution of the self as an obsessive 'health-fanatic') while still allowed access to some of the moralized benefits thereof (the constitution of the self as a responsible citizen who is able to thoughtfully take responsibility for and manage one's health). While this appears to be benefiting participants by facilitating the constitution of favourable subject positions, it also individualises the responsibility for health and upholds broader neoliberal discourses that obscure the social and structural determinants impacting on peoples' health. By concentrating the focus of health promotion on these exclusively individual activities, oppressive social structures go largely unquestioned and uncriticised. In addition, the construction of these desirable and undesirable ways of being healthy resulted in the moralisation of health and being 'insufficiently healthy', or failing to exhibit an 'appropriate' emotional orientation towards health, was constructed as morally problematic. This perspective legitimates a culture of victim-blaming where individuals who are not sufficiently healthy, as well as those who are emotionally distressed as a result of the pressure to maintain their health, are constructed as personally responsible for their difficulties. Individualising and moralising health serve political functions in that they legitimate a reduction in welfare provisions and obscure the need to address the social determinants (e.g. race, class, access to healthy environments or healthcare services) of health. If individuals are personally responsible for their health, there is little incentive for costly welfare programmes or attempts to improve access to resources or address inequities. If health is moralised, then adherence to idealised health behaviours does not need to be externally policed (or supported) as individuals internalise the responsibility to discipline themselves (Foucault 1977).

Lastly, the 'health as holistic' discourse serves to construct a health ideal which requires the individual to successfully manage all aspects of one's life to ensure that they are all serving the goal of health. At previous points in history, holism encompassed a broader sense of connectedness and unity between individuals,

communities and the environment (Shroff 2011). The more prevalent modern use of the word may have come about in opposition to more isolated, medicalized, treatment-focused approaches to health, which were sometimes deemed ineffective or even harmful. However, the neoliberal, individualized context in which the idea has recently become popular has shifted its focus from a tendency towards community and support, to a tool to encourage the permeation of internalized disciplinary techniques and self-adjustments through all aspects of an individual's life (Crawford 2006).

Conclusion

Discussions around health and balance were often closely linked to the idea of control with participants often using 'health as balance' discourses to alternately resist and affirm the demand for perfect self-control. By using 'health as balance' discourses, participants were able to construct a variety of sometimes ideally contradictory subject positions and to maintain a sense of self-esteem and social acceptability. These discourses are facilitated by ideologies of healthism, confidence culture and broader neoliberal discourses which include the idealisation of individual responsibility. 'Health as balance' discourses were often used to challenge the pressure to conform to unattainable standards of health behaviour, and to avoid negative emotions such as anxiety, stress, guilt and shame. However, they also functioned in ways that individualised the responsibility for health, moralised and depoliticised health and increased the requirements for attaining idealised 'healthy' identities. As a result, they worked to produce stress, limit emotional expression and silence dissent.

This study provides insight into how seemingly innocuous (or even positive or empowering) discourses can be used in ways which reproduce restrictive or oppressive ideologies. An awareness of, and critical reflection on, these kinds of adverse consequences and a sense of caution surrounding the use of behaviour change interventions which reinforce the individualisation and moralisation of health, is an important implication of this study for public health research and practice. This is particularly important in a South African context which is highly unequal and where health inequities are attributable to a range of social and structural determinants. Individualising and moralising health in this context, and obscuring the importance of these other significant factors, undermines efforts to achieve health equity and perpetuates injustice by fostering a culture of victim-blaming and individualism. In addition, acknowledging the importance of the meanings attached to health, and the consequences these have for identity, experience and action, may be helpful for those attempting to promote health or provide the public with educational health resources, or in the development of health-related policies.

This study was limited in that the sample was small, mostly middle-class and healthy.¹ Focusing on participants who described themselves as healthy at the time of the interview likely had important implications for the ways in which they constructed health and illness. Future research exploring how these kinds of health discourses are taken up by those from rural areas or those who are living with a chronic illness, mental illness or disability would provide a more in-depth understanding of how these discourses function and how those in more vulnerable positions are affected by their prominence.

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Declarations

Conflict of interest The authors declare that they have no conflict of interest.

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¹ While this study was based on discussions with a disproportionate number of white participants, participants who identified as being from other race groups, and who were from lower income communities, also drew on balance discourses, as evidenced in the excerpts provided. While it could be expected that those from lower-income settings may talk about the ways in which they are disadvantaged when it comes to health, this was not usually the case in this study. Blaxter (1997) proposes that the lack of discussion around social inequalities in lay health discourse may be partly because asking people to talk about their health status is asking them to talk about their social identity and 'it is unreasonable to expect people to devalue that identity by labelling their own "inequality"' (p. 747).

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