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ARTICLE

The Gap Between Knowing and Doing: How Canadians Understand Physical Activity as a Health Risk Management Strategy

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In Canada, as in other neo-liberal states, a physically active lifestyle is discursively constructed as a moral activity, whereas a sedentary lifestyle is criticized as a failure to take charge of one's health (Bercovitz, 2000; Lupton, 1997). This study aims to understand how Canadian men and women articulate the discursive connections between physical activity and health risks and how those connections are reflected in their reported behaviors. Analysis shows that some of the 37 men and 36 women interviewed not only "talk the talk" regarding physical activity, they also claim to lead an active lifestyle. However, "active" participants were disciplined into frequent physical activity not simply by the discursive effects of the fitness mantra promising better health, but because they enjoyed it. Conversely, the not-active-enough participants were unwilling to fully comply with the requirements of the fitness discourses because they found no pleasure in "exercise." Despite adopting physical activity as a key strategy to manage their health risks, interviews revealed that the latter group were not docile bodies (Foucault, 1995).

Au Canada, comme dans d'autres états néolibéraux, l'activité physique est discursivement construite en tant qu'activité morale et la sédentarité est vue comme un échec en termes de prise en charge de sa santé (Bercovitz, 2000 ; Lupton, 1997). Cette étude visait à découvrir la façon dont les connexions discursives entre l'activité physique et les risques sanitaires sont articulées par des Canadiens et des Canadiennes ainsi que la façon dont ces liens se reflètent dans leurs comportements. L'analyse permet de voir que certains des 37 hommes et 36 femmes interrogés ne font pas que « parler d'activité physique » mais disent aussi mener une vie active.

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> Les participants « actifs » étaient disciplinés et faisaient régulièrement de l'activité physique non seulement à cause des effets discursifs du mantra de la condition physique qui promet une meilleure santé, mais parce qu'ils y prenaient plaisir. A l'inverse, les participants « pas suffisamment actifs » n'étaient pas disposés à se conformer pleinement aux exigences des discours de condition physique parce qu'ils ne trouvaient aucun plaisir à faire de « l'exercice ». Malgré l'adoption de l'activité physique comme stratégie-clé pour la gestion des risques pour la santé, les entrevues ont révélé que les personnes du groupe sédentaire n'étaient pas des « corps dociles » (Foucault, 1995).

Physical activity is promoted by the World Health Organization (WHO, 2010, 2011a) and the Public Health Agency of Canada (PHAC, 2010) as an important part of a healthy lifestyle. These influential organizations advocate for increased levels of physical activity to achieve or maintain an ideal body weight, especially in light of the current perceived "obesity epidemic" (Gard & Wright, 2005). In fact, regular physical activity is considered a key strategy in preventing chronic diseases such as cardiovascular disease, stroke and type-2 diabetes as well as reducing the risk of certain cancers and osteoporosis, increasing job satisfaction and alleviating depression and stress (PHAC, 2010; WHO, 2011a, 2011b, 2011c). In these expert discursive fragments, physical activity becomes medicalized and is prescribed to Canadians in an effort to promote a culture where individuals are responsible for their well-being (PHAC and CSEP, 1998b; PHAC 2010).

In Canada, as in other neo-liberal states, a physically active lifestyle is discursively constructed as a moral activity, whereas a sedentary lifestyle is criticized and viewed as a failure to take charge of one's health (Bercovitz, 1998, 2000; Lupton, 1997). While physical activity and health risk discourses target all Canadians, sedentary citizens become "risk objects that require care" (Thing, 2008: 199), while physically active Canadians are valued as productive citizens who conform to expected health conduct. "People who are physically active live longer, healthier lives. Active people are more productive and more likely to avoid illness and injury" (PHAC, 2010). Such institutional discourses constructing physical activity as a strategy to maximize one's physical and psychological capacity draw heavily on scientific knowledge, namely, health and exercise sciences, and reflect as well as produce the current sociocultural context that emphasizes the desirability of the fit body (Pronger, 2002). These public policy discourses not only influence how individuals appreciate their level of physical activity as something they must improve or maintain to be healthy (Thing, 2008), they also have behavioral effects made visible by the enactment of self-regulating practices seen among "fit" Canadians. Foucault (2003) termed this system of power employed by the state but deployed through institutionalized expert discourses, by which such individualized self-management practices occur, as governmentality. In this modern strategy of social control, scientific knowledge circulating in the above normalizing discourses translates into instructions exhorting individuals to be physically active, and into norms for performing advised health practices (Lupton, 1999a). As such, individuals are constructed as free subjects who, through their self-improvement efforts, contribute to their own surveillance. Thus, the government of the entire population works through self-regulation where the end goal—the protection and enhanced productivity of the population—is achieved through totalizing technologies of

power-reinforcing discourses about health, risk and physical activity, as well as through technologies of the self, whereby individuals problematize their behavior and voluntarily comply with the norms, values and actions exhorted through these discourses (Foucault, 1988, 2003; Lupton, 1999a). Physical activity—when done to improve health—is such a practice of the self, whereby the individual constructs himself or herself as self-regulating and is able to work toward achieving the ideal body (Lupton, 1997: 143). In this way, governments are not directly involved in managing the behavior of individuals, but rather in reinforcing the discourses of self-regulation as good citizenship (Smith Maguire, 2002).

Health risks in general are similarly discursively, constructed as a strategy to govern or manage populations. Statistics are produced as evidence of the likelihood of mortality and morbidity related to particular practices. Citizens are monitored through the surveillance systems of screening programs which observe, measure and normalize individuals. This process creates groups ranked by their susceptibility to risk (Lupton, 1999a), such as obese versus healthy and active versus sedentary. Members of groups considered to be most at risk are expected to engage in the ethical work necessary to decrease their probability of disease or health problems, while members of groups considered not at risk/healthy are expected to work at maintaining this status. As a result of these expectations, risk, fear and guilt become an ever-present enemy one must constantly be aware of and take measures to avoid.

Physical activity is one such method promoted as an effective means of managing health risks and, therefore, of controlling citizens' bodies. In addition, a lack of physical activity is constructed as a risk factor in itself (e.g., WHO, 2009; WHO, 2011a, 2011c); inactivity must therefore be avoided at all costs if one is to continue contributing to the productivity of the population. This dual construction (physical activity as a risk-management strategy and physical inactivity as a risk factor), deployed through current health risk discourses, can be effective as a technology of power as long as it convinces Canadians to adhere to normative health behaviors, that is, to increase their level of physical activity.[1] The purpose of this study was to uncover how these discursive connections between physical activity and health risks are articulated by Canadian men and women and how those connections are reflected in their reported behaviors. While scholars have analyzed the institutional expert discourses linking physical activity to health risks (see for instance Pronger, 2002; Gard & Wright, 2005; Bercovitz, 1998, 2000; MacNeill, 1999; Wheatly, 2006), few studies have explored how individuals (or laypeople) make sense of these discourses (Monaghan, 2008; Wheatly, 2006; Wright, O'Flynn & Macdonald, 2006). Yet it is important to understand not only how institutional and expert health risk discourses are deployed, but also how they succeed and concurrently fail in normalizing individuals. Indeed, Foucault (1976, 1980) explains that power is coupled with resistance and that where there is power, there are multiple points of resistance. Discursive power presumes a free subject who can take up or challenge the expert knowledge put forth in physical activity and health risk discourses. It can thus be said that individual Canadians are "faced with a field of possibilities in which several ways of behaving, several reactions and diverse comportments may be realized" (Foucault, 1983, p. 221). The following analysis focuses on how Canadian men and women reproduce physical activity and health risk discourses. Do they conceive of physical activity as a health practice? Are they engaged in the prescribed fitness practices or do they resist the call to activity?

Methods

How Canadians make sense of physical activity was analyzed with reference to a larger study[2] examining Canadians' perceptions of health risks. For this project, advertisements inviting adults to participate in interviews about "health risk perception and risk acceptability" were placed in the local newspapers of a selection of towns and cities in four large regions across Canada: West Coast—British Columbia; Prairies—Alberta; Central—Ontario and Quebec; Atlantic—Nova Scotia. In areas where an insufficient number of adults responded to these newspaper advertisements, more participants were recruited in collaboration with local health agencies (i.e., rural health associations, a women's health center) or community organizations such as a safe community coalition and a community center serving marginalized urban populations. In total, 73 adults from each of these regions took part in 11 semistructured individual interviews and 10 group interviews. At the start of each interview, participants were asked to answer a short-answer questionnaire to collect sociodemographic information. These quantitative data reveal that participants represented varying characteristics across age (30–65 years old, except for one participant over 65 years of age), language (14 interviews conducted in English and 7 in French), gender (37 men and 36 women), ethnocultural background (including Canadian, Acadian, French, English, German, Irish, Scottish, Polish, Metis, Chinese and more) and urbanization (13 interviews conducted in urban areas and 8 in rural areas). However, the men and women who answered the invitation to participate in this interview study had a relatively high level of education compared with the Canadian population in general, with the largest proportion of all participants (about half of the women and 43.2% of the men) holding an undergraduate university degree. In total, 79.5% of all interview participants had the equivalent of college or university education compared with 50% of Canadian adults 25–64 years old (Statistics Canada, 2011). Similarly, many of the participants declared a higher income than the Canadian average. In fact, about two-thirds of the women reported earning an income over $40,000 compared with the average income of Canadian women in 2008 of $30,000 (Statistics Canada, 2010). In contrast, the earnings of male participants were more evenly spread and closer to the 2008 average total income of Canadian men ($47,000; Statistics Canada, 2010), with approximately one-fifth of them in each of the following income brackets: under $19,999; $20,000 to $39,000; $40,000 to $59,999; and $60,000 to $79,999. One man reported earning between $80,000 and $99,999 while three others did not answer this question.

Notwithstanding our efforts to attract a variety of participants, this form of qualitative inquiry does not aim to generalize conclusions from a representative sample of the population. While the participants in this study represent diverse characteristics, many of the adults who volunteered for this study were drawn from what could be loosely defined as the Canadian middle class. Yet our results should not be interpreted as typical of one social class. The following analysis should be construed in light of these constraints.[3] The recruitment process specified that participants would be asked to discuss how they perceived health risks in conversations with a university professor conducting a research project for Health Canada. Adult men and women were thus presumably taking on subject positions in health risk

discourses as they took part in this study (Gubrium & Holstein, 2002). Furthermore, they were seemingly willing to share their thoughts with a research "expert" and with the federal agency responsible for the health of Canadians. We engaged with them as subjects who could knowledgeably discuss risks to their personal health. It should be emphasized that while this particular paper focuses on physical activity, participants were not specifically recruited to discuss physical activity as a health practice. In this analysis, we explore how, in the context of broader discussions about health risks, interview participants voiced the governmental physical activity and health discursive fragments identified above (Gubrium & Holstein, 2002). We also uncover the emerging forms of resistance to these normalizing discourses.

Interview groups consisted entirely of men or entirely of women. Individual conversations lasted approximately 45 min while group discussions were about two hours in length. All interviews elicited the participants' ideas about a) what constitutes a health risk, b) what made health risks acceptable or unacceptable, c) which health risks were of most concern for their own health, d) what and how decisions were made regarding those health risks and e) perceptions about six risk exemplars: carcinogens, terrorism, cellular phones, climate change, motor vehicles and recreational physical activity. It is important to note that a priori definitions of "health risk" and "physical activity" were not used to frame questions about health management practices or steer the investigation. Participants were asked to provide their own definitions and examples of these two constructs. All excerpts throughout the audio recorded interviews pertaining to physical activity were selected as the focus of this analysis. While recreational physical activity was included as a risk exemplar discussed at the end of the interviews to understand whether participants associated health risks with leisure forms of physical activity, most of the results that follow were drawn from the participants' spontaneous[4] explanations of how they deal with the health risks that most worry them. Consequently, they were not responding to specific questions related to whether they are physically active.

The goal of this paper was to uncover the meanings expressed by the participants to understand how they make sense of physical activity in discussions about health risks. Foucault's notion of discourse was used to understand how the participants in this study understood truths about physical activity and health risks (Foucault, 1995, 2005). Discourses are collections of statements that produce truths about a particular subject and direct social practices. Through discourse we understand what constitutes physical activity, what health risks we should be concerned with, and how physical activity can be a means to avoid those risks. However, individuals may reproduce—verbally or behaviorally—alternative discourses (Foucault, 1976, 1983). In this study, we engage with Foucault's work on discourse and governmentality, while following our own path, informed by the work of others (e.g., Lupton, 1997, 1999b; Lupton & Tulloch, 2002; McCuaig & Tinning, 2010). Analyses of risk discourses "reveal the shifting meanings around risk phenomena and the struggles over these meanings" (Lupton, 1999a: 15). We do not claim that what we produce here constitutes the definitive truth about the discourses reproduced by these participants. Instead, we offer a grounded interpretation of their narratives stemming from familiarity with the interviews and transcripts[5] as well as a commitment to reflexivity.

"Talking and Walking the Talk": Physical Activity To Manage Health Risks

We asked participants what risks most concerned them for their own health and how they deal with them. Their answers show that they were acutely aware of, and could articulate, the various dangers to which they believed they were exposed. Not surprisingly, obesity, cancer, diabetes, high cholesterol, heart disease/attack and stroke were mentioned as the health risks participants worried about the most in nearly all interviews. These discussions revealed that physical activity was used as a key strategy for minimizing these health risks. Men and women participated in a variety of sports and physical activities to prevent potential health problems, such as this Ontario woman, worried about the risk of stroke:

> I exercise whenever I can. I'm an active person so I don't like the concept of not being able to do activities. So whenever I get the chance I'll walk, I'll rollerblade, I'll go rock climbing; do anything just to keep myself busy (Penny,[6] Ontario woman).

For some interviewees, like the above participant, adopting an active lifestyle was not narrowly motivated by health concerns, but also by a variety of other factors including enjoyment and quality of life. Other men and women, however, radically changed their lifestyle after a health scare or a change in health status, as illustrated by the following excerpt:

> So when I was 32, (...) I had been having problems, abdominal pains and I ended up with a duodenal ulcer and [the doctor] said, "The next thing is a heart attack, unless you slow down, unless you change your diet and unless you do dah, dah, (...)." So I immediately thought "Holy smokes! I've got an ulcer. I could have a heart attack? I've got to slow down." (. . .) I got into an exercise regime and I've never really totally changed that too much. I still exercise three or four times a week, eat well. My weight's never changed, ten or 15 pounds. (. . .) I'm only 63 now. I feel like I'm in pretty good shape. I work out religiously. Yes, I go to the gym, but I rollerblade. I bike, I hike, I swim. I should get back into tennis, but I've played sports, (. . .) and I've done so many things, martial arts for seven years. It's a way of life (Stewart, British Columbia man).

Regardless of the risk identified, engaging in physical activity was, after diet, the second most frequent behavioral change interviewees reported adopting to manage their health risks. They joined a fitness club or took on swimming, jogging, walking, aerobics, cycling, outdoor activities or other sports. Interestingly, becoming "out of shape" and "running out of stamina" was even identified as the health risk that most concerned one Alberta woman. But she was the only participant that explicitly focused on physical inactivity as her most pressing health worry. The significance of physical activity in our participants' management of their perceived health risks makes sense in a context where physical activity is constructed as a risk and stress management strategy and where physical inactivity is listed in PHAC and CSEP

(1998a, 1998b) and WHO (2009, 2011a) publications as a risk factor in itself. In fact, the role of physical inactivity and obesity as risk factors for cardiovascular disease, diabetes and cancer has emerged as prominent discursive fragments in the Canadian media (Higgins, Naylor, Berry, O'Connor & McLean, 2006). Furthermore, obesity is now discursively constructed as a disease itself, requiring investigation, measurement and prevention (Gard & Wright, 2005; Wheatley, 2006). Predictably, the impact of physical inactivity with regards to weight concerns was clearly and frequently articulated during interviews:

> It's very much a concern to me because [of] my weight. I could stand to lose a good 30 pounds and a lot of it is to do with whether or not I'm active and that. I mean diet is a concern as well, but if I can very carefully watch what I eat and what I don't eat, but if I'm not keeping active and enjoying myself and… (John, Alberta man).

Participants reinforced such discursive constructions and characterized inactivity as a primary cause of health risks such as cancer, stroke, diabetes and heart disease/attack. By engaging in regular physical activity—even something as simple as walking the dog—they believed they could reduce the probability of the identified health risk they were most concerned about. They were aware, however, that engaging in physical activity would not eliminate health risks and they often cited family history and genetics as well as previous lifestyle habits as additional causes of the health risks identified.

The idea that physical activity is a tool to improve well-being was never once questioned by the participants during the interviews—they all stated it as fact. Information about the health benefits of physical activity came from health professionals, news media, information packages from health services and the Internet. The participants acknowledged the expertise of health professionals and further explained that the media provided additional access to this know-how. Expertise is essential to risk management within the context of governmentality; it enables the exercise of power that helps produce self-regulating citizens by providing credibility in the form of scientific knowledge. Although the presumption of scientific knowledge does not guarantee an unquestioned acceptance of the health professionals' prescriptions for behavior (Nettleton, 1997), the participants in this study did not mention any misgivings about the credibility of the experts or their pronouncements, except with regard to some Internet sources. In fact, interviewees revealed that health professionals played a significant role in convincing them to engage in physical activity by reinforcing normative health risk discourses. For many participants, like the British Columbia man quoted earlier and the following Nova Scotia woman, exercise was prescribed by a health professional:

> [I walk to] try to maintain my weight and to feel better. It feels like it gives me energy to walk. It brings me adrenaline in the system. I had a pinched nerve in the neck about three years ago and the physiotherapist told me: "Walk. It will warm up your muscles and you will see, you will feel better." So I walked, I walked and I have never stopped. And I encourage myself every day. (Monique, Nova Scotia woman, translation).

While men and women alluded to the importance of being physically active to be fit and strong, only women explicitly identified the need to be physically active as a means to prevent the loss of independence—particularly with respect to the diminished physical ability associated with aging (Alberta, Ontario, Nova Scotia and Quebec Women). They linked it to the loss of dignity, clearly implying an undesirable future identity.

> We assume our responsibilities and all that together, well, we feel better (...) So I do a lot of exercise, I walk a lot, I ride my bike, I swim because I'm a country girl. (...) And I consider myself lucky because I am 57 years old and I feel good. I feel healthy. (...) Life is beautiful. That is why my phobia is of becoming dependant. If I can no longer walk at some point, or if I can't… if I no longer have any brains… communication… Unplug me (Agathe, Quebec Woman, translation).

This was a clearly a shared sentiment: "And to be dependent on somebody else for all my physical needs, I'd rather walk out and be hit by a truck" (Penny, Ontario woman); "I would rather die than have to live like that" (Sandy, Nova Scotia woman). As in Pike's (2011a) study of British women, the women we interviewed evidently believed that being active was helpful in avoiding this particular subjectivity, i.e., of an incapacitated senior.

In looking to the future, however, both men and women spoke about physical activity as a proactive measure. Many believed that advancing age brought additional health risks, such as arthritis, Alzheimer's disease and mobility impairments. Remaining or becoming active was their attempt at slowing the aging process and minimizing the attendant risks. In addition, increasing their levels of physical activity now was expected to make it easier for them to maintain an active lifestyle as they age. But the aging process also demands taking care in one's physical activity choices and performance. For instance, one woman talked about how she decided she needed to change sports to something presumably safer as she was moving to another stage in her life: "And I have changed my exercises. It's not that I exercise more but I'm exercising different. More age appropriately. And I have cut down some of my high risks sports [i.e. skydiving] to more age appropriate sports" (Suzan, Alberta woman). She believed this was an effective way to manage the risks of aging and living alone, which also related to her psychological well-being. This mitigation of risk due to aging also emerged in the conversation with a retired high school teacher who explained his need to be careful when working out on the treadmill and doing weights now that he is older. Our participants' perceptions about aging, physical activity and health risks speak to the governmental and media discourses regarding healthy aging, as well as those directed at autonomy. In fact, Rudman (2005) found that a selection of Canadian newspaper articles between 1999 and 2000 created four subjectivities for retired Canadians. While all four subjectivities describe retirees as having an active lifestyle, the "prudential" subjectivity appears to be the closest model that our interviewees reproduce in describing themselves as individuals who reduce risks and have a low probability of disability and dependency (Rudman, 2005). Such discourses, like those enunciated by Canadian and European government and institutional agencies, dictate that aging men and women are responsible for preventing the body's decline and for maintaining youthfulness

through physical fitness (Pike, 2011b; Pronger, 2002). Katz even suggests that "most gerontological and policy discourses pose activity as the 'positive' against which the 'negative' forces of dependency, illness, and loneliness are arrayed" (2000: 147).

While not all participants discussed the role of physical activity in relation to aging, the men and women interviewed for this study discussed physical activity as a vehicle to well-being and often associated it with healthy eating and lifestyle choices, such as reducing or eliminating tobacco or alcohol consumption. Indeed, physical activity was consistently described by our participants as a preventive strategy or an intervention technique:

> At one point, I became aware that it is important and that the body is like a vehicle. It is the only one we have and if we take good care of it, we will do more mileage with it. I had the chance to understand this when I was young and to have always applied those tricks and I've never been to the hospital in my life, I have never been sick, I've never had anything. (…) I don't smoke, I don't drink, I exercise three or four times a week. I eat well. I've made it simple. It has become a habit. (Armand, Quebec man, translation).

This participant's account is illustrative of interviewees' understanding of a direct link between physical activity and the reduction of health risks. The primary goals for engaging in physical activity among these men and women included improvements in physical, mental, aesthetic and social health. Indeed, losing weight and getting in good or better shape were commonly stated goals for improving physical health, along with lowering cholesterol and increasing energy levels. Mental health goals included reducing stress, feeling better, staying youthful and having fun. Participants kept active to fulfill an aesthetic element of good health as well; they wanted to *look* better.

Embodied Experiences of Health Benefits Confirm Expert Physical Activity Discourses

The association they repeatedly made between fitness and health is a truth not only reiterated in institutional health risk discourses that our participants merely reproduced as "docile" (Foucault, 1995) active citizens, but also a truth they reported experiencing, thus confirming, in their minds, the credibility of these normative discourses. Indeed, throughout our conversations, physically active participants sometimes associated their reasons for being active with the benefits they felt they gained from sport and exercise.

> And then one thing in that I always seemed to have something that kept me active and I noticed that when I was fit, I felt better than when I wasn't fit and it was no willpower or genius or spark of intuitive insight on my part. It was just that if I'm fit I feel better and I like feeling better. And I discovered that as I leave my 20s and 30s, it became more important (Mike, Ontario man).

They commonly described advantages that intersected with their stated reasons for engaging in physical activity such as losing weight, feeling better and stronger, improving or maintaining fitness, and increasing energy levels.

> Judy: After I had my third baby, I had some excess weight and it wouldn't go away. (...) So, to me it was important now to start rebuilding my metabolism or, you know, being more active to try and make it go away. And it sort of has.
>
> Q: Okay. So it was weight loss that mostly motivated you?
>
> Judy: Yes, that started the process, absolutely, yes.
>
> Q: And now what keeps you motivated in [walking the dog and taking up dancing and going swimming]?
>
> Judy: I find the more I do, the more active I am. So I'm less likely to sit around if I'm… If I go and do things and I want to keep going, I don't want to stop that momentum, so I keep, you know, I'll leave the house more and do stuff more with the kids and, you know, happier at work, I'm more active at work as opposed to more lethargic sitting around. [...] Yes, well it comes again to mental, I guess, but it makes me feel, yes it does make me feel better. It makes me feel happier or my perception of myself is that I'm a stronger person or that I'm a productive person because I keep being active and keep doing things (Judy, Alberta woman).

This excerpt is a rare example from our interviews showing how Canadians may assume that they become productive citizens through physical fitness as mentioned by PHAC (2010). This participant spontaneously and explicitly explained how being active allowed her to be a morally responsible citizen (Lupton, 1997) as opposed to "completely lazy" since it enhanced her output or performance, not only at work, but as a mother and as a person. While other men and women discussed physical activity as a strategy to maintain physical and mental health or strength to ensure autonomy, few so unequivocally outlined the need for such self-regulation to fulfill their role as productive citizens, thus adhering to the values promoted through governmentality (Foucault, 2003; Lupton, 1999a).

Another participant described how he became more conscious of the rewards of intense physical activity after he renounced tobacco and joined a group exercise program. Here, the physical health benefits are not only constructed and sensed as a result of the actual increase in the intensity of his workouts, but also as an effect of a greater lung capacity. In comparing his workouts at the local YMCA to his boot camp training sessions, he explains:

> I wasn't getting the kind of endorphin kickback that you get from doing the boot camp outdoors first thing in the morning. You know, drop and give me 20 [push ups] kind of experience. And then, from doing that I realized, "Oh, there's something to this because you really can feel…" (. . .) [B]ut there was something about the activities that you engage in, in a gym, that weren't as rewarding as what I discovered from the boot camp. (. . .) First of all, I felt more conditioned. My lungs were better. And it was the way that the experience was set up: it took place over 14 weeks or something like that. (. . .) So it was long enough so that you could see, you know. And one of the activities that we would engage in is that, at least once a week, we would run up this really unspeakably steep hill. And the first time, you just couldn't do it, you know. You'd get half way up there, it was like: "Okay I'm just going to chill

> here for a minute and walk the rest of the way." And then by the end of it, you could run up. I mean, still, you'd get out of breath and you're sweating, but you could run up more times (Paul, Nova Scotia man).

His account of the benefits derived from the high-intensity workout program also alludes to a sense of accomplishment from pushing oneself physically. Mental health benefits that other participants outlined also included decreasing stress.

> I found a way to manage my stress. It's with sport. I do a lot of sports. I really work on my fitness and I have integrated it in my way of life that, so many hours a day, I am doing sports. I work on my fitness. So that, I would say with diet and with stress, well sport, I get healthy but I also get lower stress levels because [sport] allows me to evacuate [stress] (Alex, Quebec man, translation).

This quote, like earlier accounts of British Columbia and Nova Scotia men, again illustrates how the gains from physical activity were constructed by our interviewees as being inexorably linked to other lifestyle changes, frequently associated with diet or reduced tobacco and alcohol use, or stress.

Despite this deep connection with improved health, the participants did acknowledge that physical activity can have negative health effects, but only after much probing. Only one man observed, without being prompted, that his previous sporting pursuits were now causing him pain despite their initial benefits:

> But I overdid it, far too much overdid it and my body finally about six years [ago] said "We're going to teach you a lesson." (. . .) Well, I always thought it was really beneficial to get a lot of exercise, but unfortunately I did it to excess (. . .). I didn't do it in as much moderation as I should have and I'm paying the price now because of overdoing it. I mean, I've had back surgery. Two ruptured disks, double laminectomy [from playing golf] (. . .) Then I was playing 30 hr of tennis a week. (. . .) [B]ut I love the game. I never got really good at it, but I had a lot of fun. That was the important thing. And, you know, my body, medial collateral ligament and neuroma, tennis elbow, tendonitis, rotator cuff. I dealt with them, played through them, had them treated. Physios, tensor bandages, bandages on the knee. Six years ago, the neuroma, I couldn't stand the pain. (. . .)[I]f you do anything to excess, you're going to pay the price eventually. And I found that out too late. If I used more moderation I'd still probably be playing tennis and I'd be 25 pounds lighter (Ron, British Columbia man).

To be clear, however, this participant never challenged the idea that physical activity is useful in preventing and maintaining good health. He was instead qualifying this "truth" by underlining that physical activity should be practiced in "moderation" to maximize health benefits while reducing health risks and to ensure lifelong engagement. No other interviewee spontaneously referred to physical activity as a potential threat to their well-being. In fact, they responded with consternation to the question posed at the end of the interview when we inquired about their concerns regarding the health risks of various exemplars, including recreational physical activity. Only after probing into the sport, fitness and outdoor activities they had referred to in the earlier part of the conversations did some of the men and women say they had experienced at least one injury or episode of pain related to physical

activity. The pain and injury they spoke of was framed as a fleeting experience, whereas the health risks identified earlier in this paper were discussed as acute or chronic conditions with long-lasting, debilitating or even fatal effects. Moderation, training and expertise as well as caution were cited as ways to avoid the possibility of injury from physical activity, which was considered more of a *safety* issue than a health risk. It appears, then, that the men and women participating in this study clearly understand the discourses that construct physical activity as more healthy than unhealthy, more beneficial than detrimental.

Intersecting Discourses: Physical Activity for Pleasure, Despite Acknowledging Health Benefits

The men and women we interviewed who reported being the most active were not merely using physical activity as a health risk strategy, they enjoyed being active:

> Me, to get in shape, physical fitness, it has to something that is fun. I will play hockey, I will play baseball, soccer, things where you are doing an activity and you are not thinking that you are *training,* you are not forcing yourself to *train.* I am doing because I want to, not because I am forced to (Marc, Nova Scotia man, translation).

It became clear in some of our interviews that engaging in sport and other physical activities had not been initiated for health reasons, but that the health benefits were a welcome by-product and helped sustain self-regulation. Therefore, the most powerful effects of the fitness discourses in disciplining our participants appear in contexts where physical activity is not only discursively connected to physiological and psychological health, but where it takes on meanings associated with pleasure, sociability and aesthetics. On their own, fitness discourses do not suffice to encourage men and women to engage in daily physical activity. The most disciplined participants were successful in self-regulating their behavior because physical activity meant more to them than a health practice per se. They were taking on the identity of active citizens by performing the requirements of the discourse, yet they were alluding to an alternative justification to explain their adherence to the prescribed norms. Despite reproducing the knowledge promoted and legitimized through physical activity and health risk discourses, they were at the same time challenging their position within these discourses by claiming that they were active because they enjoyed physical activity. Foucault (1976) describes such discursive fragments as "discours 'en retour'" (translated as "reverse discourse"), which are alternative forms of knowledge that may or may not use the same vocabulary as institutional discourses and may or may not produce the opposing social effects. In this study, active men and women drew on a reverse discourse that intersected with the medicalized discourse of physical activity in a way that resulted in the performance of normative behaviors. Their resistance was not manifested in their actions, but in how they made sense of their physical activity practices in light of their embodied experiences. This relates to the contestation space generated by the disparity between the individuals' felt experience and the health imperatives (Lupton, 1997). The sensation of enjoyment they derived from physical engagement was more powerful in disciplining them into being active than the rationale constructed in health risk discourses.

Repeating Fitness Discursive Fragments, Without Entirely "Walking the Talk"

After discussing the choices they had made with regards to the health risks of most concern to them, we asked participants whether they thought they could do "more" to manage their health risks. What changes, if any, had they yet to act on, but opted not to, or at least, not entirely? Again, increasing their level of physical activity was the second most frequent answer, after modifying eating habits. Despite previously identifying physical activity as a key strategy in managing their health risks, interviews revealed that some participants paradoxically "admitted" that they were not "active enough." They were not docile bodies (Foucault, 1995) because they were not as physically engaged as the discourses demand them to be.

In the mid- to late-1980s, the *Active Living* program was created to increase Canadians' participation in physical activity, with a special focus on the sedentary segment of the population (Bercovitz, 1998, 2000). This program discursively constructed active living—and, therefore, healthy living—as something for which each Canadian was accountable to himself or herself. Likewise, the Canadian Society for Exercise Physiology collaborated with the Public Health Agency of Canada to produce the *Canadian Physical Activity Guide* and *Handbook* offering advice about how to become more active; it detailed the health benefits of regular physical activity and outlined the health risks of inactivity (PHAC & CSEP, 1998a, 1998b). The *Guide* and the 32-page *Handbook* (used until January 2011) outlined detailed temporal control to regulate the frequency (number of times a week) and duration (minutes) of different types of physical activity (strength, endurance and flexibility) as well as specific intensity levels (very light, light, moderate, vigorous or maximum effort). In fact, from 1998 to 2011, Canadians were encouraged to engage in at least 60 min of light activity daily or 30 min of moderate-intensity activity four times per week. The *Guide* and the *Handbook* even provided a table to help individuals plan how and when they would achieve the desired amount of daily physical activity. Both the *Active Living* program and the 1998 *Canadian Physical Activity Guide* and accompanying *Handbook* also reproduced the disciplinary technique of referring to "science" and "experts" to influence the behavior of individuals and improve the health of the population (Foucault, 1995), outlining their recommendations for ideal amounts of physical activity and listing a variety of scientific, governmental and professional organizations that endorsed these prescriptions (Bercovitz, 2000; PHAC & CSEP, 1998a, 1998b).

Our participants' narratives suggest that such expert discourses about the role of physical activity in achieving and maintaining health have successfully permeated the Canadian adult population. The participants could certainly articulate the relationship between physical activity and health set forth by the *Active Living* program and the *Canadian Physical Activity Guide*. However, the men and women interviewed did not repeat the detailed intensity or temporal prescriptions in characterizing themselves as active or not-active-enough. They very rarely alluded to physical activity intensity levels and when they did, they referred to the idea of "sweating" or, like the Nova Scotia participant cited earlier in discussing his "boot camp" training experience, the idea of "being out of breath." Similarly, few participants mentioned the duration of their physical activities in terms of minutes or hours. The rate of recurrence of physical activity, though, was the focus of interviewees

who considered themselves active. As earlier quotes indicate, the idea of engaging in physical activity as a "habit," "routine," "religiously" or "daily" emerged repeatedly within the narratives of the men and women who depicted themselves as active and gaining the most benefit from this lifestyle. Participants who positioned themselves as inactive or not-active-enough subjects also referred to this general idea of frequency, but none explained in detail how they were "lacking," whether in terms of the frequency, duration or intensity of their physical activity. In this sense, the participants' focus on the regularity of engaging in physical activity reproduced the overall dominant theme in the *Guide,* encouraging Canadians to "build physical activity into your daily life" and "into your daily routine" (PHAC & CSEP, 1998). Our participants repeated the exhortation to "get active your way, every day - for life!" (PHAC & CSEP, 1998), but not the detailed prescriptions regarding how often they should undertake strength training or how often and for how long they should engage in endurance activities and so on.

While all of the interviewees appeared to accept the normative belief that physical activity should be an integral component of their lives to improve or maintain their health, some men and women admitted to not fully complying with fitness recommendations. Many of them expressed an evident dislike for "exercise" or practices specifically associated with fitness centers (i.e., weight training or aerobic training on exercise machines) to explain their failure to reach prescribed levels of physical activity:

> I was just like this gentleman here and I would not join a gym. I did join a gym about six to eight months ago. Finally now I'm going. I hate it. I hate gyms. I can't even stand it. Like my eyes glaze over, but I still have to go and do it. And the doctor said do more aerobic exercise every day and biking all the time too. (...) I got my wife to join too so we both do it, but it's just, it's not fun. At all, no. I don't find it fun to go into a gym in that clinical environment (Glen, British Columbia man).

Men and women who stated that they "should be more active" manifested their strong aversion to fitness practices with expressions such as: "hate gyms," "can't stand it [the gym]," "I'll die of boredom," "I'd rather be in prison," "doesn't turn my crank" and "I'm allergic to exercise." Some women noted that they did not "like sweating," which may refer to the expected level of intensity required by the expert discourses. Going to the fitness center was obviously not an enjoyable experience, but was inexorably linked to these participants' conceptions of what physical activity as a health risk strategy *is*. This dissonance between the discursive health risk representation of physical activity and their unpleasant, embodied experience generated a similar space for resistance (Lupton, 1997) that emerged in active participants' narrative, but with opposite effects. While active participants drew on a reverse discourse to make sense of their lived experience, the sedentary participants adhered to knowledge of physical activity and health risk discourses but rejected the behavioral norms because of their dislike for "fitness activities."

Indeed, a clear distinction emerged between men and women who considered themselves active and the others, not only with regards to the frequency of their physical activity, but also the type of activities they engaged in and the pleasure they derived from them. The participants who reported that they should be more active and the few who claimed they were inactive predominantly associated physical

activity with "working out in a gym" and "exercise." Despite engaging in physical activities such as walking, cycling, hiking, dancing and swimming, these participants considered that "exercise" was the type of activity they needed to increase to reap optimal health benefits. For these participants, the notions of "exercise," "working out" and the "gym" entailed not just the idea of intensity level but also the aerobic fitness and muscle or bone strength required to prevent or manage health risks.

Participants who constructed themselves as active listed a variety of sports (i.e., hockey, soft-ball, tennis and more), exercises (i.e., jogging, endurance and resistance training) and outdoor activities (i.e., cycling, walking and hiking, white water rafting, climbing, diving and kayaking) they engaged in and mentioned the pleasure they derived from this lifestyle, whether in terms of the social dimension of working out in a fitness center, the camaraderie of sport, physical activity as a valued "family" activity, the sense of accomplishment from boot camp, the enjoyment of being outdoors, the high of riskier sports, or the love/fun of sports and competition. In partaking in and considering a variety of physical activities as part of an active lifestyle, the active participants more closely repeated the discourse promoted in the *Canadian Physical Activity Guide,* which listed different types of "acceptable" activities to improve health from walking, hiking, biking, swimming, hockey, aerobics, jogging and more (PHAC & CSEP, 1998).

Despite Some Resistance, Participants Take on Identities Produced in Fitness Discourses

In summary, the men and women we interviewed spontaneously reproduced institutional discursive fragments constructing regular physical activity as an effective and almost mandatory practice to manage their personal health risks. The motivation to exercise and the benefits of physical activity reported by participants that constructed themselves as active subjects unmistakably reproduced governmental discourses circulated through PHAC, CSEP (e.g., CSEP, 2011a; PHAC, 2010; PHAC & CSEP, 1998b) and WHO publications (e.g., 2010, 2011a, 2011c) and reiterated by health professionals. Evidently, some of the participants not only "talk the talk" regarding physical activity, they also claim to lead an active lifestyle, to feel more fit and healthier and to benefit psychologically and aesthetically. But other men and women did not fully comply with the prescribed norms. Similar versions of the first four of the five ideal types identified by Monaghan (2008) to describe the role of physical activity in weight loss emerged in our interviews when participants instinctively discussed physical activity as a strategy for managing a variety of health risks including overweight or obesity. In fact, the men and women we interviewed clearly reproduced statements that situated them in categories similar to: the (1) *physical activist and totally compliant;* (2) the *excusable and partially compliant;* (3) the *guilty and apologetic;* and they even offered variations related to (4) the *critically compliant* (Monaghan, 2008, p. 107–108). Surprisingly, we did not encounter participants who described themselves as (5) the *justifiably resistant and defiant*. None of our participants expressed any resistance to the idea that physical activity is a useful practice for improving or maintaining health. Perhaps such critical doubts about the role of physical activity might have emerged had we asked specific questions about the physical activity of participants who did not identify

physical activity as either a behavior they adopted or should adopt to explain why they did not allude to fitness practices as strategies to manage the health risks they were concerned about.

The effects of physical activity-related health discourses are evident first in the general agreement among the men and women we interviewed that regular physical activity is a good strategy for achieving or maintaining good health and that inactivity is a genuine health risk. The discursive effects are secondly manifested in the identities they consciously embody as active or inactive citizens. The problematization of identity (as not-active-enough or sedentary) and the use of physical activity by some of our interviewees to alter this identity can be considered a technology of the self (Foucault, 1988). That is, physical activity becomes self-work which "permit[s] individuals to effect, by their own means, a certain number of operations on their own bodies, (...) on their own conduct, and this in a manner so as to transform themselves, modify themselves, and to attain a certain state of perfection (...) and so on" (Foucault, 1988: 18). In other words, by self-regulating their behavior through regular physical activity, the reportedly active men and women we interviewed voluntarily work on themselves to enact a lifestyle, to embody the active identity and ultimately to be healthy. The young men and women studied by Wright et al. (2006) also spoke about one's duty to eat right and stay active to maintain health. The authors found that young men engaged in technologies of the self to construct themselves as fit, ethical citizens who conform to the discourses of health and fitness. The young women in their study sometimes resisted discourses relating to body shapes, but still drew on physical activity discourses to construct themselves as healthy (Wright et al., 2006). Likewise, most of our participants were not only aware of the discursive prescriptions that should guide their behavior, but they *chose* to appropriate the discourses and construct themselves as productive citizens. In this sense, our results confirm Pronger's (2002) observation that the technology of physical fitness produces individuals who work on their bodies to be free from various health risks. Of course, the individual, while assumed to have decreased his or her risk, must continually subject him- or herself to the technology of physical fitness to maintain this status. Our participants engage in technologies of the self in a context of power relations, and within those relations, they recognize their own roles and act accordingly (Foucault, 1988, 1993).

Our interviews reveal that most participants engaged in some self-work to take on at least a part of the active identity and gain some health benefits even if they were all not disciplined into embodying the complete prescriptions of physical activity. Indeed, they underlined that being a sedentary person was socially undesirable; physical activity therefore became a means to achieve a favorable self- and social-image as a healthy Canadian:

> Mike: It is more fashionable to be healthy now or to be active. Healthy lifestyles [are] definitely more fashionable.
>
> Brad: The jogger has a very good image socially (Ontario men).

Lupton (1997) illustrates the link between subjectivity and discourse in the example of a young man who exercises regularly, eats healthily and feels good about his physical appearance and his subscription to dominant discourses of physical activity. However, as he ages, finds success at work and starts a family, he exercises

less and eats more unhealthy foods. He no longer has the same confidence in his appearance. The discourses that he is subjected to have not changed, but his subjectivity has (Lupton, 1997). Some of our participants described the same changes in their physical activity patterns and identity, explaining that while they were once active, they are no longer active enough. Especially for the participants who no longer wanted to see themselves as sedentary and overweight, "the interaction of discourse, practices of the self and subjectivity in the context of health promotional and other governmental imperatives is not stable" (Lupton, 1997: 149). Even if they did not enjoy physical activity, they disciplined themselves to "work out" at least a few times a week because they did not "like what they had become." The use of physical activity as a health-risk management strategy by the Canadian men and women we interviewed demonstrates the power of discourse and the relationship between discourse and the subjectivity that Lupton describes. While fitness discourses alone fail in disciplining all participants into being active, they succeed in preventing sedentary adults from resisting the identity produced by the normative health discourses. Indeed, the men and women who reported not being active enough not only accepted the label, but also appropriated the idea that they were responsible for their inactivity. Rarely did they express the idea that the demands of the fitness discourses might be unachievable in light of their specific circumstances. Only two participants justified their "lack" of physical activity based on work pressures which resulted in time constraints and lack of energy. None of the participants referred to family responsibilities, lack of financial resources, limited access to facilities/outdoor venues or any other type of socioeconomic constraint to explain their failure in meeting the fitness prescriptions. Some men and women even blamed their own personal moral failures, voluntarily taking on the label "lazy" assigned to sedentary individuals in the public health fitness discourse:

> Albert: Not enough exercise. I still haven't changed that. He [physician] wants me to exercise more, which is very difficult for me, but a lot of times I'm just… I guess I've become lazy or just not motivated to do. So I think that part, you know, I'm not doing what I should be doing.
>
> Q: And the major influence for not exercising more would be, you think…
>
> Albert: Lack of motivation and laziness, yes (Albert, British Columbia man).

These narratives reflect the discourses about physical activity and health found in federal government initiatives and adopted by the provincial and territorial governments of Canada. In fact, Bercovitz (1998, 2000) found that the term "lifestyle" used in the Active Living program was a discursive technology, underlining a shift toward a discourse of individualism and self-improvement focused on personal responsibility, but ignoring the broader social conditions that may constrain access and engagement in physical activity. The obstacles to being active have been historically silenced in the marketing of health and fitness to Canadians (MacNeill, 1999) and the 1998 and 2011 editions of the *Guide* are no exceptions. For the most recent version of the *Guide*, CSEP (2011a) has partnered with ParticipACTION to implement and disseminate these guidelines (CSEP, 2011b; ParticipACTION, 2011). ParticipACTION, a program designed to increase the activity levels and improve the health of Canadians, has previously ignored the sociocultural condi-

tions of possibility within which Canadians engage in physical activity. Much like the current guidelines, which overlook how factors such as geography and gender influence Canadians' ability to be active, ParticipACTION's early campaigns did little to challenge the expert discursive fragments of fitness and health or the moral judgments ascribed to sedentary individuals (MacNeill, 1999).

Yet despite the current discursive environment that blames individuals for not engaging in an active lifestyle, there were, albeit rare, participants who identified institutional demands, such as work pressures, to justify their own "lack" of physical activity. In addition, there was also some discussion of structural social changes required to ensure an active lifestyle in some of the interviews. In discussing what they felt governments should do to ensure the health of Canadians, participants did mention the need to increase physical education in schools, to provide sponsored physical activities in community centers for low income earners, to increase mandated holidays or reduce work hours to improve the work-life balance. Despite these atypical allusions to required public policy changes, our interviews show that fitness discourses imposing an individual moral responsibility on engaging in an active lifestyle have much currency among Canadians, but are not successful in convincing all citizens to engage in regular physical activity. Our participants' acknowledgment that they were not meeting the desired levels of physical practice demonstrates that this current mania for exercise is not necessarily succeeding in creating docile and disciplined active Canadians (Pronger, 2002). Lupton (1997, p. 133) explains that resistance emerges in everyday life in the "ways in which individuals fail to acquiesce in, conform or consent to the imperatives of governmentality." Our analysis shows that while self-declared not-active-enough or sedentary participants still adhere to the idea of physical activity as an individualized strategy to improve one's health, they neglect to fully enact the prescribed behaviors. As opposed to the active participants who challenge the health risk discourses by attributing an alternative explanation for their behavioral compliance with the norms, the inactive participants pose a much greater resistance to the fundamental objective of governmentality, which is to direct the conduct of individuals and populations (Foucault, 1983).

Conclusion

This analysis makes a significant empirical contribution in outlining the ways different Canadian men and women talk about physical activity in conversations about their personal health risks. Our interviews confirm that participants reproduce the dual construction of physical activity (physical activity as a risk-management strategy and physical inactivity as a risk factor) deployed through institutional health risk discourses. Furthermore, the participants that declared being the most active spoke of gaining various health benefits as a result of their engagement in physical activity. Their performance of the requirements of fitness discourses combined with their embodied experiences reinforced the legitimacy of the knowledge circulated through expert discourses and convinced them of value of normalization. One man's lived experience of high intensity involvement in sporting activities did, however, lead him to nuance the health benefits of physical practices: they can be positive

if performed in moderation but harmful if excessive. His comments indicated a form of resistance in that he provided an alternative knowledge about the health benefits of physical activity. Other forms of resistance also emerged in the participants' narratives with regards to how they reproduced institutional discourses in that they did not comprehensively repeat all possible discursive fragments. For instance, they did not refer to the detailed prescribed norms with regards to the temporal and intensity controls of physical practices for health management. Only one participant constructed herself as a productive citizen through her involvement in physical activity, but others did refer to a desire to ensure their functional capacities and autonomy through the aging process. Finally, none of the men and women interviewed disputed the neo-liberal notion that maintaining one's health through engagement in physical activity is an individual responsibility. But some did allude to the idea that public policy changes were necessary to improve structural social conditions that constrain the performance of behavioral norms.

While we have focused on drawing parallels between our participants' statements and governmental public policy documents, Pronger (2002) reminds us that such texts do not exist independently from other discursive production such as scientific texts, popular texts, physical fitness products and a variety of media representations of the fit body. His analysis shows that this intertextual ensemble establishes as a main message that physical fitness can be a form of self-control in managing health and increasing the body's physiological and psychological capacity. He argued that the current deployment of physical activity as a health management strategy leaves little space for alternative discursive constructions of physical activity. Yet our analysis does reveal some cracks in the enunciation of fitness discourses among the Canadian men and women we interviewed. Some of our participants, while they reportedly reaped health benefits from their active lifestyle, also assigned other significant meanings to physical activity. Even in the context of conversations about health risks, they underlined the importance of pleasurable experiences when explaining their adherence to prescribed physical activity norms or to justify their noncompliance. Active participants were disciplined into frequent physical activity not simply because of the discursive effects of the fitness mantra promising better health, but because they enjoyed it. Conversely, the not-active-enough or inactive participants were unwilling to fully comply with the requirements of the fitness discourses because they found no pleasure in "exercise." It would appear, then, that despite taking part in a study about health risks, the men and women we interviewed articulated an enjoyment imperative and the prevailing effect of the felt experience that intersected with the health risk discourses to produce active bodies in some circumstances, and inactive bodies in others. Our empirical evidence then points to an original theoretical problem: the effect of embodied activity as a condition of possibility for two distinct forms of resistance. First, felt experience may lead individuals to accept or reject truths produced in expert discursive fragments. Second, how individuals live and sense embodied practice becomes a condition of possibility enabling or constraining their voluntary performance of the behavioral discursive requirements.

Although this research contributes toward understanding how Canadian men and women who volunteered to participate in a study on health risks instinctively reproduce discursive fragments constructing physical activity as a strategy to ensure

well-being, it merely scratches the surface with regards to their performance of prescribed norms. Our interviews allowed us to explore how participants make sense of physical activity on the one hand, and how they make sense of their embodied experiences of physical activity on the other. Their narratives also depicted how they adopted the categories of active, inactive or not-active-enough citizens, yet permitted only a glimpse of their level of compliance with the behavioral discursive requirements. What types of practices did they engage in and how did they go about evaluating whether the modalities of these practices were adequate? More research would be useful to further explore how men and women actually perform these subjectivities and how this lived experience enables or constrains their normalization in health risk discourses. Other forms of individual resistance might emerge regarding participant interpretations of prescribed norms compared with the standards circulated in expert discourses, such as activity guides produced by public health agencies or recommended by health professionals. Indeed, there could be further dissonance between how men and women experience physical activity and how they construe of the minimum standards put forth in institutional discourses. Since the ultimate aim of processes of governmentality explored in this paper is to lead individuals to self-regulate and become active, more research is required to better understand how Canadian men and women not only articulate the discursive fragments, but also how they voluntarily work, or not, toward achieving the ideal body.

Notes

1. A similar dual construction has been previously noted by Krewski et al. (2007) with respect to health services.

2. The data analyzed for this study were initially collected as part of a Health Canada financially supported research project, *Public perception and acceptable levels of health risk among Canadians* (Project No. 6795–15–2002/4770021).

3. We certainly recognize that social class plays a role in encouraging individuals to engage in different forms of physical activity and that "class habitus" may inform the meanings they assign to these practices (Dumas & Laberge, 2005; Laberge & Sankoff, 1988). Indeed, physical activity has been shown to act as a means to "distinguish" among socioeconomic groups and as a strategy to gain cultural capital (Dumas & Laberge, 2005; Laberge & Sankoff, 1988; Stempel 2005, 2006). Our data, however, does not allow us to infer generalizations related to social class. On the one hand, the men and women we interviewed cannot all be classified as belonging to the middle class. On the other hand, because the sociodemographic data were collected anonymously, it cannot be linked to individual participants. It is then impossible to contextualize interview statements with regards to socioeconomic characteristics.

4. In using the term "spontaneous" here, we are not implying that participants were free from the discursive effects of governmental physical activity and health risk discourses. On the contrary, our analysis focuses on the subject positions they took within such discourses. Rather, we use this term here to indicate that the men and women evoked physical activity in response to questions about health risks.

5. The first author designed the qualitative interview study, conducted all interviews, analyzed the transcripts and completed significant and major revisions to the draft manuscript. The second author made a noteworthy contribution to the analysis of transcripts and wrote a draft of the manuscript. The third and fourth authors participated in the conception of the overall health risk perception research project, the design of the qualitative study and reviewed the manuscript.

6. Pseudonyms are used to identify interview participants.

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