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Research Paper

Lifestyle as living, or lifestyle as health behavior? A Danish case study of the contradictions and entanglements of contemporary health promotion in practice

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In this paper, we examine the discursive dynamics of lifestyle within a Danish municipal lifestyle-changing program, focusing on how contemporary and sometimes conflicting understandings of lifestyle shape health-promoting practices. We identify two dominant discourses: lifestyle as living, which emphasizes well-being, pleasure, and quality of life; and lifestyle as health behavior, rooted in New Public Health approaches that frame lifestyle through notions of 'right' and 'wrong' behaviors aimed at preventing overweight and obesity. Drawing on ethnographic fieldwork and semi-structured interviews with participants and educators, our study reveals that while holistic lifestyle interventions aim to improve well-being, quality of life, and physical health, they remain discursively entangled with behavioral and responsibilizing approaches. We argue that expanding the concept of lifestyle to include broader aspects of living may intensify experiences of failure, not only in relation to 'right' health behaviors but also in pleasure, enjoyment, personal values, and self-acceptance. Efforts in a municipal program to emphasize lifestyle as living, in practice, extended rather than displaced behavioral logic, as well-being and quality of life became incorporated into the same framework of evaluation, responsibility, and potential failure. By critically reflecting on these entanglements, we call on health promoters to consider the unanticipated consequences and ethical implications of lifestyle interventions, particularly when expanding the concept of lifestyle while simultaneously responding to worldwide health challenges such as so-called lifestyle-related diseases.

Introduction

'I thought it was a weight loss program wrapped in something about lifestyle,' Susan, a participant in a municipal lifestyle program, wondered during an interview. But what did she mean by lifestyle? And how is it related to weight? A dietitian in the same program reflected on her teaching that 'Lifestyle is the way you live your life […] it is not only what you eat and how much you exercise. It is the whole life.' Through

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the empirical case of a municipal lifestyle program in Denmark, we illuminate the discursive dynamics of the concept and practice of lifestyle. In the field of health promotion, there is a growing emphasis on incorporating individual's preferences, circumstances, choices, and wishes for their lives and health (Nehushtan 2021, Vogel & Mol 2014). This shift provides the framework for the lifestyle intervention analyzed in this paper and falls within what we term the *lifestyle as living* discourse. Simultaneously, we argue that a more responsibilizing understanding of lifestyle has a stronghold in health-promoting practices (Cohn 2014). This understanding is grounded in the New Public Health paradigm (Petersen & Lupton 1997), managing illness and disease by changing health behavior (Mayes 2016). This paradigm categorizes lifestyle into healthy and 'right' behaviors versus unhealthy and 'wrong' behaviors, which aligns with what we refer to as the *lifestyle as health behavior* discourse in this paper. Our study explores how these two discourses are expressed in the municipal lifestyle program and in the participants' everyday lives. Further, we analyze the interaction of *lifestyle as living* and *lifestyle as health behavior*, and how this interaction affects the participants' and educators' attempts to change 'something about lifestyle.' Our analysis indicates that while holistic lifestyle interventions, sympathetically, aim to improve well-being, quality of life, and physical health, they remain discursively entangled with behavioral and responsibilizing health promotion approaches and culturally rooted equations between, for instance, lifestyle and weight loss. We argue that by broadening the concept of lifestyle from health behavior to more fully embracing people's lives, health promoters also introduce more parameters of success or failure in obtaining a 'good' lifestyle. We will show how these discourses seem contradictory and unobtainable for the participants in the municipal lifestyle program.

Lifestyle as a concept entails a multiplicity of meanings, relations, practices, and knowledge (Mayes 2016). Yet, as the introductory quote of 'wrapping weight loss in something about lifestyle' indicates, lifestyle often condenses as a mode of governing against universal threats such as overweight, obesity, and poor health in general. Therefore, lifestyle is usually understood as a form of bio-power (Mayes 2016): a discursive power coupled with the understandings of the government of a healthy population that have been characterized as the New Public Health (Petersen & Lupton 1997). The New Public Health paradigm is based on the expectation that individuals take responsibility for the care of their own bodies and manage their relationship with societal and cultural risks (Petersen & Lupton 1997) such as the availability of sugar and sweets, smoking, alcohol consumption, and sedentary behavior (Statens Institut for Folkesundhed 2023). In Denmark, New Public Health aligns with liberal ideas of freedom and autonomy, framing health behavior as a matter of individual choice and responsibility (Petersen & Lupton 1997, Vallgårda 2007). However, as Lars Thorup Larsen highlights in discussions of the tension between biopolitics and governmentality, Danish health authorities try to guide individuals toward specific, health-promoting behaviors through recommendations of individual behavior change, shaping individual choices towards public health goals (Larsen 2011). Within a New Public Health logic, individuals are expected to constantly assess their lives in the quest for self-improvement, achievement of authenticity, maximization of life chances, and the exercise of choice among alternatives. New Public Health encompasses a set of moral tenets based on desirable-undesirable health behaviors such as healthy-diseased, rational-emotional, and controlled-unruly (Petersen & Lupton 1997). These oppositions help define what is considered 'good' behavior in terms of health, reinforcing a moral framework where health, rationality, and self-control are seen as successes. In opposition to that, disease, lack of control, and emotional decision-making are seen as failures (Petersen & Lupton 1997). A key facet of the emergence of New Public Health was the attention to personal risk factors of future illness (Armstrong 1995), and the concept of lifestyle moved from a broad sociological and psychological understanding of everyday practices, social identity, and personal meaning (Larsen 2011) to becoming a concern of public health and clinical medicine (Macdonald & Bunton 2003).

In line with responsibilization and understanding *lifestyle as health behavior*, biopolitical mechanisms such as lifestyle interventions aim to normalize, control, and shape the individual's choices toward healthy, rational, and responsible decisions through norms and incentives (Mayes 2016). In a comparative genealogical document analysis of lifestyle politics in the United States and Denmark, Larsen identifies

an inherent theoretical tension between the logic of biopolitics, which aims to optimize the biological life of a population, and governmentality, that is concerned with the modes of governing that regulate individual behavior and place responsibility on the individual (Larsen 2011). This tension implies that the biopolitical aim of managing and improving population health conflicts with the development of governing technologies of lifestyle politics that intensify a focus on lifestyle as a matter of culture, individual morality, responsibility, and choice, which are considered beyond state ability and responsibility to regulate. We see these governing technologies when public health research and policy target health behavior (Vogel & Mol 2014) or healthy living (Lindsay 2010) that is, to control 'lifestyle risk factors,' including lack of physical activity, poor nutrition, tobacco use, and excessive alcohol use (Cohn 2014, Larsen 2011, Petersen & Lupton 1997). However, as Simon Cohn pointed out in an introduction to a special issue on health behavior, the concept of health behavior has had a remarkably unquestioned effect in health research and policy (Cohn 2014). Health behavior, Cohn argues, can be dichotomized into 'good' or 'bad' behavior, detached from what people actually do, and, crucially, conceptualized as relating to the agency and responsibility of the individual. Cohn suggests that replacing the concept of health behavior with that of health practices would focus instead on the contingencies, interactions, and relations that are part of what people actually do. This would set the grounds for a more modest claim of understanding and intervening in the ambiguity and complexity of how people practice health in real-world settings (Cohn 2014). Similarly, the general practitioner Per Fugelli made a compelling case for promoting 'joie de vivre' to avoid 'public health promotion side effects' such as fear, healthism, and injustice (Fugelli 2006). We see these arguments as part of a counter-stream in approaches to what can be considered lifestyle factors towards a more holistic focus on 'lifestyle as the whole life,' as the dietitian from the municipal lifestyle program quoted above framed it. Social science and the humanities are critically reflected in arguments 'against health as the new morality' (Metzl & Kirkland 2010) and in interrogating New Public Health assumptions of what health, behavior, and lifestyle might mean and how to approach and understand worldwide health challenges such as overweight and obesity (Berlant 2010), physical inactivity, unhealthy diet (Vogel & Mol 2014), and smoking (Risør 2003).

In our empirical case of a municipal lifestyle program, the differing approaches to lifestyle described above were evident among educators and program participants alike. During ethnographic fieldwork these approaches appeared as two main and often conflicting discourses of lifestyle, which we analyze as *lifestyle as living* and *lifestyle as health behavior* in this paper. From a Foucauldian perspective, discourses are historically and socially situated systems of meaning (Foucault 2002). In our case they thus shape how lifestyle is understood, discussed, and practiced. Discourses facilitate particular ways of thinking about lifestyle and marginalize other approaches (Foucault 2002). This relates to Foucault's notion of governmentality, which demonstrates how disciplinary governing aims to influence people's field of possible action rather than relying on direct regulatory control (Foucault 1995). Emanating from this, New Public Health regimes fostered lifestyle interventions that encouraged individuals to manage, reflect on and regulate their own practices in relation to particular understandings of what lifestyle is (Crawford 2006, Petersen & Lupton 1997). The municipal lifestyle program, therefore, can be understood as a site where approaches to lifestyle associated with the New Public Health and those more contemporary approaches to lifestyle, which center participants' own preferences and values, are both promoted, interpreted, negotiated, and sometimes resisted. In this paper, we explore these discursive dynamics embedded in the lifestyle program designed to support participants in living good and healthier lives through a holistic lifestyle approach. Specifically, we analyze how the program reflects an expanding public health agenda that extends beyond individual health behavior to encompass the social, circumstantial, and affective dimensions of health practices. We further examine how this broadening shapes, enables, and constrains people's efforts to live what they perceive as good lives.

Managing Lifestyles in Denmark

Health behaviors such as unhealthy diet, smoking, and physical inactivity are associated with an increased risk of noncommunicable diseases (World Health Organization 2025), which are therefore often referred to as so-called 'lifestyle conditions' (Cohn 2014). These conditions are considered to constitute a major economic burden on the free-for-all Danish healthcare system. These are the rationales in Denmark, as elsewhere, for local municipalities to offer interventions to address public health challenges such as overweight and obesity by promoting 'healthy lifestyle'. Along the same lines, governing technologies, such as official national healthy living guidelines, recommend limiting sweets and snacks to 'five handfuls a week' (Fødevarestyrelsen n.d, b) and consuming '6 a day' to encourage more fruits and vegetables (Fødevarestyrelsen n.d., a). Additionally, the slogan 'But Why' aims to prevent smoking (Sundhedsstyrelsen 2019), and the '10/4' slogan guides healthy alcohol consumption by advising no more than 10 drinks per week and four per day (Grønbæk et al. 2022). Furthermore, individuals are recommended to participate in at least 30 minutes of moderate-intensity exercise each day and two weight training sessions per week (Sundhedsstyrelsen 2024). This study examines how lifestyle is articulated, practiced, and negotiated within this discursive context in a municipal lifestyle program in Denmark, My Lifestyle in Balance.

My Lifestyle in Balance

The fieldwork took place in a municipal health center that integrates regional, municipal, and private health services, promoting the health and lifestyle of the people in a large municipality in Denmark. My Lifestyle in Balance is publicly funded and has been a health promotion offer since 2020. It was led by a dietitian, physiotherapist, and psychomotor therapist who taught participants about diet, physical activity, and mindfulness during 16 sessions concerning diet, physical activity, habits, values, and relationship with their bodies. The perspective adopted by the educators was embedded in the program design and municipal guidelines, which framed the intervention in terms of living rather than health behavior. My Lifestyle in Balance is thus positioned as an alternative to more conventional Danish municipal lifestyle programs by explicitly downplaying weight loss as a central outcome while still promoting a healthy lifestyle.

Participants included in the program were adults aged 18 to 65 who lived in the municipality and had a Body Mass Index (BMI) higher than 25, indicating overweight, a somewhat paradoxical inclusion criterion considering the educators' intention of not focusing on weight. The participants heard about the program either from their general practitioner or through Facebook. Eleven participants enrolled in the program that was observed. Five women and two men completed it.

Methods

The analysis is based on ethnographic fieldwork from September 2022 to April 2023, consisting of repeated field visits with participant observations and semi-structured interviews with 12 program participants and three educators. The participant observations occurred during nine sessions where the first author participated in exercises and informal conversations with the program participants during breaks, before and after each session. The observations provided insights into how the educators delivered the municipal lifestyle program and how the participants responded to it (Bernard 2017). Field notes were written afterwards rather than during sessions to be fully present in the sessions and the conversations with the educators and participants. The concept of lifestyle in the program was studied from an outside perspective as the first author did not have overweight nor had previously participated

in a municipal program like the other participants (Berger 2013). However, she followed their lead by taking breaks during cardio workouts and sat next to them during the sessions. In doing so, she positioned herself more as a participant than an educator to learn about the concept of lifestyle and the experiences of the program from a participant's point of view.

Seven in-depth interviews with participants from the observed team were conducted face-to-face at the participants' homes. Five in-depth interviews were conducted online with participants from a previous team. The interviews were guided by observations and open-ended questions such as 'In what circumstances do you feel healthy? Unhealthy?' to invite nuanced perspectives from the participants' everyday lives. Additionally, in-depth interviews were conducted with the three educators utilizing a separate semi-structured interview guide, including questions like 'Which session means the most to you and why?' that aimed to uncover the professional engagement behind the lifestyle program.

Ethics

The study and its data management procedures were approved by the Central Jutland region's list of research projects (1-16-02-321-22). According to Danish legislation, the study did not require formal ethical approval, as it was classified as non-biomedical research involving ethnographic fieldwork and interviews rather than biomedical or interventional research (LBK nr 1083 af 15/09/2017) (Nørby 2017). At the beginning of the fieldwork, the participants and educators were informed about confidentiality and the use of pseudonyms. Due to the educators' unique roles in the municipal lifestyle program, complete anonymity could not be guaranteed, and they consented to this condition.

Data Analysis

Fieldnotes and transcripts were read iteratively to identify recurring ways in which lifestyle was discussed and practiced within the municipal lifestyle program. Fieldwork revealed tensions between weight and well-being and between the educators' holistic ambitions and their governmentality-informed focus on individual behavior change (Larsen 2011). Informal conversations showed that many participants strongly desired to lose weight and were willing to make significant efforts to achieve this, while simultaneously wishing that weight and health concerns would not dominate their everyday lives. These tensions served as the starting point for exploring the discursive dynamics of the lifestyle intervention, alongside concurrent attention to how we, as researchers, were positioned within these dynamics throughout fieldwork and analysis. The data were coded crosswise in NVivo to identify similarities and differences in practices and verbalizations related to lifestyle. The subsequent analysis examines practices, interactions, and conversations to understand the meaning of lifestyle and explore the outcomes when different lifestyle discourses interact (Gubrium et al. 2012).

Findings

In the first session of My Lifestyle in Balance, the educators explained that this program differs from other municipal lifestyle programs by promoting healthy habits to achieve a balanced lifestyle without focusing on weight loss, diets, and restrictions. This was reflected in the program curriculum, which included topics such as self-acceptance and personal values, and in their teaching, where they often emphasized the importance of being good to oneself and that 'A small improvement is better than nothing'. However, the educators also communicated formal guidelines on healthy behavior and operated within institutional frameworks of public health governance. One example is the inclusion criterion of a BMI above 25, which implicitly frames participants through a biomedical risk category despite the intention not to focus on weight within the program. From a governmentality perspective, this illustrates

how biomedical issues are embedded in the municipality's work and contribute to the entanglement of the discourses of *lifestyle as living* and *lifestyle as health behavior* in practice. This entanglement was particularly salient across three lifestyle themes where the holistic and balancing approach of the program was challenged or permeated by health behavior: 1) Body weight and body size: Challenging the elephant in the room, 2) Values and well-being: Broadening lifestyle beyond health behavior, and 3) Right or wrong health behavior: Persisting moral categorizations.

Body weight and body size: Challenging the elephant in the room

Even though My Lifestyle in Balance was not presented as a weight loss program, weight remained a central concern for all the participants. When the first author asked about their everyday lives, they consistently mentioned aspects related to weight loss, such as their morning routine, which included stepping onto the bathroom scale to see if they had lost weight since the previous day. As overweight and obesity have become health challenges worldwide, biopolitical strategies like lifestyle interventions and healthy living guidelines are activated and set the norms of right health behaviors with the purpose of people losing weight (Mayes 2016). This responsibilization of the individual and Western body ideals favoring a thin body (Neighbors & Sobal 2007) frame the concerns participants expressed about their everyday lives. As Mary explained: 'I am in a life crisis […] If I am still fat for the next two years, I will be fat for the rest of my life.' The participants' widespread negative experience of having overweight and their strong desire for change highlight the prevailing connection between body weight, size, health, and the moral responsibility of being a good citizen in Danish society (Offersen et al. 2017).

Further, most of the participants viewed the lifestyle program as a remedy for their overweight. For example, John described it as 'My medicine against my problem.' This reflects the framing of lifestyle choices as opportunities for self-management, where overweight is treated as a condition to be mitigated. It also illustrates how participants navigate moral tenets between desirable and undesirable health behaviors within the logic of New Public Health, where individuals are expected to modify their conduct to be considered responsible and healthy (Petersen & Lupton 1997). All the participants had previously undertaken various weight loss efforts, including diets and municipal weight loss programs that should teach them 'healthy' choices to lose weight, and thus, as proper people, take responsibility for their physical health. The depth of their desire to lose weight is exemplified by Ann, who described herself with a low income, yet having paid for weight-loss surgery with the equity in her house two years before entering My Lifestyle in Balance. However, she gained weight again and participated in the municipal program with a desire to lose weight by changing habits. Despite the educators' intention to position My Lifestyle in Balance as a lifestyle-changing program rather than a weight loss program, most participants prioritized behavior change for weight loss over other aspects of the program, such as mindfulness. 'It [mindfulness] does not help me lose weight', as Susan noted.

Body size was also an unspoken but pervasive focus in the day to day delivery of My Lifestyle in Balance. The educators did not want to give much attention to body size as they wished to shift the focus from achieving a normatively understood 'normal weight' body towards self-acceptance of their bodies. However, not verbalizing body size did not mean it was not a focus. For example, the very physical surroundings of the health center reinforced a particular idea of what a good and 'normal-sized' body might be when the participants sat in chairs with armrests in the health center, and it appeared that none of the chairs fitted them comfortably. Most of the participants struggled to fit their legs under the table, and when standing up for breaks or exercises, some had challenges rising, using the armrests to push themselves up. Another instance highlighting body size as a focus in the lifestyle program occurred during a physical activity session. While everyone stood in a circle, one of the participant's exercise band broke when she stretched it around her thigh. She speculated that it might have been brittle or damaged, but the physiotherapist noted that the bands were new. These moments created a brief sense of awkwardness, with the room briefly going silent as it appeared that Patricia's body size exceeded the capacity of the new, supposedly strong exercise band, despite her attempt to attribute the break to a fault in the elastic

rather than to the fit of the equipment. A conflict between not focusing on body size and the physical settings made an implicit definition of what kinds of bodies are considered appropriate within the program's practices.

Values and Well-Being: Broadening Lifestyle Beyond Health Behavior

At home, all the participants reported enjoying a calm everyday life and engaging in activities such as walking their dogs, watching TV, lying on the couch, and sleeping late. The health authority's formal physical activity guidelines categorize walking the dog as 'good' behavior as it is an active behavior and watching TV as 'bad' behavior as it is physically inactive (Sundhedsstyrelsen 2024). Drinking consumption can be categorized into 'good' or 'bad' health behavior. This was reflected during a physical activity session in My Lifestyle in Balance, where the participants walked up and down 100 steps twice on the back stairs in the health center. Most of them took breaks during the exercise, became breathless, flushed, and sweated through their workout clothes. The first author went with one of the participants in the back and felt warm and thirsty afterwards. Quenching her thirst in cold water from the water machine available at the health center, she noticed with surprise how some participants quenched their thirst with half a liter of soda. Noticing the immediate discomfort in her own body by the thought of replacing cold water with soda after exercising, the example demonstrates how our own embodied preferences manage our assumptions of what is good and right for others. This opens a question of what well-being and health might mean to the educators, participants, and the researcher, respectively.

'Lifestyle is the whole life,' the dietitian proclaimed, and the physiotherapist and psychomotor therapist agreed. They have participated in a course on Acceptance and Commitment Therapy, which they integrated into My Lifestyle in Balance, focusing on changing participants' habits and improving quality of life and overall happiness. The physiotherapist acknowledged that 'This is challenging for me because, on the other hand, we often say, "it would be beneficial for you to do x, y, z,"' referring to national healthy living guidelines. As a physiotherapist, she mainly views lifestyle as healthy behavior, which aligns with her educational background that focuses on treating physical pain and preventing injuries. The psychomotor therapist focused more on social well-being in the lifestyle program and taught the participants to accept their health practices and body sizes. She conducted a session on values, which included guidance on achieving personal goals, such as practicing self-care while attaining weight loss. The participants, however, struggled with how to achieve their values. For instance, some of them mentioned politeness as a value. Patricia explained that she felt polite eating the food served to her as a guest, even if she perceived it as unhealthy food and she was on a diet: 'If you eat the cake, for example, you treat others with courtesy but not yourself […] I do not think they should serve cake if they know you are on a diet.' As Jo Lindsay argued, healthy living guidelines are idealized and individualized, often detached from the realities of everyday life (Lindsay 2010). Such guidelines fail to resonate with people who live within contextualized social worlds, where practices such as food and alcohol consumption are central to social life, the construction of social identities, and key social practices in connection with specific situations of everyday life. In the politeness example, it was clear that social well-being shaped how Patricia practiced self-control and failed to comply with her diet. During the personal values session, the psychomotor therapist aimed to teach the participants how to treat themselves well, especially if they were trying to lose weight. This included not being angry at themselves when they, for example, ate chocolate, as it aligned with the value of quality of life if they liked chocolate. However, most of the participants found it difficult and confusing to balance the tension between perceived unhealthy behavior and being good and forgiving to oneself. This became evident when Ann categorized her new habits as 'good' and 'bad.' After two months of attending a fitness center, which she described as good health behavior, she also developed what she perceived as a 'bad' habit. The fitness center offered free hot chocolate, which she drank after each workout '[…] but I do not need it. I cannot fully explain why I am drinking it.' However, she saw the hot chocolate as a reward for her 'good' exercise habit. As such, it was not enjoyed as a value and pleasure in and of itself, as suggested by the psychomotor therapist. Instead,

it was seen merely as something permissible, balanced between good and bad habits. There was also an awareness that, from a health perspective, it would have been even better to refrain from this pleasure. This example illustrates how *lifestyle as living*, despite its focus on well-being and balance, may still produce experiences of moral evaluation and potential failure similar to those associated with *lifestyle as health behavior*.

Consumption choices about food are personal, shaped by pleasure and mental well-being, but are also shaped by social conditions and local contexts, such as offers in fitness centers (Lindsay 2010). Countervailing pressures include what Lauren Berlant (2010) notes as the incentive to consume what can be perceived as unhealthy food and drinks because people are tired of being good, tired of responsibilization. After all, food is one of the few spaces of controllable, reliable pleasure that people have (Berlant 2010). Even though the participants wanted to lose weight, they simultaneously felt pleasure in eating what is 'unhealthy' food in their opinion, and the conflict between the enjoyment of living and the desire to achieve a healthy behavior occurs. Else Vogel and Annemarie Mol argue that individual preferences and enjoyment should be prioritized more than simply adhering to government-prescribed health behavior. They emphasize that taking pleasure in one's food can lead to a sense of satisfaction and the feeling of having eaten enough, fostering a more fulfilling and self-caring approach to eating (Vogel & Mol 2014). Most of the participants found pleasure in foods not recommended by dietary guidelines and referred to cake, candy, chips, and junk food as 'comfort food,' 'delicious food,' and 'fun treats,' even though they verbalized these as 'bad' and 'wrong.' Michael explained 'If you remove everything that feels good, like eating fun things, and only focus on not being overweight, there is not so much to live for.'

Even though the participants enjoyed their food, they blamed themselves afterwards. For example, Susan blamed herself for eating two portions of dinner because 'You can see the extra portion on the bathroom scale […] But it just tasted so good.' When experiences of 'good' behavior and pleasure are not aligned, a conflict occurs between *lifestyle as health behavior* and *lifestyle as living*. This became apparent when the first author enjoyed a delicious lunch at Susan's house with white bread with butter, salmon, and a lot of mayonnaise. Susan said she liked this food when we ate, but 'If the lunch were to be healthier, the bread should be thinner, without butter, and with less mayonnaise.' She could not enjoy her food without experiencing failure due to her non-compliance with dietary guidelines, which told her not to eat white bread, butter, and mayonnaise. She got this feeling weekly, and it often led her to eat chocolate, as did some of the other participants if they had had a bad day: 'If I am sad, I eat chocolate. Then I feel worse because "why did I do that?"' When the participants sought comfort in chocolate after feeling they had failed to meet healthy living guidelines, they often experienced anger towards themselves. This self-criticism intensified their guilt and hindered their ability to accept themselves. Consequently, social well-being and quality of life came to be seen as something that one could either succeed in achieving or fail to attain. These practices can be understood as forms of self-governance, in which New Public Health rationalities are internalized and enacted in everyday life. Participants evaluated their own eating practices in relation to dietary recommendations and responded with self-criticism. The psychomotor therapist illustrated the balance of living and personal risks of non-compliance with healthy living guidelines as a drawing of an old-fashioned bathroom scale. This drawing was at the kitchen table at Ann's house, and she explained that it symbolized balancing healthy and unhealthy behaviors. She provided an example from her everyday life demonstrating how to balance adhering to dietary guidelines and weight loss with experiencing well-being and quality of life: 'It is all about being in balance, so you can eat cake when celebrating a birthday, but you should not eat the rest the next morning.'

Right or Wrong Health Behavior: Persisting Moral Categorizations

Despite the lifestyle program's aim of 'balancing lifestyle' through changes in habits and mindset rather than focusing on weight loss and specific health behaviors, the dietitian and physiotherapist provided the participants with a range of official guidelines, including recommendations on dietary choices and physical activity, throughout the program. The dietitian introduced the Danish Veterinary and Food

Administration's official dietary guidelines, which are 'good for health and climate' (Danish Veterinary and Food Administration n.d.):

1. Eat plant-rich, varied, and not too much
2. Eat more vegetables and fruit
3. Eat less meat – choose legumes and fish
4. Eat wholegrain foods
5. Choose vegetable oils and low-fat dairy products
6. Eat less sweet, salty, and fatty food
7. Thirsty? Drink water

These recommendations emphasize what to eat to avoid illness and diet-related diseases but do not include the possible pleasure of eating, for example, sweet, salty, or fatty foods. Before the dietitian presented the guidelines in a diet session, she highlighted the discursive conflict we aim to explore in this study. As a municipal employee, she explained that she was required to promote national guidelines. Yet, she expressed that she hoped for the session that the participants would develop a more relaxed relationship with food.

On advice number four, 'eat wholegrain foods,' the dietitian introduced the participants to the wholegrain logo, a symbol prominently displayed on mass-produced wholegrain products like rye bread and oatmeal in Danish supermarkets. This logo is designed to make wholegrain options more accessible and increase public awareness of their health benefits (Danish Veterinary and Food Administration 2024). By framing health as a shared responsibility and linking it to accessible consumer choices, the logo serves as a governing tool for guiding people's behavior toward the desired norm of risk prevention through dietary adherence. The participants desired to align their health practices with these recommendations to reduce their risk of illness and disease. At the same time, the session revealed that dietary advice may rely on implicit assumptions about shared healthy food knowledge. For example, when the dietitian encouraged participants to 'choose legumes,' Ann asked, 'Where can I buy legumes, and how do they look?' The participants' willingness to engage with the dietary guidelines became evident in a subsequent session. Susan shared her experience of attempting to purchase bread labeled with the wholegrain logo, reflecting on her effort to make choices aligned with the guidelines. However, she realized the bakery she frequented did not display such logos, illustrating how the practicalities of everyday life can complicate their own desires to align practices to *lifestyle as health behavior*.

While these discussions centered on food and nutrition, they were not the only focus. In a physical activity session, the physiotherapist presented the national physical activity guidelines on a slideshow: 'You should engage in 12 minutes of high-intensity cardiovascular exercise two to three times per week. Further, you should engage in weight training exercises, one to three sets of eight to fifteen repetitions, also two to three times per week.' After the presentation of this, the participants did not ask any questions as they usually did to this kind of information, and the information seemed more confusing and destructive of any motivation. The physiotherapist moved on to the next slide, stating, 'Sitting is the new smoking,' and explained ways to incorporate more movement into daily life, such as walking while talking on the phone or brushing teeth. Just like the dietitian, the physiotherapist was stretched between formal public health promotion requirements and the more holistic focus of the program on habits, values, and self-acceptance. At the end of the session, the physiotherapist, therefore, emphasized, in contrast to the relatively comprehensive recommendations at the beginning of the session, that 'Even minimal physical activity is better than none,' aiming to reassure the participants that engaging in even small amounts of exercise is still beneficial for their overall health. However, they struggled with physical inactivity and accepting their behavior as not aligning with recommendations for an active and thus healthy lifestyle. As Susan expressed during a physical activity session, 'There are so many good reasons to be physically active, but I am not,' and 'I want to start running, but I cannot run.' Susan shared this after she learned

that Ann both exercised in a fitness center and walked her dog, which are habits Susan admired but felt unable to replicate.

Regardless of whether the participants followed the national guidelines, they categorized their behaviors as healthy and right when, for instance, eating salads or engaging in physical activity. In contrast, they labeled behaviors like eating chips, candy, or lying on the couch as unhealthy and wrong. This dichotomization of right and wrong behavior is supported by other literature (Lindsay 2010) and discursively permeated participants' and educators' engagement in My Lifestyle in Balance. Ann, who regularly drank sugar-free cola despite the recommendation of drinking water, said to Jennifer, 'I just read how bad and unhealthy it is to drink cola without sugar, but it just tastes so good.' Jennifer answered that she liked soda with sugar the most, but they always had both at home. Though Ann enjoyed her sugar-free soda, she still viewed her behavior as unhealthy and wrong. Later in the lifestyle program, Ann proudly showcased a bottle of water, placing it in front of her with a triumphant 'tada,' symbolizing her belief that choosing water was a healthier, more correct choice.

Within My Lifestyle in Balance, the discourses *lifestyle as health behavior* and *lifestyle as living* emerged through the talk and practices of both participants and educators. However, despite the program's intention to promote a broader understanding of lifestyle, the discourse of *lifestyle as health behavior* remains dominant. This is evident in how the expansion of lifestyle to include self-acceptance and well-being becomes framed within the same logic of achievement and failure as more traditional health goals, such as attaining a 'normal' weight. This entanglement suggests that broadening the concept of lifestyle does not necessarily move beyond a behavioral logic but may instead extend it into new domains.

Concluding Discussion

This paper has unpacked how weight and lifestyle are easily equated despite deliberate attempts to disentangle the two in the municipal lifestyle program. The participants sought to lose weight, as achieving a 'normal' weight is often equated with a healthy lifestyle and strong notions of beauty, with weight loss frequently highlighted as the central objective of lifestyle interventions (Bombak et al. 2020). This understanding is consistent with the New Public Health paradigm, which frames individual behavior change as the primary solution to public health concerns such as overweight and obesity. The participants in the lifestyle program similarly expected that their participation would result in weight loss through health behavior changes, and the educators were committed to disseminating national healthy living guidelines. The relation between weight and lifestyle is often tacitly implied among authorities such as the educators, participants, and researchers alike. It runs in structures when BMI is used as an inclusion criterion in a program that explicitly does not deal with weight. It runs in language, where overweight and obesity are labeled as 'lifestyle conditions,' and My Lifestyle in Balance is understood as a form of 'medicine' for managing overweight. It also runs in the physical environment when the furniture and equipment in the health center do not fit people with larger body sizes. It is no wonder, then, that the participant in the introductory quote of this paper could mistake the municipal program for '[…] a weight loss program wrapped in something about lifestyle.' These examples show a powerful discourse that makes lifestyle primarily a question of (over)weight and health behavior that this municipal program sought to challenge as part of a growing counter-stream of a holistic discourse about *lifestyle as living* (Berlant 2010, Cohn 2014, Fugelli 2006, Larsen 2011, Vogel & Mol 2014).

A key contribution of this paper is to demonstrate how these discourses become entangled in practice within the teaching and experience of the municipal lifestyle program. Our analysis shows how the two main discourses, *lifestyle as living* and *lifestyle as health behavior*, are both contemporary and contradictory. This entanglement leads to conflict and confusion in the participants' daily lives. They do not associate eating vegetables or exercising with a sense of well-being or quality of life. Instead, they tend to blame themselves for engaging in 'risky' or 'unhealthy' behaviors like eating chocolate, chips, and candy or spending too much time on the couch. They also acknowledge the pleasure and well-being these

'fun treats' provide. The program educators sought to promote lifestyle as a holistic concept, focusing on social well-being and quality of life. The educators aimed to set themselves apart from other municipal lifestyle programs by emphasizing mindfulness, acceptance, and values rather than weight loss, body size, and restrictions. However, these efforts extend, rather than displace, behavioral logic, as well-being and quality of life become part of the same framework of evaluation, responsibility, and potential failure.

Monique Lhussier and Susan Carr argue that people move between competing narratives of expert medical knowledge and personal empowerment (Lhussier & Carr 2008). They suggest that health professionals help individuals navigate different perspectives by acknowledging different understandings of lifestyle rather than forcing them into one rigid identity. Mayes (2016) suggests that lifestyle should consider individual interests, hobbies, and priorities. Similarly, Vogel and Mol (2014) advocate a focus on enjoying food by asking oneself, 'Is this good for me?' rather than, 'Am I being good?' This perspective aligns with the broader holistic understanding of *lifestyle as living* that the educators pursued, and the participants found hard to appreciate. Our analysis pointed to an important implication of such a shift in the understanding and practice of lifestyle. Broadening the concept of lifestyle to include how you live your life also introduces more parameters of success or failure in the participants' everyday lives. They feel they are not 'enough' physically active, do not eat 'healthy' foods, and do not have a 'normal' weight according to healthy living guidelines: they fail at lifestyle as health behavior. When the participants do things they enjoy, such as drinking hot chocolate or eating cake, they criticize their behavior and feel conflicted: they fail at lifestyle as living. This is a simplified depiction, but we argue that when the concept of lifestyle is broadened to include more aspects of living, it might introduce a flipside. Our analysis indicates that the concept of lifestyle might not be able to escape the discursive framing of right and wrong health behavior while it grows into a broader moral and existential project, encompassing pleasure, values, and self-acceptance, producing possibilities of 'being right or wrong' at these more deeply personal matters. This raises the question of how this expansion of the concept of lifestyle may affect people's perceptions of their own health and even personhood?

In his warning against the potential side effects of the (new) public health project, Fugelli noted, 'It is fascinating to observe how the sinister [health] hazards are connected to pleasures' (Fugelli 2006, p. 268), somewhat in anticipation of the tension between health hazards and pleasure expressed by the participants in our study. What he did not contemplate was how the praise of pleasure and 'joie de vivre' that he called for may create similar side effects of its own when introduced in a real-world public health setting that is already saturated with the side effects of the new public health that he warned against.

When health authorities design and implement lifestyle programs, it is therefore essential to consider the unanticipated consequences of powerful discursive dynamics and the ethical implications following this, such as the expanding possibilities of failing at lifestyle. We are sympathetic towards a more nuanced and inclusive perspective on health and lifestyle, which is needed to understand and act on contemporary worldwide health challenges such as overweight and other so-called lifestyle-related diseases. However, our study demonstrates that we must simultaneously be curious about how such discursive changes and dynamics, concretely expressed in programs like My Lifestyle in Balance, may affect the daily lives of the people it seeks to support.

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Conflicts of interest

The authors declare they have no conflicts of interest.

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