Embodying Policy?

Young People, Health Education and Obesity Discourse

by

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Contents

Abstract

This thesis stems from a large, international research project funded in the UK by the Economic and Social Research Council (ESRC) (RES-000-22-2003) and led by Dr. Emma Rich and Professor John Evans at Loughborough University between 2007 and 2009. The study investigated how new health imperatives and associated curriculum initiatives were operationalized within and across eight schools located in a county in the Midlands region of England. The schools were chosen to reflect a variety of socio-cultural settings in the UK, and specifically those that were typical of the Midlands county in which the study took place. The research findings formed part of a three-way international collaboration with parallel studies conducted in Australia (led by Professor Jan Wright) and New Zealand (led by Associate Professor Lisette Burrows) and revealed, among other significant findings, that whilst some young people are deeply troubled by obesity discourse, others are emboldened by it. In pursuit of this key finding, this PhD study departs from the aforementioned project through detailed case study exploration of the 'emplacement', 'enactment' and 'embodiment' of health policy in three of the eight UK schools from the ESRC-funded study, focusing specifically on the class and cultural mediations of health imperatives in each setting and the various ways these can affect a young person's developing sense of self (particularly the relationships they develop with their own weight/size). Young people are considered to be 'body subjects' (Blackman, 2012) whose embodiments are assembled, performed and enacted in situ. I therefore speak of 'troubled', 'insouciant' and 'emboldened' bodies as categories which reflect the fundamentally agentic, contingent, relational and fluid nature of young people's embodiment in time, place and space. Hence, whilst highlighting the deleterious and indeed ubiquitous effects of *some* health education programmes on *some* young people's relationships with their weight/size, key findings presented in this thesis offer nuance and complexity to the notion of 'the neoliberal body' (Heywood, 2007; Rizvi and Lingard, 2010; Rose, 1999) through exploration of the ways in which contemporary health imperatives also have potential to privilege and empower some young people. The thesis concludes with a discussion of the implications of these findings for policy makers, educators and researchers whose work concerns young people's health and well-being.

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Illustrations

Abbreviations and Acronyms

BMI..Body Mass Index

DCSF...Department for Children, Schools and Families

DfES..Department for Education and Skills

DoH...Department of Health

EAL..English as an additional language

ESRC...Economic and Social Research Council

Fig. ....Figure

HAES ....Health at Every Size

HE ....Healthy eating

ISI..Independent Schools Inspectorate

LDD ....Learning difficulties and/or disabilities

NCMP ....National Child Measurement Programme

NHS...National Health Service

NHSP ....National Healthy Schools Programme

Ofsted..Office for Standards in Education

PE..Physical Education

PSHE...Personal, Social, Health and Economic (Education)

RA..Research Assistant

RQ...Research Question

SEAL...Social and Emotional Aspects of Learning

SPSS..Statistical Package for the Social Sciences

TPMS ....Totally Pedagogised Micro Society

UK..United Kingdom

USA..United States of America

1. Obesity Discourse, Health Education and Young People

1.1 Introduction

This introductory chapter sets the scene for this research project by providing an overview of contemporary obesity discourse and government approaches to health education, before briefly discussing the ways these have influenced young people's lives, particularly in terms of their schooling. The aims and research questions guiding the project are introduced and discussed before providing justification for the methodological and theoretical components of the study in relation to the aims of the study. The chapter concludes with an overview of each of the subsequent chapters of the thesis.

1.2 'Obesity Warning to Nation'

Popular mass media has long been drawing on dominant health science claims in the reporting of a global 'obesity epidemic' across affluent Western and westernised societies (e.g., Australia, Canada, Hong Kong, New Zealand, UK, USA). Newspapers, magazines, television, radio and the Internet are saturated with reports warning these nations of the health risks associated with being overweight or obese, namely medical conditions such as diabetes and heart disease which are largely assumed to be caused by particular lifestyle choices, such as poor diets and inadequate levels of physical activity (Evans, Davies and Wright, 2004; Evans, Rich, Davies and Allwood, 2008). For example, in the UK, *The Guardian* newspaper published an article in August 2006 entitled 'Obesity Warning to Nation' in which it stated that by 2010 "a third of adults and a fifth of all children will be obese, leading to greater suffering from cancer, heart disease and type 2 diabetes". The same article advised: "people need to want to change their lifestyles and take responsibility for their health, before they face problems in later life". Similar messages, placing an emphasis on individual and community responsibility for health, are repeated by popular media figures, politicians and health educators alike across these countries and are characteristic of the forms of neoliberalism that have dominated governance and politics in Western/ised societies over the last thirty or so years (see Hall, 2011). Furthermore, in 2005, the UK government commissioned *Foresight*, its 'science based futures think tank' (Department of Health, 2007) to conduct a review of obesity in the UK. The Foresight project report '*Tackling Obesities: Future Choices*'

published in 2007 (see Butland, Jebb, Kopelman, McPherson, Thomas, Mardell and Parry, 2007) exemplified UK government attitude and policy toward weight and health, advising, amongst other things, that "[t]ackling obesity requires far greater change than anything tried so far, and at multiple levels: personal, family, community and national" (Department of Health, 2007). Wright (2009, p.1) suggests that this expression of obesity discourse (i.e., the reduction of complex health issues largely to matters of weight, exercise and diet) is "one of the most powerful and pervasive discourses currently influencing ways of thinking about health and about bodies" in contemporary Western society.

1.3 A Knowledge-Deficit Model for Health Education

> The assumption underpinning a focus on building knowledge is based on the premise that if we have knowledge we can change our behaviour (Leahy, 2009, p.175).

The above quotation captures an issue that is of central relevance to this thesis. The 'medicalisation of weight', implicit in contemporary obesity discourse and described above, has pointed to a number of health 'risks' associated with particular lifestyle choices ('choices' which, in the main, reflect a 'poor diet' and 'lack of exercise'). Thus, the 'obesity epidemic' is largely attributed by government health officials (in the UK and elsewhere) to a 'knowledge deficit' among certain individuals and sections of the population, i.e., a lack of 'expert' knowledge about the risks associated with certain lifestyle choices and excess weight. Put simply, lack of knowledge = poor lifestyle choices = obesity and associated health problems, according to the government. Government solutions to this public health 'crisis' are therefore focused on reversing this assumed trend by educating the population about the risks associated with certain lifestyle choices to bring public behaviour (and, therefore, waistlines) in line with government 'requirements'. Embedded within government health policy aimed at tackling the 'obesity epidemic', then, is an assumed relationship, firstly between an individual's increased knowledge about lifestyle choices and risks and their subsequent performance of government-prescribed 'health' behaviours (largely concerning diet, exercise and an appropriate body weight), and secondly between the performance of these health behaviours and an individual's achievement and maintenance of a 'healthy' weight. This approach is summarised here as: expert knowledge = 'correct' lifestyle choices = 'health', and illustrated in hierarchical terms in Fig. 1.1 below, whereby from the bottom up each level serves as a prerequisite for the next:

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                         /  \
                        /    \
                       /      \
                      /        \
                     /  'Health' \
                    /  Achievement   Performance \
                   /_____\
                  /        Behaviour             \
                 /                                 \
                /     Diet   Exercise   Weight      \
               /_____\
              /             Knowledge                   \
             /                                            \
            /      Risks   Choices   Responsibility        \
           /_____\
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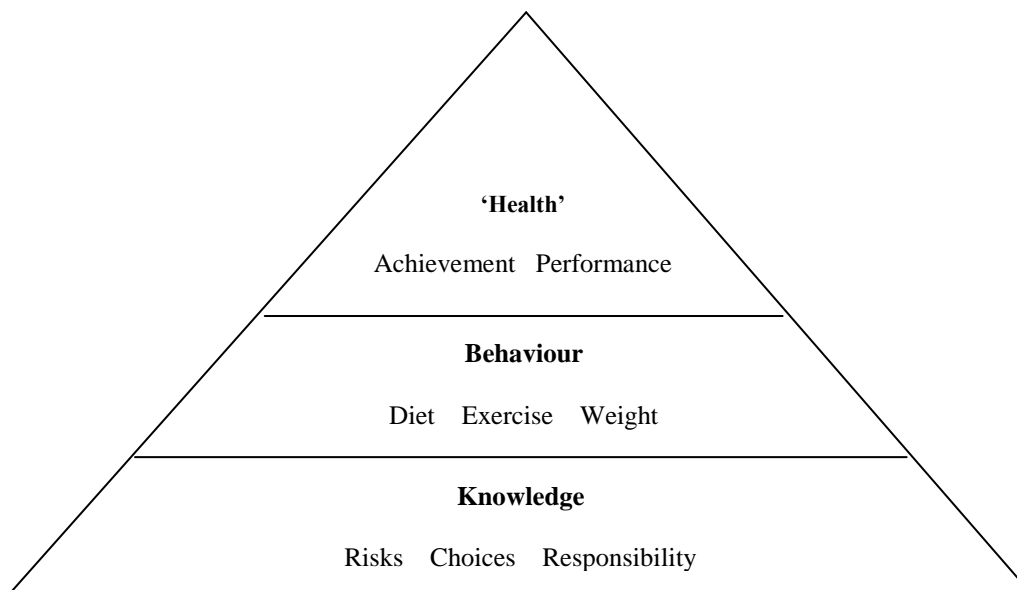
Fig. 1.1 Knowledge-Deficit Model for Health Education

This model, and the neoliberal principles underpinning it, frame 'health' as an entity to be achieved and continually performed by individuals. It is perhaps unsurprising, therefore, that the weight, size and shape of individuals' and populations' bodies (as indicators of health) have become a focal point of contemporary Western life over the last three decades. The widespread conception of the 'healthy' body is now at the centre of government programmes, industry and individuals' every day conversations and of particular interest to this study is how this ideal, and the assumptions underpinning its achievement, have influenced health education and pupils' subjectivities in schools.

1.4 School Health Policy

Attention of this kind has been increasingly directed at children and young people, a population defined as most 'at-risk' of being affected by the ever increasing 'obesity crisis'. This, coupled with the widespread belief that health-related behaviours and attitudes (namely relating to diet and physical activity) are formed during childhood (Food and Drink Federation, 2004; Hark and Deen, 2005; Jefferson, 2006) has resulted in a variety of government early intervention strategies targeting schools, families and wider community settings, as the key to tackling obesity, not only in the UK but worldwide (Department of Health, 2004; 2005; 2008). To address the aims of this doctoral research project (see section 1.6 below), this thesis focuses on the plethora of UK government health policy aimed

specifically at schools over the last decade. In-keeping with the government's knowledge-deficit model for health education (outlined in section 1.3 above), these policies have intended to 'educate' all young people about the health risks associated with a poor diet, lack of exercise and excess weight, with the intention of urging them to alter their behaviour accordingly (e.g., by eating the 'right' foods, doing the correct amount of physical activity etc.) in the name of 'achieving' health.

Other countries, such as Australia and New Zealand, have placed a far greater emphasis upon health education through school curricular than in the UK, where school Physical Education (PE), for example, has traditionally been dominated by competition and sport (Penney and Chandler, 2000). Until recently, health education in the UK has predominantly been taught outside of PE, for example in Personal, Social, Health and Economic (PSHE) education[1] or as a marginal component of a PE curriculum. However, contemporary government health policy has increasingly encouraged UK schools to adopt a 'whole school approach' to the design and delivery of their health education programmes. This approach involves nine key 'themes' listed in Box 1.1 below, and has been heavily influenced by the rhetoric of the UK government's National Healthy Schools Programme (NHSP), jointly funded by the Department of Health (DoH) and the (then) Department for Education and Skills (DfES).

Box 1.1 Key Themes of the NHSP Whole School Approach (DoH, 2011)

1. Leadership, management and managing change
2. Policy development
3. Learning and teaching, curriculum planning and resourcing
4. School culture and environment
5. Giving children and young people a voice
6. Provision of support services for children and young people
7. Staff continuing professional development (CPD) needs, health and well-being
8. Partnerships with parents/carers and local communities
9. Assessing, recording and reporting the achievement of children and young people.

The DoH and DfES published revised standards for the programme in 2005, which stipulated that in order to achieve 'Healthy School Status', schools were required, through a 'whole-school approach', to provide evidence of specific health education criteria across four themes

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[1] Previously known as Personal, Social and Health Education.

that comprise the 'healthy school': Personal, Social and Health Education[2]; Healthy Eating; Physical Activity and Emotional Health and Well-being (DoH, 2005). This programme, along with the whole school approach, resulted in a number of changes to the internal organisation of schools through schemes such as '5 A DAY', the removal of vending machines, revised lunchtime menus, monitoring of packed lunches, and 'healthy snacks' by way of promoting 'healthy eating'. A number of PE and school sport initiatives have also been introduced to schools in recent years to 'combat obesity' by improving the quality of PE provision and encouraging increased participation in sport and physical activity. For example, in July 2011, the Department of Health published revised recommendations of "vigorous intensity activity for school-age children of at least 60 minutes a day" (National Audit Office, 2012, p.24) and funding has recently been made available for initiatives which provide increased opportunities for physical activity, such as Change4Life Sports Clubs and the UK School Games, inspired by the Olympic and Paralympic games. Furthermore, an emphasis has been placed on the availability of 'quality information' to monitor young people's bodies. The National Audit Office (2012, p.27) has argued that:

> [g]ood information is essential to tackling obesity. Without accessible and robust information, decisions cannot be taken on both preventing and treating obesity. The availability of accurate, complete and timely data will be increasingly important as local authorities become responsible for tackling obesity.

The measurement of children's Body Mass Index (BMI) provides a key example of such data gathering for monitoring purposes. An individual's BMI is calculated by dividing their body mass (weight) by the square of their height. Individuals can quickly and easily work out their BMI using the BMI 'table' or 'chart' which is widely available online, in popular health magazines and in diet and nutrition books. Individuals can now also input their weight and height into an online BMI calculator in order to receive their BMI score and related health advice (see Department of Health, 2012, for example). This health assessment method was introduced to UK schools in 2005 through the National Child Measurement Programme (NCMP), which requires children to be weighed and measured when they begin primary school (aged 4 or 5) and again when they leave primary school (aged 10 or 11), firstly, "to inform local planning and target local resources and interventions", and secondly, to "enable tracking of local progress against the goal of halting the year on year rise in obesity among

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[2] Now known as Personal, Social, Health and Economic education.

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children under the age of 11 years by the year 2010" (Department of Health, 2006). More recently, however, Primary Care Trusts have been encouraged to report back to parents and carers, to advise about their child's weight and health (Department of Health, 2010). Other examples of information gathering and health monitoring techniques in UK schools include the introduction of biometric fingerprint scanning systems to record information about young people's lunchtime meal choices. Similarly, this information can be fed back to parents via a report which can be used to assess the extent to which their child is complying with 'expert' health knowledge.

Clearly, then, a plethora of UK government health policies and initiatives have been introduced to schools in the last decade, through which all schools have become increasingly accountable for young people's health. Whilst these policies reflect the government's good intentions to improve the health of the next generation, the next section briefly discusses recent research which has highlighted the ways in which these strategies, deriving from dominant health and obesity discourse, may in fact be detrimental to young people's health and well-being.

1.5 Research Context

Despite its wide acceptance and influence across the Western world, the rhetoric of the obesity 'epidemic' described above has, in recent years, been problematised by a growing number of academics who have begun to document the damaging effects of this health and obesity discourse on individuals', particularly young females', subjectivities (see Allwood, 2010; Burrows and Wright, 2007; Campos, 2004; Campos, Saguy, Ernsberger, Oliver and Gaesser, 2006; Evans et al., 2004; Evans et al., 2008; Gard and Wright, 2005; Monaghan, 2005; Rich, Evans and De Pian, 2011 and Warin, Turner, Moore and Davies, 2008, for example). However, the ways in which this discourse also has potential to privilege and empower young people (male and female) have largely been unexplored. This thesis stems from a large, international research project funded in the UK by the Economic and Social Research Council (ESRC) (RES-000-22-2003) and led by Dr. Emma Rich and Professor John Evans at Loughborough University between 2007 and 2009. The study involved semi-structured interviews with health/physical education teachers (n = 19) (see Appendix 2), pupil questionnaires (n = 1176) (see Appendix 3) and semi-structured interviews with pupils (n = 90) (see Appendix 4) to investigate how new health imperatives and associated curriculum initiatives (such as those described in section 1.4 above) were operationalized and experienced within and across eight schools located in a county in the Midlands region of

England. The schools were chosen to reflect a variety of socio-cultural settings in the UK, and specifically those that were typical of the Midlands county in which the study took place (see Table 3.1, Chapter 3, for details of each school). The research findings from the ESRC project formed part of a three-way collaboration with parallel studies conducted in Australia and New Zealand and revealed, among other significant findings, that not all young people feel negatively about their weight/size. This PhD research pursues this key finding and, in so doing, departs from this international collaboration through detailed case study exploration of the 'emplacement', 'enactment' and 'embodiment' of health policy in three of the eight UK schools, to broaden current understanding of young people's subjective, embodied experiences of their school health education (specifically the ways their experiences shape the relationships they develop with their weight/size) and the implications of this for a young person's developing sense of self. Whilst highlighting the deleterious and indeed ubiquitous effects of *some* health education programmes on *some* young people's relationships with their weight/size, key findings presented in this thesis offer nuance and complexity to the notion of 'the neoliberal body' (Heywood, 2007; Rizvi and Lingard, 2010; Rose, 1999) through exploration of the ways in which this discourse also has potential to privilege and empower some young people.

1.6 Aims and Research Questions

As noted above, the key aim of this study is to broaden current understanding of young people's subjective, embodied experiences of their school health education (specifically the ways their experiences shape the relationships they develop with their weight/size) and the implications of this for a young person's developing sense of self. Hence, the key research aims and questions guiding the study are:

- **Aim 1: To contribute empirical and theoretical insights into the 'emplacement' of health policy in schools that heighten understandings of how the unique 'contextual dimensions' of a school shape constructions of health/obesity in situ.**
- *RQ 1: How do the unique 'contextual dimensions' of a school shape constructions of health/obesity in situ?*

- **Aim 2: To contribute empirical and theoretical insights into the 'enactment' (pedagogy and practice) of health policy in schools, that heighten understandings of how young people learn about 'health' and 'obesity' in school.**

- *RQ 2: Through which pedagogies and practices do young people learn about 'health' and 'obesity' in school?*

- **Aim 3: To provide empirical and theoretical insights into young people's 'embodiment' of health policy in schools, that heighten understandings of the role school health education programmes play (if any) in the relationships young people develop with their own weight/size.**
- *RQ 3: What role (if any) do school health education programmes play in the relationships young people develop with their own weight/size?*

- **Aim 4: To develop theoretical understanding of how the above processes of policy emplacement, enactment and embodiment shape a young person's sense of self.**
- *RQ 4: How do the above processes of policy emplacement, enactment and embodiment shape a young person's sense of self?*

- **Aim 5: To outline and discuss the implications of this study for policy makers, health educators and researchers whose work is concerned with young people's embodied health and well-being.**
- *RQ5 5: What are the implications of this study for policy makers, health educators and researchers whose work is concerned with young people's embodied health and well-being?*

1.7 Theoretical Underpinning

In an attempt to build upon extant linear, over-determined understandings of young people's subjective, embodied experiences of their school health education (specifically the ways their experiences shape the relationships they develop with their weight/size), this study draws upon 'affect' and post-structuralist theory to both acknowledge and interrogate the roles of structure, agency and embodied emotion in this process. Health policy is conceptualised as discursively constituted knowledge/truth, which shapes and is shaped by the idiosyncrasies of a school context as a site of governance, surveillance and learning. Hence, young people's bodies become *situated* (pupil) bodies in time, place and space that variously experience and embody health policy, both through their school's mediations as well as the histories and biographies they themselves bring to their learner encounters in

school. Thus, a child is conceptualized in this study as "an active, social agent and sense-maker who shapes and is shaped by their social environment" (Duckett, Sixsmith and Kagan, 2008, p.94). Drawing on affect theory and Evans et al.'s (2008) 'corporeal device' in particular, I discuss 'body-subjects' (Blackman, 2012) that are assembled, performed and enacted in situ (see Chapter 8). I therefore speak of 'troubled', 'insouciant' and 'emboldened' bodies as categories which allow theorisation of pupils' bodies beyond the individual, whilst reflecting the fundamentally agentic, contingent, relational and fluid nature of young people's embodiment in time, place and space. This research thus highlights and engages with the complexity of both the policy process itself as a product of the organisational and social relations of schooling, and the idiosyncratic nature of young people's embodied subjectivities.

The research addresses a significant gap in existing knowledge concerning young people's subjective, embodied experiences of health policy and the impact of this on their developing sense of self. Its findings potentially have significant implications for young people's well-being as well as for researchers, educators and policy makers whose work concerns young people, social class and relationships between public health discourse, health pedagogy and individual pupil subjectivity. It is anticipated that findings from the study will provide insights into alternative ways of educating young people, which have the potential to enable *all* young people to experience 'health' and form positive relationships with their weight/size.

1.8 Research Design

The key aim of this study is to broaden current understanding of young people's embodied experiences of their school health education (specifically the ways their experiences shape the relationships they develop with their weight/size) and the implications of this for a young person's developing sense of self. The research therefore seeks to understand the subjective experiences of school-age children and in so doing places an emphasis on the collection and analysis of in-depth, qualitative data. Furthermore, Ball, Maguire and Braun (2012) highlight an apparent lack of 'real-life' analyses of education policy in schools, which involve 'real', and diverse school settings, policy actors (health educators and young people in schools) and the various nuances that take shape in each specific context. This study, therefore, sets out to address this gap; to bring health policy in schools 'to life', thus allowing detailed and meaningful theorisations of how schools *'do'* health policy and the various ways in which young people embody this (see Chapters 5 to 8). Hence, this study adopts a case study approach to data collection to "investigate and report the real-life, complex, dynamic and

unfolding interactions of events, human relationships and other factors in a unique instance" (Cohen, Manion and Morrison, 2007, p.253). Thus, case studies are said to "portray what it is like to be in a particular situation" (ibid.). Three schools were identified and selected for study by the initial quantitative analyses of the data gathered for the ESRC study (see section 1.5 above) and case studies were compiled involving descriptive quantitative and qualitative data collected via pupil questionnaires (n = 360) and qualitative data from semi-structured interviews with health education staff (n = 7) and young people (n = 32) across the three schools (see Table 3.1 for a breakdown of data collected at each school).

1.9 Overview of Thesis

Chapter 2 develops this introductory chapter through an in-depth critical appraisal of the 'obesity epidemic' and, in so doing, reveals the positioning of this study within the existing body of literature concerned with obesity discourse, health education and young people's embodiment. The aim of the chapter is to review current literature, which offers counter arguments to dominant obesity discourse in the context of children's embodiment and their learning about health in school. Through this review, I will discuss the ways in which the current debate and theorising of the 'obesity epidemic' can move forward and demonstrate that by drawing on affect and poststructuralist theory, counter discourses to those which dominate the media and current health policy can be developed. **Chapter 3** outlines the methodological principles underpinning this research and the methods employed to collect data in accordance with its aims. The realities of data collection across three school sites are explored through a reflexive commentary relating to the methodological and ethical issues, which arose as the research process unfolded, largely as a result of conducting research with children. **Chapter 4** draws upon some of the questionnaire data provided by the larger ESRC study and its more diverse population of young people (n = 1176) compared with those used in previous research in this field. Focusing on young people's embodiment in particular, this chapter draws on the quantitative (descriptive) questionnaire data provided by 1156 of the young people in the sample from across the eight schools who responded to the prompt 'I am happy about my current weight/size' by choosing from the options: 'never', 'sometimes' or 'all the time'. **Chapters 5, 6 and 7** build upon initial findings presented in Chapter 4 through in-depth case study analysis of the emplacement, enactment and embodiment of health policy in three divergent school contexts, to better understand young people's learning about health and their own bodies, and particularly why some young people appear to fare better than others in the relationships they develop with their weight/size. **Chapter 8** discusses key

findings from the case studies presented in the preceding three chapters, to build on literature discussed in Chapter 2, and, in so doing, offers some nuance to the relationship between policy, pedagogy and pupil subjectivity, adding complexity to the self-actualising, self-realising, disciplined, compliant, independent, neoliberal body (Rizvi and Lingard, 2010; Rose, 1999). **Chapter 9** moves the discussion beyond the three schools explored in this study, to demonstrate the relevance of findings for contemporary and future research, policy and pedagogy concerning obesity discourse, health education and young people's embodiment. Given that this research is not a policy evaluation *per se*, its implications for health policy are by no means taken for granted. Nor are the views offered to be taken as concrete or absolute. Rather, by focusing on the meaning and relevance of health policy when emplaced and enacted in different contexts, Chapter 9 seeks only to provide information and *insights* that may contribute to debate and inform practices, especially those overly driven by narrow, reductive constructions of health (e.g., concerned with eating the right food, doing exercise and producing/maintaining the slender body). Consequently, revisions to dominant health curricular will be suggested and, in so doing, I consider ways in which counter arguments to dominant obesity discourse can be framed to move forward debate about 'health' and explore a range of possibilities for further study in this field. **Chapter 10** concludes the thesis with a summary of the key content, reminding the reader, in particular, of the original aims and research questions set out in this introductory chapter. The chapter then critically reflects on how and where these aims have been addressed throughout the thesis, before making suggestions for future research concerned with health policy, pedagogy and young people's embodied subjectivity.

2. A Critical Appraisal of the 'Obesity Epidemic'

2.1 Introduction

The aim of this chapter is to build on and develop the preceding introductory chapter through a critical appraisal of the 'obesity epidemic'. In particular, the chapter provides an in-depth review of existing literature, concerning obesity discourse, health education and young people's embodiment and therefore reveals the positioning of this study within this existing body of literature. I begin with a discussion of Foucauldian-influenced writing on this topic, with particular reference to the work of Gard and Wright (2005), Halse (2009) and Wright and Harwood (2009). Whilst acknowledging the role of power and discourse in the critical examination of young people's embodiment and learning about health at school, however, attention is drawn to the limitations of a linear, top-down approach to this task. Alternatively, a case is made for the utilisation of affect theory (see Blackman and Venn, 2010, for example) to broaden current understandings of young people's embodied experiences of school health policy and therefore address the aims of this research. Through this, conventional opposition between discourse and affect is challenged, to bring young people's social and emotional experiences of 'health' and their bodies to the fore. In discussing the credits and limitations of the aforementioned literature, I point to the implications of privileging structure *or* agency, rather than acknowledging both structure *and* agency simultaneously in young people's learning about and embodied experiences of 'health'. I therefore argue not for dissolution of top-down/bottom-up dualisms/distinctions altogether (see Giddens, 1971, for example), but rather a need for both 'bottom-up' *and* 'top-down' perspectives on young people's learning about health, to capture a deeper and more nuanced understanding of young people's embodiment.

2.2 A Critical Social Analysis of the 'Obesity Epidemic'

Chapter 1 provided an overview of contemporary obesity discourse and government approaches to health education, before briefly discussing the ways these have influenced young people's lives, particularly in terms of their schooling. Despite its wide acceptance and influence across the Western world, the rhetoric of the obesity 'epidemic' discussed in Chapter 1 has, in recent years, been problematised by a growing number of academics.

Drawing largely on the work of Michel Foucault (1973; 1984), this literature engages in critical social analysis of the 'obesity epidemic', particularly in terms of how dominant constructions of obesity and excess weight are materialised and experienced by individuals and populations across a range of contexts. Particular attention has been paid to the damaging effects of dominant health and obesity discourses on individuals' subjectivities, particularly for young, middle class females in school (see Allwood, 2010; Burrows and Wright, 2007; Campos, 2004; Campos et al., 2006; Evans et al., 2004; Evans et al., 2008; Gard and Wright, 2005; Monaghan, 2005; Rich et al., 2011 and Warin et al., 2008, for example). Thus, many of the aforementioned scholars, among others, have been concerned with what this discourse *does*. The remainder of this section engages with this literature through critical discussion of the ways in which obesity discourse has contributed to constructions of a normative, 'healthy' body, "rational expert systems of governance" (Leahy and Harrison, 2004, p.135) and the conceptualisation of schools as 'institutions of normative coercion' (Turner, 1997).

2.2.1 Constructing a Normative 'Healthy' Body

At the core of health monitoring and surveillance practices, such as those mentioned in Chapter 1 (section 1.4), is the notion of a 'normative' body weight, which simultaneously defines all other bodies in comparison. Drawing on Bernstein, Evans et al. (2008, p.18) refer to this normative construction as the '*imaginary subject',* which works to define who and what individuals are and who and what they should become (Ivinson and Duveen, 2006, p.109). Thus, through asserting that a 'normative', slender body, is what every individual should aspire to achieve in the context of an 'obesity epidemic', the government and related institutions (e.g., schools) are simultaneously confirming what we *shouldn't* be; that it is wrong to be inactive and 'fat'. Hence the 'fat' body is conceptualised through obesity discourse as 'diseased', 'risky' and lacking control (Rich, Evans and De Pian, 2010). As a consequence, an individual's body is defined through obesity discourse by and in relation with the 'obese body' as a 'potentiality' to be avoided (ibid., p.5), thus positioning all bodies as 'at risk', and all individuals as personally accountable for managing this risk (ibid.).

2.2.2 'Rational Expert Systems of Governance'

The 'medicalisation of weight' discussed in Chapter 1 (see section 1.2) through the naming of obesity as a disease and the identification of various risk factors associated with it is also said to have generated "rational expert systems of governance" (Leahy and Harrison, 2004, p.135) and "public health discourses of individual responsibility, morality and the drawing up of distinctions between the normal and the pathological" (Wright, 2009, p.9). Hence, the

promotion of imperatives associated with particular health behaviours such as those discussed in section 1.4 (e.g., doing 60 minutes of intense physical activity per day, eating 5 pieces of fruit and vegetables each day) and/or achieving and/or maintaining a 'healthy' body weight (e.g., through regular weighing, BMI calculations), have prompted individuals to measure, govern, compare and judge their own and others' bodies and lifestyle choices in the name of achieving 'health'. This discourse is characteristic of the forms of neoliberalism that have dominated governance and politics in Western society over the last thirty or so years (see Hall, 2011), a discourse which promotes the self-actualising, self-realising, disciplined, compliant, independent individual (Rizvi and Lingard, 2010; Rose, 1999), represented by the lean, fit, active, weight-watching, diet-following, health-seeking body.

The above approach has largely been theorised through Foucault's (1984) notion of 'biopower' – "the governance and regulation of individuals and populations through practices associated with the body" (Wright, 2009, p.1), in this case prescribing how people *ought* to behave in relation to one main objective; individual conformity to the normative body weight discussed above. This discourse is further substantiated by the BMI (see section 1.4 for details), which has been regarded by the aforementioned scholars as a means through which to assess individual efforts to regulate and maintain one's health (and thus a normative body). Deriving from scientific positivism, the BMI "invokes an aura of truth, trustworthiness and transparency" (Halse, 2009, p.47) and is widely accepted and referred to throughout medical, government and media reporting. Nevertheless, the use of the BMI to measure *young people's* bodies in schools, through the NCMP (see section 1.4), for example, has been heavily criticised, not least by parents and carers who are told their child is 'overweight' or 'obese', despite no apparent weight or health problem. Halse (2009) has drawn on the work of Foucault to compare this body measurement tool to Jeremy Bentham's (1785) panoptican, legitimated by "a truth discourse" that a BMI measurement that falls outside of the statistical 'norm' "constitutes a social, economic and/or health problem" (p.55). As a result of its purportedly objective, numeric nature, "devoid of personal prejudice and subjective value" (Halse, 2009, p.47), the BMI is believed to have contributed to the simplification of the relationship between weight and health (ibid.) to the extent that 'fat' is synonymous with 'unhealthy' (poor diet and a lack of exercise) and 'thin' with 'healthy' (the 'correct' diet and regular exercise) (Harding and Kirby, 2009).

Thus, the normative body weight circulating through obesity discourse and reinforced by the BMI is the "virtuous mean to which we should *all* aspire" (Burry, 1999, p.610). The notion of a normative weight therefore extends beyond an imperative of health, to one of virtue;

> values, beliefs, practices and behaviours that establish regimes of truth and shape subjects and subjectivities by articulating and constructing particular behaviours and qualities as worthy, desirable and necessary virtues (Halse, 2009, p.47)

Thus, in addition to weight being regarded as an indicator of health, it also represents one's virtue, for "a low BMI is aligned with self-discipline and restraint and a high BMI (overweight or obese) is the binary 'Other' – the physical manifestation of self-indulgence and a lack of self-discipline and moral fortitude" (ibid., p.48). An individual's weight, regardless of genetics, it is argued, therefore "remains a matter of self-control and personal responsibility" (Burry, 1999, p.610). In this respect, Halse (2009, p.54) affirms that the 'product' of bio-power' is the 'bio-citizen':

> a public-minded, socially responsible individual who is concerned about the common good and well-being of society. S/he adheres to the social contract between the individual and the State by renouncing irresponsible weight-related behaviours as an active demonstration of care for the health and economic well-being of self, family and nation.

Implied here is the notion that teachers, parents and pupils are culpable in the (re)production of health and illness (Burrows and Wright, 2004) and 'failure' to comply with the production and maintenance of a normative 'healthy' body results in profound social implications such as individuals being ridiculed, alienated and 'othered' (Burry, 1999; Halse, 2009) and parents deemed to be 'bad parents' (Halse, 2009, p.52). In extreme cases, parents have faced punishment from the state with the loss of child custody and parental rights, as in the case of 3 year-old Anamarie Martinez-Regino in the USA. Weighing 54 kilograms, Anamarie was three times heavier than an average 3 year old and she was subsequently removed from her parents' custody by the Government of New Mexico (Halse, 2009). Conversely, individual efforts to successfully comply with a 'normative' weight are celebrated (ibid.), further reinforcing the aforementioned discourse of virtue. Thus, the virtuous bio-citizen is embodied through the appropriate/moral conduct of an *individual* in the context of the *common good* (ibid.).

Obesity discourse is therefore premised on the notion that individuals are free to make these 'choices'; that individuals' agency around 'health' is unrestrained and free from structural inequalities (e.g., socio-economic), which may have significant bearing on *which* choices are available to them and indeed sections of the population. This is perhaps surprising given that successive governments' documentation of varying obesity levels between socio-economic groups has clearly shown that obesity might more reasonably be regarded as a 'disease of poverty' (Smith, 2004 in Fox and Smith, 2011). The following section critically engages with literature concerned with the ways in which this discourse, its imperatives and practices have materialised in school contexts and are experienced and embodied by young people, therefore providing a key backdrop to this study.

2.2.3 Schools: 'Institutions of Normative Coercion'

According to Shilling (2004, p.xv), the ways in which schools regulate, discipline and civilise the bodies of their pupils are a reflection of "specific norms and expectations of societies at particular stages in their development". Rich, Evans and De Pian (2011) refer to messages deriving from the assumed relationship between physical activity, body regulation, dietary habits, sedentary behaviour and weight as 'new health imperatives' in schools and argue that such imperatives are increasingly encouraging young people to govern their own and others' conduct around health. Hence, anti-obesity policy and practice is said to have generated changes to the organisation of schooling in such a way that young people's bodies are subject to the previously discussed notion of biopower. Drawing on this concept, Wright and Harwood (2009) have furthered theoretical understandings of obesity discourse and the practices it endorses by bringing together notions of biopower and pedagogy in the term 'biopedagogy':

> the normalising and regulating practices in schools and more widely which have been generated by escalating concerns over claims of a global 'obesity epidemic' (Wright, 2009, p.8).

Furthermore, over the last decade, the monitoring and assessment of school performance by the UK government Office for Standards in Education (Ofsted) has extended beyond academic indicators to include 'health' performance indicators, particularly those associated with healthy eating (Ofsted, 2006; 2010). Hence, 'expert' knowledge about health is, unsurprisingly, uncritically accepted and interpolated as 'fact' by many educators (Evans et al., 2004) thus constituting schools as 'institutions of normative coercion' (Turner, 1997).

Following Bernstein, Evans et al. (2008) argue that schools have increasingly become 'totally pedagogised micro-societies' (TPMS) whereby concern for health and the body is no longer the responsibility of specific curriculum subjects alone e.g., PE and PSHE education; rather, through government endorsed approaches (such as the NHSP whole school approach discussed in section 1.4 and Box 1.1) it is everywhere, embedded within all aspects of schooling, and as such "no 'body' escapes the evaluative gaze" (ibid., p.17). Furthermore, Evans et al. (2008, p.xii) state

> [o]f all the ways in which messages about health and well-being could be incorporated into a curriculum, knowledge about body management in schools is framed against the backdrop of a normative and highly partial vision of 'corporeal perfection'.

These practices are not experienced uniformly by all teachers or pupils, however. As Shilling (2004, p.xv) argues

> knowledge is not dispensed and received by a 'circuit of minds', but flows within a corporeal context that determines its salience and that shapes what particular individuals make of the curriculum on offer to them.

The following sections of this chapter therefore focus on the ways in which scholars in education/health policy studies have shifted their attention in recent years from policy implementation to processes of policy 'emplacement' and 'enactment' (see Ball, Hoskins, Maguire and Braun, 2011 and Ball, Maguire and Braun, 2012, for example).

2.3 Policy Processes: From Text to Practice

A growing body of research in the sociology of education has begun to challenge conventional writing about education policy 'implementation', arguing that if we are to fully and more accurately understand policy (what it is and how it functions), then it must be regarded as 'a process' (Ball et al., 2012; Evans et al., 2008), taking account of the various ways in which policy both shapes and is shaped by a multitude of situational and contextual factors as it is enacted in specific school settings. Thus, in adopting this view, the concepts of policy 'emplacement' and 'enactment' are introduced and discussed below and referred to throughout the remainder of this thesis.

Ball et al. (2012) maintain that existing school-based policy implementation studies (e.g., Spillane, 2004; Supovitz and Weinbaum, 2008) have tended to 'homogenise' and 'de-contextualise' schools, considering them to be an "undifferentiated whole into which various policies are slipped or filtered into place" (Ball et al., 2012, p.5). However, with reference to Lauder, Jamieson and Wikeley (1998, p.62), Ball et al. (2012) draw attention to the "different capacities, potentials and limits" of schools for 'coping' with and responding to policy. They argue, therefore, that policies inevitably transform in accordance with the specific 'contextual dimensions' of a school, which Ball et al. (2012) categorise as "situated, professional, material and external contextual dimensions" (p.21). These are complex and interrelated factors (including buildings, budgets and facilities of a school, which are inevitably and inextricably connected to its locale, setting and reputation – see Box 2.1 below), and all are important for understanding and conceptualising the ways in which policy enactment is mediated by emplacement.

Box 2.1 Contextual Dimensions of Policy Enactment (Ball et al., 2012, p.21).

- **Situated contexts** (e.g., locale, school histories and intakes)
- **Professional cultures** (e.g., values, teacher commitments and experiences, and 'policy management' in schools)
- **Material contexts** (e.g., staffing, budget, buildings, technology and infrastructure)
- **External contexts** (e.g., degree and quality of LA support; pressures and expectations from broader policy context, such as Ofsted ratings, league table positions, legal requirements and responsibilities).

Global, national and regional policies thus become localised as their enactments are enabled and/or constrained by school-specific factors, which are often beyond the control of school staff (Ball et al., 2012). Hence,

> [policy] texts cannot simply be implemented! They have to be translated from text to action – put 'into' practice – in relation to history and to context with the resources available. (Ball et al., 2012, p.3).

In light of this perspective, Ball et al. (2012) argue the need to move beyond conventional, taken for granted, top-down theorisations of education policy which view "all policies and all

schools and all teachers in the same way" (p.4), and which imply an over-simplified and 'socially thin' notion of 'implementation'. Rather, they stress the "jumbled, messy, contested, creative and mundane social interactions, what Colebatch (2002) calls the 'policy activity' of negotiations and coalition building that somehow link texts to practice" (p.2). Hence, Ball et al. (2012) speak of policy 'enactment' rather than implementation, which involves

> creative processes of interpretation and recontextualisation – that is, the translation of texts into action and the abstractions of policy ideas into contextualised practices (ibid., p.3).

This perspective resonates with some of Walkerdine's (2009) musings, which suggest that globalised modes of regulation

> enter into different communities of practice (Lave and Wenger, 1991) [and invoke] different relations of affect [as they] circulate through particular arrangements of time and space (p.201-2).

In this vein, Braun, Ball, Maguire and Hoskins (2011) stress the importance of 'taking context seriously' when analysing the enactment of education policy in schools. Data analysis for this research project therefore begins, first and foremost, with an exploration of the ways in which school contexts, comprising "buildings, budgets, staffing, intakes etc." (ibid., p.581) shape the ways health policy is 'made sense of', mediated and struggled over, ignored or enacted in schools. In line with Braun, Ball, Maguire and Hoskins (2011), the complexities of policy 'as a process' (p.586) are captured through this study, which therefore "set[s] the work of policy within a framework of contingencies and materialities" (ibid., p.581) which are unique to each school setting. The emplacement of policy therefore enables and/or constrains policy enactments in schools, generating "differences in policy enactments between similar schools" (ibid., 2011, p.585). The enactment of policy is, therefore, "intimately shaped and influenced by school-specific factors" (ibid.) an aspect which will be explored in detail across the three schools in this study.

2.3.2 Enacting Policy

> Enactments are always more than just implementation; they bring together contextual, historic and psychosocial dynamics into a relation with texts and imperatives to produce action and activities that are policy (Ball et al., 2012, p.71).

Drawing on the above definition, this next section theorises the way in which health policy is 'enacted' in relation to the contextual dynamics discussed in the previous section. Given the focus on 'live' accounts of policy in this study, it seems apt to begin by discussing what Ball et al. (2012) refer to as the 'peopling' of policy; the initial ways policy is read, interpreted and discussed by policy 'actors' (e.g., in staff meetings) and delegated to an individual member (or group) of staff who become responsible for a particular policy. As Ball et al. (2012) state:

> [t]hese are all moments of recontextualisation, different points of articulation and authorisation that make something into a priority, assign it a value, high or low (p.44-45).

Inevitably, these initial readings, interpretations and discussions, and any subsequent actions will be shaped by many of the situated, material, professional and external factors discussed in the previous section of this chapter; factors which 'emplace' policy in context. Thus, existing discourses, values, interests and practices along with the context and history of the school and the necessity to enact a given policy, shape responses to new policies (ibid.). However, Ball et al. (2012) also highlight possible tensions between these initial responses to policy at Head or Senior Management level and the enactments of policy in classrooms.

Whilst Ball et al.'s (2012) work adds useful nuance and complexity to policy processes in schools, their theorisations stop short of covering the ways in which policy – when emplaced and enacted by health educators – is 'embodied' by young people in school contexts. Drawing on the work of Evans and Davies (2012), De Pian, Evans and Rich (2014, p.138) suggest that:

> If we are to understand how global health imperatives (and obesity discourse) impact the lives of young people, we have then to interrogate not only how neoliberal *policy* imperatives are *emplaced* in context and *enacted* as action and performance, consciously/knowingly, unconsciously/unknowingly but also are *embodied*, i.e., how they affect and effect an individual's sense of being "some-body" in the social world in time, place and space.

Thus, this study departs from (and builds upon) the work of Ball et al. (2012) to

make visible the ways the ideas or discourses associated with the obesity epidemic work to govern bodies and to provide the social meanings by which individuals come to know themselves and others (Wright, 2009, p.5).

Thus, it is in this section that I turn my attention to the *embodiment* of neoliberal health imperatives deriving from the UK government's health policy in its drive to 'tackle obesity'.

2.3.3 Embodying Policy

Drawing on Deleuze's (2000) conceptualisation of the human subject as 'the outside folded in', obesity discourse and associated imperatives of health and virtue are believed to "[incorporate] the 'outside' world (values and beliefs) into the 'inside' (psyche and bodily practices) of individuals", making an individual "an immanently social, political and embedded subject" (Halse, 2009, p.49). Through recognition of "the complexity of human subjectivity and its socio-political contingencies" (Evans et al., 2008, p.2), questions have therefore begun to be asked about how health messages deriving from obesity discourse are being received and interpreted by various sections of the population (see Burrows, Wright and Jungersen-Smith, 2002; Wright and Burrows, 2004) and whether such messages are in fact having the intended effect, i.e., to improve the health of the nation.

Shilling (2003; 2004) argues that whilst much has been said about the *minds* of school children, the cognitive processes of learning and indeed the influences of their social backgrounds on their learning, up until approximately 10 years ago, the *corporealities* of school children (i.e., the physical bodies these minds belong to) were nothing more than an 'absent-presence' within sociology of education literature. Thus, "it was never properly clear how the *physical* habits, senses and dispositions of embodied students responded to and were shaped by the organization and transmission of knowledge within schools" (Shilling, 2004, p.xv). Bernstein, Peters and Elvin (1973 [1966]) began to highlight the significance of the pupil subject in school contexts and Wolfson and Jackson (1969), for example, documented the regulation and constraints of the body in educational contexts as early on as nursery age. However, only recently (along with a heightened interest in the body among sociologists more generally) have social scientists begun to more explicitly consider "the embodied nature of schooling" and thus begun to fill a significant void in this literature, concerning the impact of structures of power and control "on the bodies of those subjected to them" (Shilling, 2004, p.xv).

Hence, despite the resources the UK government has invested in schools to control those most 'at-risk' of being affected by the 'obesity crisis' (based on a knowledge-deficit model of health education discussed in section 1.3), until recently, little thought has been given to how health messages generated by obesity discourse are experienced and embodied by young people. In response to government efforts to tackle childhood obesity, particularly in schools, within this critical body of literature are a growing number of academics from the sociology of education concerned with young people's experiences of new health policies and practices, "including potentially damaging consequences for young people's body images and developing sense of self" (Evans et al., 2008, p.2). A growing body of literature has also started to highlight the ways this is affecting both boys and girls at a much younger age than has previously been recognised (see Hutchinson and Calland, 2011, for example). Foucault made specific reference to the 'material practices of schooling' and how these contribute to "discourses and the subjectification of individuals" (Halse, Honey and Boughtwood, 2007, p.222). Building on this, Burrows and Wright (2007), Evans et al. (2008) and Gard and Wright (2005), for example, have focused on the way changes to policy and practice within school settings as a result of obesity discourse effect young people's lives and bodies. Other literature has emerged internationally to question the socially constructed and politically regulated contemporary discourses of 'obesity', 'childhood' and 'health' (e.g., Evans et al., 2004) which are "mediated by government policies and school practices" (Evans et al., 2004, preface). This has challenged the benefits of health education for children and young people's health and well-being (see Evans et al., 2004; Evans et al., 2008). Building on the work of Evans et al. (2004), Halse et al. (2007) have searched for more contextualised and politicised understandings of the socio-cultural contribution of schooling to eating disorders, departing from bio-medical and psychological notions of "anorexia as an embodied pathology located within the individual" (p.221). For example, they ask

> what are the discursive practices and technologies in schools that (might) engender perfectionism and a focus on performance? [and] what are the theoretical implications of construing compliance with dominant social codes and modalities as a form of deviancy?

Leahy (2009) attests that "the pedagogies invoked in health classrooms in the name of teaching about bodies, nutrition and health are explicitly designed to permeate and creep into students' ways of thinking and being", and Halse et al. (2007, p.219) argue that this occurs through the articulation of three virtue discourses; 'discipline', 'achievement', and

'healthism'; which, they argue, "play into the formation of the anorexic subject". Schooling is therefore not only

> implicated in the construction of the 'ideal body' (see Shilling, 1991; Wright, 1997) but also the development and maintenance of eating disorders (Halse et al., 2007, p.219-20).

Thus, it is argued that the neoliberal principles implicit in obesity and health discourses have encouraged individuals to think reductively and negatively about their bodies, essentially as objects to be relentlessly monitored, displayed, worked on and improved in the interest of achieving an imaginary (but for most people) unattainable ideal. Despite this extant work, however, "[t]he complex relationships between 'society', schools and the 'embodied self'" still require further investigation (Evans et al., 2004, Preface).

Furthermore, the rational nature of expert knowledge and education policy has resulted in an 'anaesthetisation of the emotions' (Woodward, 1996, p.760). More specifically, Fullagar (2009, p.113) has argued that the 'technocratic rationalities' of obesity discourse

> ignore the tensions between pleasure, desires to consume and disciplined healthy lifestyles that generate a range of emotions, or affects, that individual and families have to constantly negotiate.

This is particularly evident in the government's knowledge-deficit approach to health education outlined in section 1.3, which is devoid of the sensitivity and ethics with which research in this area must be conducted (see Chapter 3). Thus, until recently, little attention has been paid to the emotional, affective and embodied experiences of discourse and policy, particularly when emplaced and enacted in the local contexts of schools, yet, as Fullagar (2009, p.113) argues

> theories of emotion, or affect, offer a different way of thinking through the body as a site of subjection that does not simply privilege self-conscious knowing or discursive regimes.

Despite its widespread popularity in recent years, the term 'affect' still remains ambiguous and without a universal definition, especially across disciplines. At times it has been used interchangeably with 'emotion', and at others as distinctly separate, but as Gibbs (2002, p.335) explains, "what is meant by the 'emotions' in other disciplines and by 'affect' in

Cultural Studies is somewhat variable". A common theme across this array of uses, however, is a move away from traditional, biological definitions of 'affect' as an innate form of communication (see Nathanson, 1996 and Tomkins, 1963; 1991, for example) toward considerations of the productive functions of affect. In line with this shift, and central to this study, is a Deleuzian conceptualisation of 'affect' which emphasises its capacities to provide "opportunities for becomings through which bodies may be remade" (Gibbs, 2002, p.335). Hence, whilst the politics of teaching has previously gained much attention, with few exceptions (such as Gallop, 1995; Garber, 1994; Hooks, 1994), less is known about what 'actual bodies' *do* and *feel* in the classroom (Probyn, 2004). It must be acknowledged, however, that health education in schools is not restricted to the classroom. Chapter 1 (section 1.4) documented the processes through which knowledge about health is increasingly circulating whole school environments including, but not limited to, school halls, dining rooms, PE departments, corridors and playgrounds. Moreover, pupils' families and the local communities of schools are increasingly becoming recognised as being part of this 'environment'. Thus, considering how individuals feel about 'being healthy' and what those feelings *'do'* in relation to lifestyle choices can tell us much about how health is a negotiated and contested moral terrain in everyday life (Fullagar, 2009, p.113-4).

2.4 Summary

Evans and Davies (2012) have argued that policy is to be considered not only as a process 'emplaced' and 'enacted' but also 'embodied' in specific contexts, and that "taken together, these concepts add nuance and sophistication to understandings of relationships between discourse, policy, in situational activity, subjectivity and actor differences" (Evans and Davies, 2012, p.617). With reference to processes of emplacement, enactment and embodiment, they have begun to illustrate the complex mediations of health policy – globally, nationally, regionally and locally. The aforementioned literature, largely influenced by Foucault (and Bernstein), however, has tended to adopt an overly linear, top-down perspective whereby the body is regarded as a material entity, controlled and manipulated by power and policy flowing from above, and through which individuals' bodies are defined and understood. Implicit within this perspective is an assumption that individuals are merely products or 'effects' of obesity discourse, which, I argue, overestimates the authority and capacity of 'discourse' to influence individuals' lives and determine subjectivity. Furthermore, the discourse of 'responsibility' discussed earlier in this chapter fails to account for 'obesogenic environments' (Butland et al., 2007) or structural inequalities (e.g., socio-

economic resources) (Centre for Strategic Healthcare Development, 2008), despite acknowledging these as important determinants of health throughout official health reports. Nor is sufficient attention paid to the interpretive agencies of individuals throughout this process, to consider the knowledge and experiences pupils bring to their pedagogic encounters in schools and how this might shape their understandings of health and the relationships they form with their bodies. Furthermore, young people tend to be conceptualised as an undifferentiated category that somewhat negatively understand their bodies through a simplistic, causal, linear process. As Bernstein (1990, p.126) pointed out, this theorisation lacks

> substantive analysis of the complex of agencies, agents, social relations through which power, knowledge and discourse are brought into play as regulative devices

and with reference to Walkerdine (2009, p.201), Rich, Evans and De Pian (2010) state

> [i]f we are to develop this critical work on biopolitical issues on weight and obesity then we need be cautious about invoking a simple relation between the effectivity of biopower and the subject working on the self, or resisting.

2.5 Current Research

Clearly, many studies to date have been "concerned with interrogating the role of expertise as it informs and shapes governmental work" (Leahy, 2009, p.177) such as health policy in schools, but fewer studies have engaged with the "messiness of the governmental project" (ibid.) and particularly the affective relationships between (bio)pedagogy and pupil subjectivity. It is therefore imperative to consider the complex, messy entanglements of embodied and lived relations which constitute young people's everyday lives, which would provide a more nuanced and detailed understanding of issues of responsibility for young people's health (Colls and Evans, 2008). Tamboukou (2003, p.209) regards education as "a site of intense power relations at play, but also as a place for the production of intense flows of desire and affect". Drawing on Tamboukou (2003), Leahy (2009) therefore attests that 'affects' have significant implications for those of us who are interested in developing understandings of governmental and biopedagogical work. Furthermore, Fullagar (2009, p.113) argues that

[t]heories of emotion, or affect, offer a different way of thinking through the body as a site of subjection that does not simply privilege self-conscious knowing or discursive regimes.

Drawing on the voices of young people, I intend to develop these documented ideas concerning young people's embodiment in health education contexts, to capture the embodied relationships young people develop as they engage in, resist, or indeed remain unmoved by the obesity discourse and associated health pedagogies and practices found in their school.

Ellsworth (2005, p.3-4) suggests that in order to fully understand how pedagogy functions,

we need concepts and languages that will grasp, without freezing or collapsing, the fluid, continuous, dynamic, multiple, uncertain, nondecomposable qualities of *experience in the making*.

Thus, whilst the work of Foucault is particularly useful for theorisations concerning governance and subjectivity, I suggest a need to depart from this line of inquiry in order to add nuance and complexity to this relationship, through considering subjectivity as being constituted by more than expert knowledge or governance alone. Drawing on the Deleuzian notion of the 'becoming subject' and Simondon's (1989) concepts of 'pre-individual' and 'metastable bodies', this thesis highlights the *mediating* affects/effects of policy and (bio)pedagogy for an individual's sense of self. Furthermore, Evans, Rich, Davies and Allwood (2005) suggest that embracing issues of corporeality in analyses of schooling may help us to better understand not only the complexity and importance of 'emotions' (or rather the affective dimensions of corporeality) in teaching and learning, but also the immense 'risks' involved, for some children, in displaying them when cultures of 'performativity' dominate and prevail in schools.

Throughout this thesis, I therefore aim to further develop the concepts of emplacement, enactment and embodiment through exploration of

how these surface features of policy are shaped, structured and regulated in situ […] to explain why health education policies, pedagogies and the subjectivities they affect/effect, are configured in particular ways in specific school settings (Evans and Davies, 2012, p.617).

I return to reflect on these conceptual matters later in the thesis, with reference to the data and analyses provided in Chapters 5 to 8.

3. Methods and Methodology

3.1 Introduction

This chapter outlines the methodological principles underpinning this research and the methods employed to collect data to meet its aims. As outlined in Chapter 1, this thesis draws on a selection of data collected for a large, international research project funded in the UK by the Economic and Social Research Council (ESRC) (RES-000-22-2003) and led by Dr. Emma Rich and Professor John Evans at Loughborough University between 2007 and 2009. The wider project was entitled 'The Impact of New Health Imperatives on Schools' and aimed to build upon previous research exploring 44 young females' experiences of eating disorders in relation to their education (see Evans et al., 2008) by focusing on a larger and more diverse sample of young people (not limited to those with eating disorders) across eight schools located in a county in the Midlands region of England. The schools were chosen to reflect a variety of socio-cultural settings in the UK, and specifically those that were typical of the Midlands county in which the study took place (see Table 3.1 for details of each school). More specifically the study involved semi-structured interviews with health/physical education teachers (n = 19), pupil questionnaires (n = 1176) and semi-structured interviews with pupils (n = 90) to investigate how new health imperatives and associated curriculum initiatives (such as those described in section 1.4) were operationalised and experienced within and across the eight schools (see Table 3.2 for a breakdown of data collection by school). The research findings from this wider project formed part of a three-way collaboration with parallel studies conducted in Australia and New Zealand and revealed, among other significant findings, that not all young people felt negatively about their weight/size. This PhD research pursues this key finding and in so doing departs from this international collaboration through detailed case study exploration of the 'emplacement', 'enactment' and 'embodiment' of health policy in three of the eight UK schools (see highlighted rows in Table 3.1). Hence, this thesis draw on a sample of the aforementioned data to include 7 of the semi-structured interviews with health/physical education teachers, 360 of the pupil questionnaires and 32 of the semi-structured interviews with pupils across the three schools (see highlighted rows in Table 3.2 for a breakdown of data collection by school). The next section of this chapter provides detail about the wider project: its aims, methodology, methods and analysis, before discussing how it informed the research in this thesis.

Table 3.1 School Profiles

School Name[3]	Level (age-range)	Type	Single/Co-ed	No. pupils	Free School Meals	Ethnic composition	Location
Bentley Grammar School	Secondary (10-18 years)	Independent	Boys	1033	N/A	Majority white British (25% minority ethnic)	Suburban
Grange Park High School	Secondary (11-18 years)	Independent	Girls	604	N/A	Majority white British	Suburban
Longcliffe High School	Middle (11-14 years)	Comprehensive	Co-ed	392	Above average	Majority Bangladeshi and Indian	Suburban
Westwood Primary School	Primary (4-11 years)	Voluntary Controlled	Co-ed	95	Below average	Almost all white British	Rural
Fraser Preparatory School	Primary (4-11 years)	Independent	Co-ed	488	N/A	Majority white British (20% minority ethnic)	Suburban
Rosehill Primary School	Primary (3-11 years)	Voluntary Controlled	Co-ed	298	Below average	Almost all minority ethnic (majority Indian)	Inner City
Huntington High School	Middle (11-14 years)	Comp.	Co-ed	900	Below average	Majority white British (5% minority ethnic)	Rural
Fielding Community College	Secondary (11-16 years)	Community	Co-ed	880	Above average	Majority white British (23% minority ethnic)	Inner City

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[3] All school names are pseudonyms; shaded rows represent the three case study schools included in this PhD research

3.2 The Wider Project

3.2.1 Aims

The wider project was entitled 'The Impact of New Health Imperatives on Schools' and aimed to build upon previous research exploring 44 young females' experiences of eating disorders in relation to their education (see Evans et al., 2008) by focusing on a larger and more diverse sample of young people (not limited to those with eating disorders) across eight schools located in a county in the Midlands region of England. The specific aims of the wider project were to:

1. Identify how messages deriving from public discourse around obesity and health (new health imperatives) enter schools and are recontextualised within them as specific pedagogic discourse;
2. Investigate the cultural and institutional resources upon which young people draw (e.g., from family, peers, websites, video games, TV, film, magazines and school) to make sense of new health imperatives;
3. Identify young people's current understandings of health, in terms of how they interpret and negotiate new health imperatives, and how this has shaped their attitudes to, and understandings of, their bodies;
4. Investigate the impact of students' gender, cultural and class identities on these processes;
5. To identify the measures that might be taken by schools, teachers and other health professionals to address health issues in ways which do not damage young people's relationships with food, exercise and their embodied identities and therefore contribute to their enhanced quality of life.

3.2.2 Methodology

I was involved in designing the methodology and collecting the data to address the above aims, alongside the Research Assistant (RA), Dr. Tina Byrom, and I later replaced Tina as RA for the project (between September 2008 and June 2009), during which time I was responsible for analysing the data. Until recently, obesity-related research has either tended to focus on measuring or regulating the health of large populations within society (e.g., Butland et al., 2007; Sacher, Kolotourou, Chadwick, Cole, Lawson, Lucas and Singhal, 2010) or on individuals, such as those conducted by psychologists (e.g., Biddle, Atkin, Cavill and Foster, 2011; Atkin, Gorely, Biddle, Cavill and Foster, 2011; Pearson, Biddle and Gorely, 2009) and

paediatricians (e.g., Galhardo, Hunt, Lightman, Sabin, Bergh, Sodersten and Shield, 2012). Such studies have adopted a positivist philosophical standpoint in the search for objective, scientific 'truths'; thus neglecting individuals' subjective experiences of health and obesity discourses, particularly the young within varying economic, social and cultural parameters. Moreover, such scholars have tended to overlook providing child participants with an opportunity to express their views about their own experiences and, perhaps as a consequence, have tended to "homogenise the experiences of children" (Greene and Hill, 2005, p.xii). By contrast, and in line with the exploratory nature of the aforementioned research aims, we were interested in accessing and understanding the multiple ways in which dominant imperatives concerning health and obesity are subjectively constructed and experienced by teachers and pupils in their schools. This project was therefore premised on the assumption that "social phenomena and their meanings are continually being accomplished by social actors" (Bryman, 2001, p.18) and was thus positioned within an interpretive epistemological and constructivist ontological school of thought. Hence, the project was grounded in a qualitative, inductive methodology, with an emphasis placed on the collection and analysis of detailed, descriptive data. However, whilst we were concerned with the ways in which teachers and pupils interpreted and negotiated health imperatives, the structural forces that acted on their experiences were also central to the aims of the research (ibid.). We adopted the perspective of recent authors within the sociology of childhood (James, Jenks and Prout, 1998; Prout, 2000) who value the voice of young people as "unique and important" in providing accounts of their understandings of their worlds (Duckett, Sixsmith and Kagan, 2008, p.94). Thus, a child is conceptualized in this study as "an active, social agent and sense-maker who shapes and is shaped by their social environment" (ibid.). In-keeping with the view that young people's lives are vastly disparate and that experience is determined by one's subjective encounters with the world, we adopted a research methodology which allowed us to generate data *about* children *from* children. Consideration of methods appropriate for use with children and young people whilst facilitating their active involvement in the research therefore became paramount within this study, especially given the sensitivities this research inevitably entailed around their relationships with their bodies. The ways this was dealt with are discussed in the following sections.

3.2.3 Methods and Sampling

Ball et al. (2012, p.20) argue that conventional school-based policy implementation studies "rarely convey any sense of the built environment from which the 'data' are elicited or the

financial or human resources available – policy is dematerialised". They highlight the following shortcomings in particular:

> In many of these studies, there is no proper recognition of the different cultures, histories, traditions and communities of practice that co-exist in schools. The education and preparation of teachers, now of a variety of kinds, and the changing role and constitution of professional discourses and professional expertise are also left out of account. There is little attention given to the material context of the policy process, neither the buildings within which policy is done, nor the resources available, nor are the students with whom policy is enacted often accounted for (p.5).

Thus, attention is drawn to an apparent lack of 'real life' analyses of education policy in schools, which involve 'real' and diverse school settings, policy actors (staff and students) and the various nuances which take shape in each specific context. This study set out to address this void and thus bring health policy in schools 'to life' through case study analysis of the "complex, dynamic and unfolding interactions of events, human relationships and other factors in a unique instance" (Cohen, Manion and Morrison, 2007, p.253). This approach allows detailed and meaningful theorisations to be drawn out later in the thesis around how schools *'do'* health policy and the various ways in which pupils experience and embody this. Thus, case studies are said to "portray what it is like to be in a particular situation" (ibid.). Furthermore, Sandelowski (2000, p.338) states that it is an obligation of researchers to "defend their sampling strategies as reasonable for their purposes". Thus, to address the aims of this project, it was important to include a range of schools which reflected the diverse social backgrounds and socio-cultural contexts of young people in the Midlands county in which this study took place, hence facilitating understandings of how social class and culture bear upon teachers' and pupils' interpretations and negotiations of 'health'. We contacted a range of schools across the county, initially by telephone, to briefly introduce ourselves and the project and ascertain levels of interest and availability. A face-to-face meeting was then arranged with Head Teachers or Health/Physical Education Teachers of those schools that expressed an interest and willingness to participate. These meetings proved particularly beneficial in terms of providing an opportunity for us to clarify our intentions, check the appropriateness of our proposed methods, and organise ethical procedures (e.g., dissemination of consent letters to parents) and data collection. However, it was also in these meetings that we became aware of the constraints involved with conducting research in schools and the need to be sensitive to the demands on teachers' and pupils' time. Due to

their busy schedules, we were generally allocated short periods of time in which to collect our data; in some schools this was across one school day and in others it required several visits.

A number of methods were employed to compile the case studies for each of the schools, as summarised in Table 3.2 and discussed in detail, along with the sampling strategies used for each method below.

Table 3.2 Breakdown of Data Collection by School

School Name[4]	Policy Artefacts	Staff sample size	Pupil sample size		Field notes
			Questionnaire	Interview	
Bentley Grammar School	School Website ISI Report PE Curricular PSHE Curricular	Interviewed: 2 - Head of PE - Head of PSHE	Questionnaires: 259 All Y8, all Y11	Interviewed: 12 6 x Y8, 6 x Y11	✓
Grange Park High School	School Website ISI Report PE Curricular PSHE Curricular Food Technology Curricular	Interviewed: 4 - Head of PE - Head of PSHE - Heads of Food Technology	Questionnaires: 143 All Y8, all Y11	Interviewed: 12 6 x Y8, 6 x Y11	✓
Longcliffe High School	School Website Ofsted Report	Interviewed: 2 - Head of PE - Head of PSHE	Questionnaires: 81 All Y8	Interviewed: 6 6 x Y8	✓
Westwood Primary School	School Website Ofsted Report PE curricular Healthy Schools Policy	Interviewed: 2 - Head of PE - Healthy Schools Coordinator	Questionnaires: 25 All Y5, all Y6	Interviewed: 12 6 x Y5, 6 x Y6	✓
Fraser Preparatory School	School Website ISI Report Healthy Schools Policy	Interviewed: 2 - Head of PE - Healthy Schools Coordinator	Questionnaires: 151 All Y5, all Y6	Interviewed: 12 6 x Y5, 6 x Y6	✓
Rosehill Primary School	School Website Ofsted Report Healthy Schools Policy	Interviewed: 3 - Head of PE - Healthy Schools Coordinator - Headteacher	Questionnaires: 66 All Y5, all Y6	Interviewed: 12 6 x Y5, 6 x Y6	✓
Huntington High School	School Website Ofsted Report PE Curricular PSHE Curricular	Interviewed: 3 - Head of PE - Head of PSHE - Head of Food Technology	Questionnaires: 263 All Y7, all Y8, all Y9	Interviewed: 16 4 x Y7, 4 x Y8, 8 x Y9	✓
Fielding Community College	School Website Ofsted Report	Interviewed: 1 - Healthy Schools Coordinator	Questionnaires: 192 All Y9, all Y10	Interviewed: 8 8 x Y10	✓

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[4] All school names are pseudonyms; shaded rows represent the three case study schools included in this PhD research

Policy Artefacts

Policy artefacts were collated to 'materialise' health policy in each school and therefore contextualise and 'bring to life' the rest of the case study data. An 'intensity sampling' strategy was employed to select relevant policy documents for each school. This involves "information rich texts that manifest the phenomenon of interest intensely" (Markula and Silk, 2011, p.114). Whilst we had an idea of the types of texts this might include (e.g., websites, inspection reports, health curricular), we did not want to limit ourselves to these documents in case there were others the schools were using in their design/delivery of health education. Hence, we requested from administrative staff and/or health/physical education teachers in each participating school a copy of any documentation which captured their health education policies, pedagogies and practices. School websites and ISI/Ofsted reports were available in all schools, but the number of and access to health policies and curricular documentation varied between schools. Although this resulted in an uneven distribution of policy artefacts in each of the case studies, it enhanced the 'authenticity' of the data by providing an 'expression of reality' as experienced by the participants in each school (Sparkes, 2002, in Markula and Silk, 2011, p.208). The purpose of this method: to explore how schools *'do'* policy (Ball et al., 2012), i.e., how policy is *emplaced* and *enacted* in situ, was therefore achieved, thus addressing the first of the five research aims: to identify how messages derived from public discourse around obesity and health (new health imperatives) enter schools and are recontextualised within them as specific pedagogic discourse.

Teacher Interviews

To further explore the first of the five research aims and therefore substantiate the policy artefacts, in-depth qualitative data were obtained through semi-structured interviews of approximately 30 to 60 minutes with health/physical education staff in each school (see Appendix 2). An 'intensity sampling' strategy was again employed to recruit school staff for interview. Hence, we invited those staff who were responsible for designing and/or delivering health/physical education in each school (i.e., Healthy Schools Coordinators and Heads of PE, PSHE and Food Technology) to participate in the semi-structured teacher interview. In some schools e.g., Grange Park High School, Huntington High School and Rosehill Primary School, these members of staff were more available/willing to participate than in other schools e.g., Longcliffe High School and Fielding Community College, the most diverse schools in this study, where brief interviews had to be conducted with teachers together (Longcliffe) or where only one teacher was available for interview (Fielding). A total of 19

interviews were conducted with health/physical education staff in each school between January and June 2008 (see Table 3.2 for a breakdown of teacher interviews by school). These were conducted individually in all but one of the schools (Longcliffe High School where the Head of PE and the Healthy Schools Coordinator requested that they were interviewed together due to time constraints). All participants were briefed about the purpose and format of the interviews and the semi-structured nature of the interviews provided a general framework for discussion (see Appendix 2), which proved particularly useful in maintaining the focus of the conversation. Conversely, however, the framework allowed scope to diverge from the scripted questions, e.g., to probe further or seek clarification, thus allowing detailed, individual accounts to be obtained in accordance with the philosophical underpinnings of the research. Permission was granted from all participants to record the interviews using a Dictaphone and I transcribed each interview verbatim as soon as possible after they were conducted. With more time to carry out data collection, it may have been possible to involve all or at least an even distribution of health/physical education staff in each context, therefore offering a broader and more detailed account of the interpretations and negotiations of health and obesity discourse in some of the schools.

Pupil Methods

Greene and Hill (2005) highlight the importance of researching children's subjectivity and argue that this "requires and deserves careful analysis and the use of appropriate methods" (p.xii). It is appreciated that research involving young people differs to that with adults, namely as a result of their

> limited and different use of vocabulary and understanding of words, relatively less experience of the world and […] a shorter attention span (Boyden and Ennew, 1997 in Punch, 2002, p.324).

However, this viewpoint risks homogenising 'children and young people' as an undifferentiated category and, given the age, class and cultural diversity among the young people included in this research, such variations were expected to be evident within this sample. We felt that the questionnaire and interview (discussed below) may have been too cumbersome for young primary school pupils and perhaps patronising for older secondary school (6th form) pupils. We therefore agreed to conduct our research with pupils in Year 5 (age 9-10) and Year 6 (age 10-11) in the primary schools, pupils in Year 7 (age 11-12), Year 8 (age 12-13) and Year 9 (age 13-14) in the middle schools and pupils in Year 8 (age 12-13)

and Year 11 (age 15-16) in the secondary schools.

Furthermore, we did not have the time or resources to include all secondary school pupils in the study, so it was agreed that Year 8 and Year 11 pupils would provide a representative illustration of 'younger' and 'older' secondary school pupils' experiences of their health education respectively, whilst allowing for a period of transition and adjustment from primary school during their first year at secondary school (Year 7). However, we were also constrained by school timetables, events and examinations and thus needed to deviate from this sampling strategy in two of the schools (Longcliffe High School and Fielding Community College – see Table 3.2). Specific sampling strategies and number of participants for each method are detailed below.

- *Questionnaire*

A pupil questionnaire was designed to obtain a combination of quantitative and qualitative data in relation to the remaining four aims of the research. As such, the questionnaire was organised into six key areas: 'About You', 'You and Your Body, 'You and Your Ideas About Health', 'You and Learning About Health', 'You and Your School Life' and 'Your Ideas About Obesity' (see Appendix 3 for a copy of the questionnaire). In our initial meetings at each school, we gave a copy of the questionnaire to each gatekeeper and found it helpful to obtain their feedback to ensure the appropriateness of the design and style of questioning. Only in one school (Longcliffe High School) were suggestions made to amend the questions in accordance with the diverse needs of their pupils (e.g., to ensure that questions under 'About You' captured the complex and diverse ethnic and social class backgrounds of the pupils and allowing larger spaces for the pupils to write their qualitative responses throughout the questionnaire). This experience drew our attention to the ways in which language can act as a barrier between researchers and participants (Padilla, 2004; Squires, 2008, 2009), particularly in studies such as this, which involve young participants from diverse backgrounds. The comments made were addressed as far as possible, while not losing sight of our research aims and the needs of the remaining pupils in our sample.

There are a number of advantages to administering a questionnaire. Firstly, it is considered to be a relatively economic and efficient tool, which has the potential to generate data from a large sample. Secondly, and as May (1997) asserts, the assured anonymity of questionnaires may heighten respondents' honesty or detail provided, therefore adding richness to the dataset compared with other methods (e.g., face-to-face interviews) where the presence of the

researcher can influence responses. For these reasons, we decided to administer the questionnaire to all pupils in the aforementioned year groups across the eight schools between December 2007 and June 2008 (see Table 3.2 for details of dissemination by school), before conducting interviews with a small sample of these pupils. A total of 1176 copies of the questionnaire were completed across all year groups during an allocated period in the school day. In some schools this was in-class (usually during their PE or PSHE lesson) and in other schools all year groups were taken out of their lessons and assembled in the school hall to complete the questionnaire. An apparent drawback to using questionnaires concerns the language used and style of questioning, firstly in terms of the age of respondents and their comprehension of written questions, secondly, for those pupils whose first language is not English and lastly, in terms of the subjective interpretations of written questions. Attempts were made to minimize these issues as far as possible (e.g., by obtaining feedback on the suitability of the questionnaire from each school gatekeeper), but, inevitably, it was difficult to accommodate the needs of all of our participants in one version of the questionnaire. Hence, although the self-explanatory nature of questionnaires often allows gatekeepers (the teachers in this case) to administer them on behalf of the researcher, we felt it necessary to be present, given the age-range, class and cultural diversity of pupils in the sample, to ensure that all questions were understood, thus maximizing the quality of responses. Pupils were briefed about what was expected of them prior to completing the questionnaire and due to their associations with the settings in which the questionnaires were administered (classrooms and school halls), we felt it necessary to clarify that the questionnaire should not be regarded as a test. Moreover, we aimed to empower the pupils by emphasising that it was *their* ideas and accounts of *their own* experiences that were important to us and that the questionnaire was providing them with an opportunity to voice their opinions about issues concerning 'health' and their body.

- *Interviews*

To further explore the remaining four aims of the research and thus supplement the data gathered in the questionnaires, in-depth qualitative data were obtained through a semi-structured interview of approximately 30 to 60 minutes with a sample of the 1176 pupils who completed the questionnaire (approximately 6 pupils from each year group in each school, n = 90) between January and June 2008 (see Table 3.2 for a breakdown of teacher interviews by school). We intended to deploy a random sampling strategy to select pupils for interview, in order to capture detailed information from a range of pupils about their interpretations and

experiences of new health imperatives. However, due to time constraints, many of the pupils were selected to participate in the interview by their teachers, thus raising questions over the 'type' of pupils interviewed and the extent to which they were representative of the pupils in their school, i.e., were these pupils selected on the basis that they were considered by their teachers to be amongst the highest achieving, most confident and/or 'healthy' pupils in their school? The pupil interviews were conducted in pairs where possible, although due to time and space constraints some interviews were conducted in groups of three or four. All participants were briefed about the purpose and format of the interviews and an opportunity was provided for the pupils to ask questions and express their concerns before starting the interview. Again, we aimed to empower the pupils by emphasising that it was *their* ideas and accounts of *their own* experiences that were important to us and that the interview was providing them with an opportunity to voice their opinions about issues concerning 'health' and their body. The semi-structured nature of the interviews provided a general framework for discussion (see Appendix 4), which proved particularly useful in maintaining the focus of the conversation, especially with the younger interview participants. Conversely, however, the framework allowed scope to diverge from the scripted questions, e.g., to probe further or seek clarification, thus allowing detailed, individual accounts to be obtained in accordance with the philosophical underpinnings of the research. The interviews were based around four themes: 'Health', 'School', 'The Body' and 'Obesity', which derived from our a priori guiding interests and the questionnaire design discussed earlier. Each of the themes was written on a coloured card (see Appendix 4), which was placed face down in front of the pupils and they took it in turns to pick a card to reveal the next discussion topic. They were then given a corresponding envelope, which contained the questions for that topic, and they were asked to take it in turns to pick the questions from the envelope. This was intended to not only give the pupils a sense of control during the interviews but actively engage them in the process, thus enhancing the quality of data collected. Cooklin and Ramsden (2004, p.201) assert that "active conversations" with a child can help to "elicit that child's actual thinking and opinions, rather than those sought and/or expected", thus ameliorating issues associated with their anxiety and consequent desire to comply with the adult researcher. Furthermore, the interviews were designed using creative methods, including the use of visual aids, vignettes and short activity-based tasks (see Appendix 4), which were intended to "give reign to the child's imagination" (Greene and Hill, 2005, p.14). Whilst at times this may have restricted or indeed influenced their responses, the intention was to distract the pupils from

the interview situation with an 'active' conversation to further reduce their anxiety and enhance the data they provided (Cooklin and Ramsden, 2004). This was particularly important when discussing 'the body', which had proven to be a sensitive topic for some of the pupils to discuss. The sample of pictures allowed questions to become 'depersonalised' and it became apparent that the pupils – male and female – were generally more comfortable speaking about somebody else's body than their own. This in itself is a significant finding for the research, suggesting that children as young as nine years old displayed acute sensitivities when thinking and talking about their own bodies. In addition, the pictures served as a useful tool to generate discussion. For example, rather than simply asking the pupils about the sorts of foods they eat and why, they were given a paper plate and a large selection of pictures of different foods before being asked to create two meals; one that represented a 'healthy' meal and another that represented a meal they would regularly eat at home. A discussion then took place around the similarities and/or differences between the two meals they had created, to establish the influences over the pupils' diets across age, class and culture. Generating data in this way proved to be highly successful in that the children responded to the tasks with enthusiasm and became 'active' in the data collection process (Christensen and Prout, 2002). Permission was granted from all pupil participants to record the interviews using a Dictaphone and I transcribed each interview verbatim as soon as possible after they were conducted.

Field Notes

During and immediately after our visits to each school we also made some general covert observations of the school setting and interactions therein (see Appendix 5) and these were incorporated into each case study to add to the richness of the data collected.

3.2.4 Ethical Considerations

There are numerous frameworks and guidelines that have been published to ensure that researchers conduct their work 'ethically'. According to Markula and Silk (2011, p.11), this means ensuring that "all research participants are treated with dignity and respect… and all research should be conducted in a manner that is not harmful for the participants or the researcher". Ethical clearance was granted by Loughborough University's Ethical Advisory Committee in November 2007 and appropriate checks were carried out by the Criminal Records Bureau which permitted our access to the schools. We distributed a letter to parents/carers of pupils in the year groups identified for participation, to inform them about the project and obtain their consent for their child/children to complete the questionnaire and

participate in the interview on an opt-out basis (see Appendix 1). The letter outlined our adherence to standard ethical procedures such as assuring participants' anonymity and confidentiality; all participants, schools and locations were given a pseudonym and data were stored on a password protected computer and in a locked room at Loughborough University to protect the participants' identities. The letter also explained that participants were free to withdraw from the research at any time, as outlined in the British Educational Research Association's (2011) Ethical Guidelines for Educational Research. However, more specific ethical issues also needed to be considered in relation to this research project. McNamee, Olivier and Wainwright (2007, p.154) suggest that "the responsibility is clearly upon the researchers […] to justify the inclusion of vulnerable populations as research subjects or participants". Without the inclusion of young people, it would not have been possible to fulfil the aims of the study which emphasised listening to young people's voices. However, a power imbalance between researcher and participant is largely discussed within the realm of research methodology in terms of the researcher having knowledge and control above that of the participant (Kimmel, 1988; Wyness, 2006). This discrepancy is augmented when data is collected through interviews, i.e., when the researcher's presence and authority is all the more apparent compared with self-reporting methods such as questionnaires. It is also heightened where participants are defined as 'vulnerable' (children, the elderly, people with a disability) and, in the case of this research, it is particularly difficult to overcome the discrepancy of physical size which inevitably exists between adult researcher and child participant. A significant methodological implication of this power imbalance concerns the influence it has on the data collected, particularly where the authority of the researcher results in a 'social desirability' effect (Bryman, 2001, p.123) whereby participants provide accounts of what they think is expected of them or which conform to social norms. As Mayall (2000a and 2000b; 2002) points out, the 'subordinate' position of children cannot be ignored and must be taken into account by the researcher. In this vein, Shephard (2002) in McNamee et al., (2007, p.154) states that "care should be taken not to exploit the vulnerable in research". A number of attempts can be made to avoid 'exploiting' or 'oppressing' young participants, for example, by matching the interviewer and interviewee more closely; in terms of gender, ethnicity and social class (Wyness, 2006). The extent to which this could be achieved with two white, middle class, female academics and a diverse range of teacher and pupil interviewees in a school setting was somewhat limited, however. Moreover, speaking of class matching in particular, Mellor, Ingram, Abrahams and Beedell (2014, p.135), challenge an

assumption among academic researchers that class matching in particular fosters a better understanding and rapport between researcher and participant. They argue that "shared class position does not necessarily equate with similar life experiences, or enable a strong rapport nor a more ethical analysis or understanding" (p.135) of participants' lives and instead suggest that the class researcher can merely attempt to explore and reflect on the various ways in which their own subjectivity influences the research process. However, others (e.g., Greene and Hill, 2005), have argued that researchers can attempt to overcome such 'barriers' by delegating a share of control to the young participants. For example, they could be offered the opportunity to "choose the time and place of interviews" (ibid., p.11). This may not always be a viable option, however, especially when conducting research in schools, where adult gatekeepers (teachers in this case) act as an additional point of authority in the research process.

In light of the above limitations, considerable effort was made to ensure that the children understood what their participation would involve; assure their confidentiality and anonymity and reassure them that their participation did not involve testing their knowledge at any stage of the data collection process. Pupils were briefed about what was expected of them prior to completing the questionnaire and participating in the interview and they were given an opportunity to ask questions and express their concerns at regular intervals throughout the data collection process. As discussed above in relation to the pupil questionnaire and interview, we aimed to empower the pupils by emphasising that it was *their* ideas and accounts of *their own* experiences that were important to us and that the questionnaire and interview were providing them with an opportunity to voice their opinions about issues concerning 'health' and their body. Despite these efforts, however, the extent to which the power relationship between adult researcher and child participant can be fully redressed remains questionable. Recent literature has highlighted the limitations of much of the existing work on student 'voice' as a method to more effectively engage young people in research. Amongst these limitations are the ways in which 'voice' implies 'singularity' and 'homogeneity' (Fielding, 2007, p.306). This oversimplified conceptualisation is said to overlook the construction of voice, or rather 'voices', through the research process, and particularly during data collection. Hence, reflecting on the above literature, we, like O'Flynn (2010, p.435), conceptualise the interviews as 'contingently constructed'; the interview text production was "contingent on the interviewer, interviewee and the interview relation" (ibid.), whereby the age, gender, class and cultural positions of the researcher(s) and

teachers/pupils "potentially shape the interview dialogue" (ibid.). Thus, drawing on Arnot and Reay (2007, p.311), "caution is needed in assuming that power relations can be changed through the elicitation of student talk".

3.2.5 Analyses and Findings

Quantitative questionnaire data were analysed using the Statistical Package for the Social Sciences (SPSS). Descriptive quantitative data were generated using pupils' responses to 'closed' questions to provide contextual, demographic information about the schools and pupils in the sample, and therefore identify key trends in the young people's experiences of 'health' and the resources they drew upon to make sense of health imperatives, for example. This allowed us to "obtain a common dataset on pre-selected variables, and descriptive statistics to summarise them" (Sandelowski, 2000, p.336). The descriptive statistics used were frequencies which denoted the number of times "a value occurs in the dataset" (Field, 2009, p.18). This therefore provided a descriptive context, capturing the diversity of the pupils' daily life experience (Qvortrup, 2000). There are, of course, serious limitations to using (quantitative) questionnaire data alone to interrogate issues of subjectivity such as those at the centre of this thesis, for it is said to "obliterate individuality and richness" (Greene and Hill, 2005, p.4), therefore limiting "what can be learned about the meaning participants give to events" (Sandelowski, 2000, p.336). It is drawn on here, however, to demonstrate the demographic trends in the young people's interpretations and experiences of their health education (i.e., by school, age, gender, social class and ethnicity). Thus, these quantitative data served as a starting point for the analysis; providing a backdrop against which the qualitative questionnaire and interview data could be analysed. The qualitative questionnaire and interview data were coded using Nvivo to draw out recurring themes in relation to the research aims. In line with the philosophical underpinnings of this project, Ritchie and Spencer's interpretive 'Framework' approach was adopted to analyse the qualitative data. This involved coding the raw data (qualitative questionnaire responses and interview transcripts) to identify a thematic framework (Markula and Silk, 2011, p.105) (see Appendix 6 for coding example). The themes (e.g., 'school culture', 'enactment of health imperatives', 'performativity') were identified through an initial reading of the raw data, i.e., themes emerged from the data and were developed through rereading the data until all themes were accounted for and formed the basis of interpretation "in relation to existing literatures and wider social forces" (ibid.). These analyses formed part of a three-way collaboration with parallel studies conducted in Australia and New Zealand and revealed, among other

significant findings, that not all young people feel negatively about their weight/size (Question 12 of the questionnaire). Further analysis of responses to Question 12 revealed a 'school effect' in the relationships the young people reported with their weight/size; some schools had particularly high/low numbers of pupils who reported being happy about their weight/size 'never', 'sometimes' or 'all the time' (categorised as 'troubled', 'insouciant' and 'emboldened' bodies in the remainder of this thesis – see Chapter 4 for further detail about these).

3.3 Current Research

This PhD research pursues the above-mentioned finding that not all young people feel negatively about their weight/size, to build on and add to existing literature which has documented the damaging effects of dominant health and obesity discourses on individuals', particularly young females', subjectivities (see Allwood, 2010; Burrows and Wright, 2007; Campos, 2004; Campos et al., 2006; Evans et al., 2004; Evans et al., 2008; Gard and Wright, 2005; Monaghan, 2005; Rich et al., 2011 and Warin et al., 2008, for example). The key aim of this study, therefore, is to broaden current understandings of young people's subjective, embodied experiences of their school health education (specifically the ways their experiences shape the relationships they develop with their weight/size) and the implications of this for a young person's developing sense of self. The key aims and research questions guiding the study are outlined in Chapter 1 (see section 1.6).

This PhD research therefore both develops and departs from the ESRC-funded study while using some of its data. Having first completed data collection for the larger ESRC project, this PhD research inevitably became inductive in nature, applying grounded theory, whereby the researcher arrives at a theory largely (but never entirely) through systematically gathered and analysed data (Bryman, 2001). As mentioned earlier in this chapter, "the obligation of researchers is to defend their sampling strategies as reasonable for their purposes" (Sandelowski, 2000, p.338). Hence, a 'purposeful' sampling technique was employed to select 'information-rich cases' (Patton, 2002, p.230) for in-depth study. According to Patton (2002, p.230),

> information-rich cases are those from which one can learn a great deal about issues of
> central importance to the purpose of the inquiry, thus the term of *purposeful* sampling.

More specifically, a 'criterion sampling' strategy was used to select the case study schools, whereby "the researcher samples incidents, slices of life, time periods, or people on the basis of their potential manifestation or representation of important theoretical constructs" (ibid., p.238). The 'theoretical constructs' of 'troubled', 'insouciant' and 'emboldened' bodies derived from the initial statistical analyses for the wider project discussed in the previous sections of this chapter, and as a result, Fielding Community College, Grange Park High School and Westwood Primary School were selected for further study on the basis that they demonstrated the highest percentage of each of these categories respectively (see Chapter 4). The initial thematic analysis conducted for the wider project was drawn upon and organised for each of the three case study schools around a priori themes of 'emplacement', 'enactment' and 'embodiment' of health policy to address the aims of this research. Due to the anonymous nature of the questionnaire, it was not possible to identify the questionnaires completed by the pupils who participated in the interview. However, general links could be made between the findings from the questionnaire and pupil interview datasets for each school (e.g., where pupils in a school expressed 'troubled', 'insouciant' or 'emboldened' relationships with their weight/size in their questionnaire and possible reasons for this were found in the analysis of interview data for that school). Hence, limited interview data was drawn upon where possible, to shed light on the 'troubled', 'insouciant' or 'emboldened' relationships pupils reported with their weight/size in their questionnaire. The links between findings from the questionnaire and pupil interview data were particularly clear where pupils disclosed a 'troubled' relationship with their weight/size, however this created an uneven spread of pupil interview data across the three schools, with more of this data being drawn upon in the case study on Fielding Community College (focusing on 'troubled' bodies) and less in the other two case studies. Moreover, whilst the analysis of the questionnaire and pupil interview datasets could reveal findings around young people's experiences of their health education at a school level, it was not possible to analyse an individual pupils' questionnaire and interview data together. Hence, the above drawbacks resulted in a lack of pupil interview data being drawn upon compared with the teacher interview and pupil questionnaire data. This restricted the analysis around individual pupils' experiences and embodiment in particular and limited the extent to which aims 3 and 4 of the study could be fully addressed. Further reflections on this are included in Chapter 10.

The realities of data collection across the three school sites are explored throughout the remainder of the thesis and are concluded in Chapter 10 through a reflexive commentary on

the research process. The methodological and ethical issues which arose as the research process unfolded are discussed, largely as a result of conducting research with children.

4. Weighty Issues: Young People's Relationships with their Weight/Size

4.1 Introduction

The original project from which the ESRC project and this particular aspect of that study has stemmed (see Evans et al., 2008) centred on a relatively small and selective sample of young women (n = 44) and how they experienced and had been negatively affected by the imperatives of obesity discourse; in that it had contributed to the development of disordered eating. Building on this and other research concerned with young people's interpretations and potential embodiment of the obesity discourse addressed in Chapter 2 (see in particular Gard and Wright, 2005), this chapter draws upon questionnaire data provided by the larger ESRC study and its more diverse population of young people (n = 1176) compared with those used in previous research in this field. I focus in particular on the quantitative (descriptive) questionnaire data provided by 1156 of these young people from across the eight schools who responded to the prompt 'I am happy about my current weight/size' by choosing from the options: 'never', 'sometimes' or 'all the time'[5] (see Appendix 3, question 12 and Chapter 3 provides a detailed rationale for the data selected for use in this research). As discussed previously, there are, of course, serious limitations to using quantitative questionnaire data to interrogate issues of subjectivity. It is drawn on here, however, using the responses to this one statement, only to demonstrate the demographic trends in the young people's relationships with their body's weight/size. Thus, the quantitative questionnaire data serve as a starting point for the analysis in this chapter (with subsequent chapters providing detailed qualitative analysis), with the intention to provide the most direct and straightforward illustration of how young people variously relate to their body's weight/size (albeit at a particular moment in time). Fig. 4.1 (below) graphically displays the young people's responses to the prompt 'I am happy about my current weight/size'.

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[5] Of the whole sample (n = 1176), 20 young people did not respond to this prompt (question 12).

Fig. 4.1 Distribution of Young People's Relationships with their Weight/Size across Sample (n = 1156)
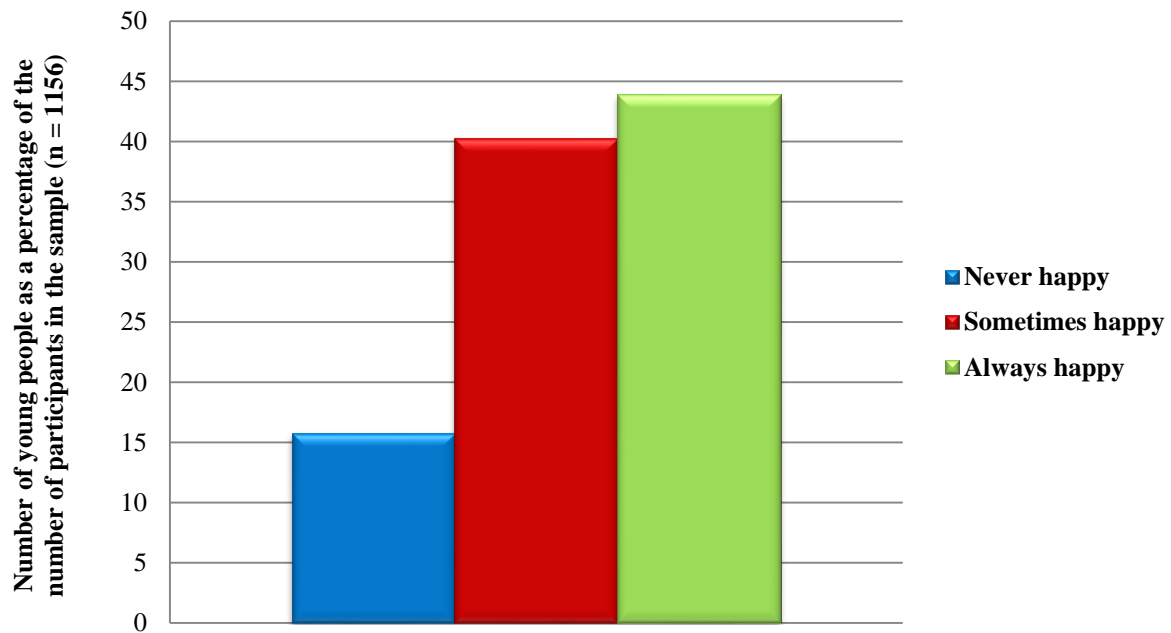
From these responses, it is evident that there were young people in this study who, very worryingly, reported that they were 'never' happy about their weight/size (16%, n = 183). Elsewhere, these young people have been referred to as 'troubled' bodies (Evans, Davies, Rich and De Pian, 2013). However, just under half of the young people (44%, n = 507) reported that they were happy about their weight/size 'all the time'. These have previously been defined as 'emboldened' bodies (ibid.). The 40% of participants (n = 466) who indicated that they were 'sometimes' happy about their weight/size are considered to have a more ambivalent, indifferent and/or transitory relationship with their body's weight/size. These have been described elsewhere as 'insouciant' bodies (ibid.)[6]. Whilst this label perhaps implies that the participants in this group were somewhat nonchalant about their weight/size, it is also intended to capture those young people who had a less exact or fixed relationship with their weight/size. Of all three groups, it is this latter group of pupils, I would argue, which most clearly exemplifies the fluid nature of young people's relationships with their own bodies within and across time, place and space (see Chapter 6 for a detailed discussion of this).

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[6] The percentage figures for each of the body types illustrated in Fig. 4.1 and referred to above are considered to be the average figures for the sample.

If the number of those young people who were 'sometimes' happy about their weight/size is conflated with the number of young people who were happy about their weight/size 'all the time' (rather than with those who were 'never' happy), these findings, at least at face value, depict a relatively positive picture of young people's relationships with their body's weight/size (84%, n = 973 feeling moderately to extremely happy about their weight/size). Conflated with those who were 'never' happy about their weight/size, however, the figures illustrate a more ominous picture, revealing that just over half (56%, n = 649) of the sample were at best 'moderately' happy and at worst 'not at all' happy about their weight/size. In either case, at least on the surface these data appear to offer some serious check on the perspective of previous research discussed in the preceding chapters (e.g., Allwood, 2010; Evans et al., 2008; Halse et al., 2007), which has emphasised only the potentially determining, all-consuming and destructive effects of obesity discourse for young people's embodiment. On the basis of this evidence alone, the effect of obesity-related health imperatives on young people's subjectivity formation is likely far more complex and varied than may have been implied in previous work. The intention here is not to dismiss the 16% of young people who, alarmingly, reported that they were 'never' happy about their weight/size. These young people not only appear to offer support to existing literature but, through the current study, allow development of this through exploration of who these young people are, why they regard their weight so negatively and the extent to which their health education influenced the negative relationships they reported to have with their weight/size.

As mentioned earlier, the categories described above are somewhat problematic as they obscure both the complexity and fluidity of subjectivity in time, place and space. Over the course of the following chapters, detail and nuance are added to these data, and subsequently to the ways in which one might begin to think about young people's subjectivities and their understandings of health and their weight/size in particular. Rather than implying that the three body typologies referred to above and throughout the remainder of this thesis are fixed or exclusive categories, it is later argued that individuals' relationships with their weight/size, and indeed other aspects of their corporeality, exist on (and ebb and flow across) a continuum whereby all individuals have the capacity to demonstrate characteristics of each of these orientations at varying degrees across different contexts. In this respect, young people's subjectivities are ever in a state of flux and becoming (McLeod and Yates, 2006) and consequently, in some cases, may be thoroughly hybridised (Azzarito, 2010; Rich, 2011). Hence, the young people (as categories of subjectivity) presented here are merely to be

thought of as idealisations − artefacts of the methodology − representing examples of those young people who displayed a higher tendency towards one body typology over another, first through their response to the questionnaire statement concerned with their relationship with their weight/size, and, second, when talking in interview about how they learned and felt about their bodies (i.e., at the time these data were collected).

4.2 Do Schools Matter?

There is no direct or linear relationship between obesity discourse, associated policies and individual (pupil) subjectivity (Evans, De Pian, Rich and Davies, 2012). Rather, cultural messages are always and inevitably mediated and recontextualised through a complex set of relationships involving the individual (the young person in this case), their family, friends and peers and the pedagogic encounters they experience at school (see Braun, Maguire and Ball, 2010; Evans et al., 2011). In order to address one of the key aims of this research and explore the role schools play in the relationships young people develop with their weight/size, the above data are thus considered below in the context of each of the eight schools in this study (Fig. 4.2). As mentioned in Chapter 3, all participants, schools and locations mentioned throughout the thesis have been given a pseudonym to protect the participants' identities.
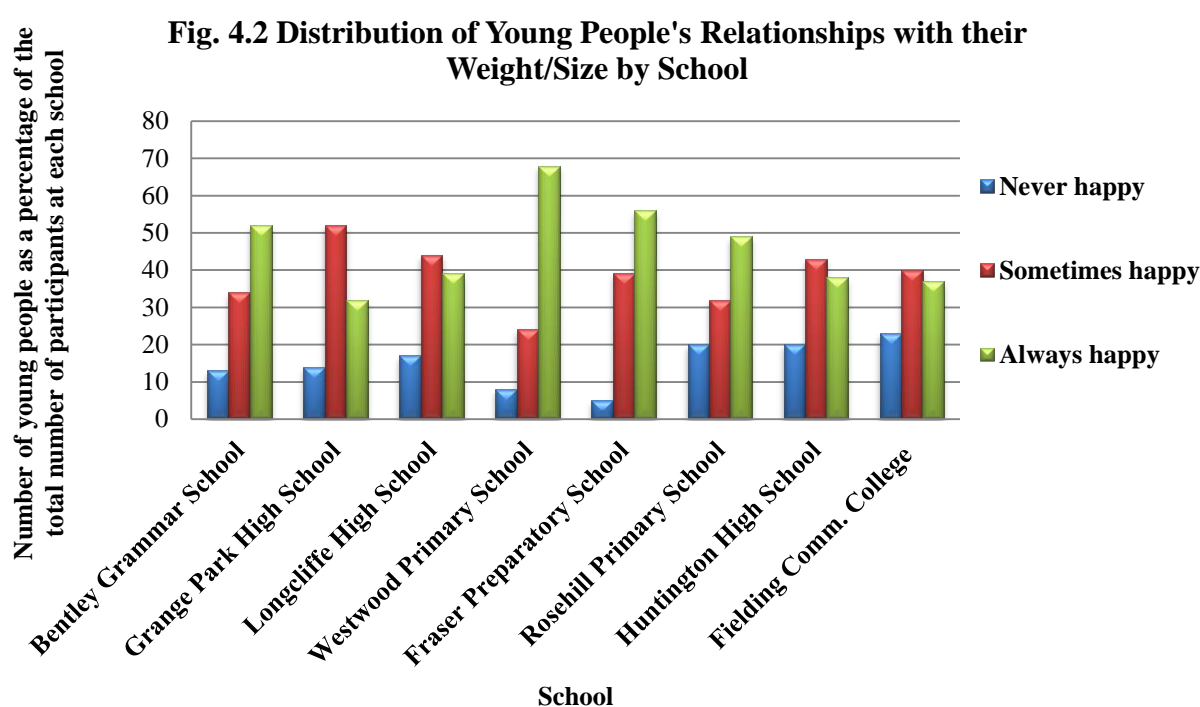

Fig. 4.2 Distribution of Young People's Relationships with their Weight/Size by School

Fig. 4.2 illustrates the proportions of pupils from each school who responded to the prompt 'I am happy about my current weight/size'. This graph clearly indicates that whether young people are happy about their weight/size 'never', 'sometimes' or 'all the time' is far more complex and multifaceted a process than at first might appear. It is apparent that all eight schools accommodate, at varying levels, 'troubled', 'insouciant' and 'emboldened' bodies, regardless of the demographic composition of their intake and/or level of education (primary, middle or secondary in this case). Looking across the schools presented in Fig. 4.2, closer scrutiny of this data against the data for the sample as a whole in Fig. 4.1 shows that with less than 15% of their participants reporting that they were 'never' happy about their current weight/size, four schools (Bentley Grammar School, Grange Park High School, Westwood Primary School and Fraser Preparatory School) appear to house a below-average percentage of 'troubled' bodies. Bentley and Grange Park are independent, suburban, single-sex secondary schools catering for pupils aged 10 to 18 years and 11 to 18 years respectively (participants at both were aged 12-13 years and 15-16 years), from predominantly white, middle-class backgrounds. Westwood and Fraser reveal the lowest levels of 'troubled' bodies within the whole sample (8% and 5% respectively). Both are suburban/rural, co-education primary schools (Westwood state-funded and Fraser independent), catering for pupils aged 4-11 years (participants at both were aged 9-11 years), also from predominantly white, middle-class backgrounds.

With over 16% of their pupils reporting that they were 'never' happy about their current weight/size, however, the other four schools in the study (Rosehill Primary School, Longcliffe High School, Fielding Community College and Huntington High School) reveal a higher than average percentage of 'troubled' bodies. Rosehill, Longcliffe and Fielding are state-funded, inner-city, co-education schools catering for pupils from ethnically diverse, predominantly working-class backgrounds: Rosehill, a primary school for pupils aged 3-11 years (participants were aged 9-11 years); Longcliffe, a middle school for pupils aged 11-14 years (participants were aged 12-13 years); and Fielding, a secondary school for pupils aged 11-16 years (participants were aged 13-15 years). The last in this group of four schools with an above-average percentage of 'troubled' bodies, Huntington High School, is a state-funded, co-education middle school for pupils aged 11-14 years (participants spanned this age-range) from predominantly white, lower-middle and working-class backgrounds in a rural village in the Midlands of England.

These findings suggest that lower than average percentages of 'troubled' bodies were located among pupils attending schools largely populated by white, middle-class young people (Bentley, Grange Park, Westwood and Fraser), and higher than average percentages of 'troubled' bodies were located at the schools housing ethnically diverse and/or lower-middle and working-class pupils (Rosehill, Longcliffe, Fielding and Huntington). With a mix of boys and girls from diverse class and cultural backgrounds across these eight schools reporting that they are 'never', 'sometimes' or 'always' happy about their weight/size, these findings – at least on the surface – appear to belie the literature discussed in Chapter 2 which suggests that 'troubled' bodies are predominantly white, middle class and female (Evans et al., 2008). Further consideration of the statistics presented in Fig. 4.2 reveals that two of the three primary schools (Westwood and Fraser) had a lower proportion of 'troubled' bodies compared with the middle and secondary schools in this study (Longcliffe, Huntington, Fielding, Bentley and Grange Park), suggesting (again against the rub of current evidence – see Hutchinson and Calland, 2011, for example), that younger children perhaps reflect less frequently and/or less negatively on their weight/size. Alternatively, it could be argued that these younger children may reflect just as frequently and/or negatively on their weight/size as the older children in this research, but are better positioned than others (through an intersection of their age, gender, class, culture and/or school context) to nevertheless develop a positive relationship with their weight/size. This theorisation sheds some light on the alarming number of young, 'troubled' bodies at Rosehill Primary School and is corroborated later in this thesis with reference to the working-class, culturally diverse context of Fielding Community College (see Chapter 7).

With more than half of their participants reporting that they were 'always' happy about their current weight/size, three of the four schools previously referred to as having a below-average percentage of 'troubled' bodies (Bentley, Westwood and Fraser), reveal an above-average percentage of 'emboldened' bodies. Of all of the schools in this study, then, these three schools, all with lower than average percentages of 'troubled' bodies and higher than average percentages of 'emboldened' bodies, appear to depict the most positive levels of young people's relationships with their weight/size. As mentioned earlier, these three schools cater for predominantly white, middle class boys and/or girls aged 4 – 11 years (Westwood and Fraser) and 10 – 18 years (Bentley), therefore suggesting that young people from these backgrounds, independent of their age or gender, are more likely to form the most positive relationships with their weight/size.

With a proportion of 'troubled' bodies comparable in size to those found at Bentley, Westwood and Fraser and a similar composition of white, middle-class pupils to those found at these schools, Grange Park High School is therefore expected to also demonstrate an above-average percentage of 'emboldened' bodies. This does not appear to be the case, however. With a below-average percentage (32%) of 'emboldened' bodies, and an above-average percentage (52%) of 'insouciant' bodies (by far the highest proportion of 'insouciant' bodies in the sample), Grange Park appears to add further complexity to the apparent association between the social class and ethnic composition of a school and the relationships the pupils therein form with their body's weight/size. Being a girls' school, a below-average percentage of 'emboldened' bodies at Grange Park was perhaps to be expected in light of previously mentioned literature discussed in the preceding chapters and above, (e.g., Allwood, 2010; Evans et al., 2008; Halse et al., 2007) concerned with the negative effects of obesity discourse on the relationships young females form with their body's weight/size (Evans et al., 2008; Halse et al., 2007). Rather than forming 'troubled' relationships, however, many of the participants at Grange Park appear to be developing less exact (ambivalent or indifferent) relationships with their weight/size.

Unexpectedly again, given its high proportion of 'troubled' bodies, Rosehill Primary School takes the place of Grange Park with an above-average percentage of emboldened bodies. With 49% of its participants reporting that they were happy about their weight/size 'all the time', Rosehill is the fourth and only other school in the sample to accommodate an above-average percentage of 'emboldened' bodies. Thus, initial speculation that younger pupils may reflect less frequently and/or less negatively on their weight/size is affirmed as all three of the primary schools in this research provide for an above-average percentage of 'emboldened' bodies. Alternatively, as suggested earlier, it may be that this proportion of 'emboldened' pupils is better positioned than other ('insouciant' or 'troubled') pupils at Rosehill to develop a positive relationship with their weight/size. This finding, however, further throws into relief the alarmingly high proportion (20%) of 'troubled' bodies at Rosehill Primary School (the only primary school with an above-average percentage of 'troubled' bodies), spurring exploration of the role of gender, cultural diversity, social class and health education curriculum in the relationships pupils form with their body's weight/size.

The remaining three schools in the study (Longcliffe, Huntington and Fielding), with above-average percentages of 'troubled' bodies and below-average percentages of 'emboldened'

bodies, provide some endorsement of earlier research claims regarding the destructive effects of obesity discourse in (some) schools.

Moreover, with 40% or more of their participants reporting that they were 'sometimes' happy about their weight/size, all four of the schools with a below-average percentage of 'emboldened' bodies (Grange Park, Longcliffe, Huntington and Fielding) accommodate an above-average percentage of 'insouciant' bodies (52%, 44%, 43% and 40% respectively), suggesting that the low proportion of 'emboldened' bodies at these four schools could be explained by a relatively high proportion of 'insouciant' bodies and in the case of three of these schools (Longcliffe, Huntington, and Fielding), a high proportion of 'troubled' bodies. So why are many young people such as those at Bentley, Westwood and Fraser forming an 'emboldened' relationship with their weight/size when a large number of young people such as those at Grange Park, Longcliffe, Huntington and Fielding are forming less positive, 'insouciant' and sometimes 'troubled' relationships with their weight/size? This question forms a basis for the remainder of this thesis and Chapters 5, 6 and 7 provide an in-depth exploration of why some pupils appear to fare better than others in the relationships they are forming with their weight/size at Westwood, Grange Park and Fielding. Furthermore, the finding that 'troubled', 'insouciant' and 'emboldened' bodies exist across a range of eight schools as diverse as those included in this research highlights the complex nature of young people's embodied subjectivities and the implications of this for health education are discussed in Chapters 8 and 9.

A recent shift in the way UK schools approach and deliver health education was documented in Chapter 2, highlighting an increase in the number of schools adopting a 'whole school approach' to health education, in line with the UK government's National Healthy Schools Programme (NHSP). However, not all schools are sufficiently equipped (with financial resources, staff or time) to take on such an approach, nor does every school interpret and/or deliver associated health imperatives in a unitary fashion, as discussed in Chapter 2. The following school case studies thus provide an exploration of the emplacement and enactment of health education across three schools (Westwood Primary School, Grange Park High School and Fielding Community College), highlighting the significance of context for young people's subjective learning about and engagement with health and their own bodies. With reference to Ball et al. (2012, p.5), it was documented in Chapter 3 (page 34) that there is an apparent lack of 'real life' analyses of education policy in schools, which involve 'real' and

diverse school settings, policy actors (staff and students) and the various nuances which take shape in each specific context. I will attempt to address this oversight through documentation of the emplacement and enactment of health policy in three schools and drawing on the work of Foucault, Deleuze and Basil Bernstein, the following three chapters "detail and describe some of the discursive artefacts and activities that reflect, and 'carry' within them, some of the key policy discourses that are currently in circulation" (Maguire et al., 2011, p.597) within and across these schools.

Chapters 5, 6 and 7 will therefore further explore the complexities of young people's learning about health and their bodies by focusing attention on three of the eight schools discussed throughout this chapter, which, I suggest, offer the clearest indication as to why some pupils appear to fare better than others in the relationships they develop with their own weight/size. These chapters draw on health policy texts and teacher interview data (n = 7) to illustrate the varying ways health policy is emplaced and enacted in each of the schools, before paying attention to the voices of a small sample (n = 32) of the 1156 young people featured within this chapter who, after completing the questionnaire, spoke in interview about how they felt about their bodies. The following chapters therefore build upon initial findings presented here and explore in more depth young people's learning about health and understandings of their own bodies in their school contexts. Chapters 8 and 9 will then draw upon and bring together the findings presented in Chapters 4 to 7, with a view to advancing extant theoretical and empirical insights into obesity discourse, health education and young people's embodiment.

5. Emboldened Bodies

5.1 Introduction

It was revealed in Chapter 4 that with the second-lowest proportion (8%, n = 2) of 'troubled' bodies and the highest proportion (68%, n = 17) of 'emboldened' bodies, Westwood Primary School is one of three schools in this research to exhibit the most positive distribution of young people's relationships with their weight/size (see Fig. 5.1 below).

Fig. 5.1 Distribution of Young People's Relationships with their Weight/Size at Westwood Primary School
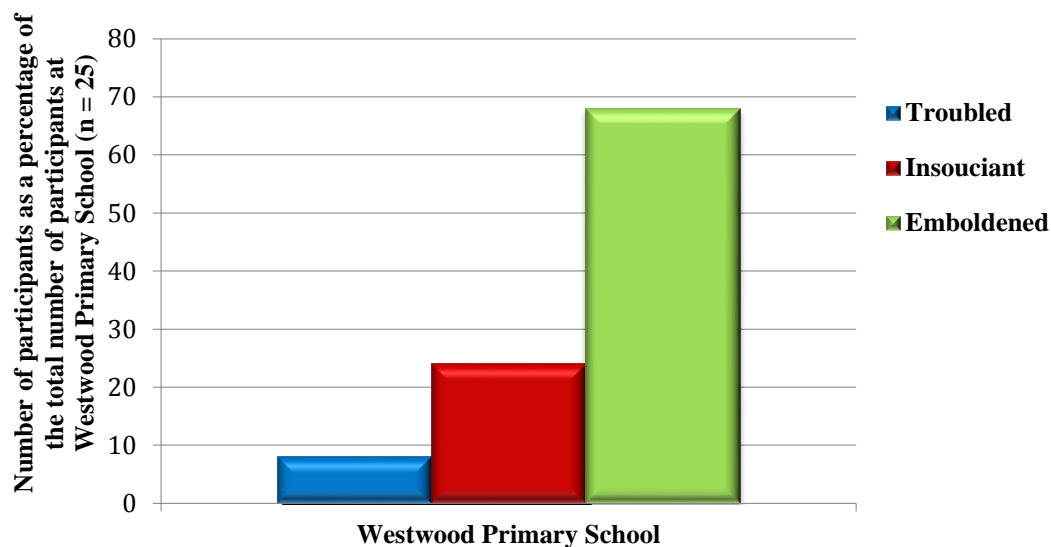
Central to the aims of this research is an exploration of *why* a large proportion of pupils at Westwood felt particularly positive about their weight/size compared with pupils at some of the other schools in this study (Longcliffe High School, Huntington High School and Fielding Community College, in particular, which all revealed large proportions of 'troubled' bodies). A class/cultural distinction emerged in Chapter 4, where it was suggested that relatively low percentages of 'troubled' bodies and high percentages of 'emboldened' bodies reside in schools populated by predominantly white, middle-class children (Bentley, Westwood and Fraser), and high proportions of 'troubled' bodies and low proportions of 'emboldened' bodies were generally found in the culturally diverse, lower-middle and

working-class schools (Longcliffe, Huntington and Fielding). In addition, the pupil responses from all three of the primary schools in the study suggested high relative proportions of 'emboldened' bodies. It was proposed earlier that this could be explained either by younger boys and girls reflecting less frequently and/or less negatively on their weight/size than older children, or through the theorisation that whilst these younger children perhaps reflect just as frequently and/or negatively on their weight/size as older children, the intersection of their age, gender, class, culture, school health curriculum and associated pedagogies contributes to the formation of subjectivities which are 'privileged' by obesity discourse. This chapter aims to explore these initial findings in more depth. Qualitative material collated from the school website, researcher field notes and a recent inspection report is drawn upon to provide a 'real life' policy context (Ball et al., 2012). Qualitative teacher interview data is then used to explore in depth the emplacement and enactment of health policy at Westwood, before turning to descriptive quantitative questionnaire data and qualitative data collected via questionnaires and semi-structured interviews with pupils to understand the various ways in which they experience and embody health policy and associated pedagogies and practices in this context.

5.2 The School Context

> *It was a pleasant drive to Westwood Primary School along open countryside and narrow, winding lanes. The village itself is quaint and, clean and it had a welcoming feel to it. There were a mix of small cottages and large houses and the school was tucked away down a narrow lane. I was struck by how small the school building was, yet it was bustling with happy and excited children playing in the brightly painted playground. The school reception /foyer walls were covered in the children's brightly coloured artwork and their paper crafts hung from the ceiling.*

(Field notes, 18th January 2008)

Westwood Primary School is a small, co-education, state-funded primary school for pupils aged 4 to 11 years, located in a rural, middle-class village in the Midlands region of England. The Head Teacher describes the school as "a successful and happy place" and believes that the school's ethos "aims to encourage all children to achieve their best, develop their interests and talents and become caring, considerate members of the community" (school website, 2010). Furthermore, Westwood is described by the Office for Standards in Education (Ofsted; UK government schools inspectorate) (2008, p.4) as 'a good school' [which is] well led and managed by staff at all levels'. Being a smaller than average sized school, each

member of staff takes on a number of roles. For example, Jess, Key Stage One Teacher for Reception Year One is PE Coordinator, Literacy Coordinator and International Schools Coordinator and Claire, Year 5/6 Classroom Teacher is the Healthy Schools Coordinator and Numeracy Coordinator. In addition to their classroom duties, Jess and Claire thus assume responsibility for the management and design of these specific areas of the curriculum, in consultation with other members of the teaching staff who are then responsible for the delivery of these areas. According to Ofsted (2008, p.3):

> Almost all pupils [attending Westwood] come from White British backgrounds and no pupil is in the early stage of learning English as an additional language.

Children entering the Early Years Foundation Stage Reception class (age 4-5) are reported to have skill levels "just above those expected for their age [and] [t]he proportion of pupils with learning difficulties is below average" (ibid.). Pupils at Westwood are said to:

> …achieve well and reach above average standards. [They] thoroughly enjoy school and this is reflected in their enthusiasm for all aspects of school life and above-average attendance. They enjoy the very wide range of activities offered and the way that teachers help them with their learning. They behave well [and] even remind themselves that they should be working when their attention wanders (ibid., p.4).

Ofsted describes the quality of care at the school as 'particularly good' and based on:

> …excellent [and] effective relationships with home […] Teachers and Teaching Assistants have established effective procedures to ensure that care and welfare have a high priority and this is evident in the confidence with which children approach adults and the relationship between staff and parents.

The school's website includes a 'parents' page' which facilitates two-way communication between the school and pupils' parents who are said to:

> think highly of the school and of, in particular, the welcoming environment of the school, the friendliness of staff and the wide range of activities provided (Ofsted, 2008, p.4).

In short, by government-endorsed Ofsted definitions and criteria, Westwood is a 'good school' with good teachers providing 'care and welfare' to all its pupils, while enjoying positive relationships with parents and the wider community. Boundaries between school and

family are weak; the formal and informal education/educations of the school and home synchronised to ensure the achievement of shared aims and ideals.

5.3 Health Education at Westwood

This next section draws on qualitative teacher interview data to explore the ways in which UK government health policy was emplaced by school staff in relation to the 'contextual dimensions' described in the previous section.

5.3.1 The Obesity Crisis 'Out There'

> I do think there is an obesity crisis out there. I don't think we have a problem personally, in this school or this village in particular, but nationally I think we are going down the American route as it were. (Jess, PE Coordinator)

Although the school had been awarded 'National Healthy School Status' by the UK government for meeting specific health-related criteria and demonstrating a whole-school approach to health education (see Chapter 1, p.13-14), the teaching staff at Westwood expressed a certain ambivalence towards obesity concerns. Jess, the PE Coordinator, like other staff in the school, voiced uncritical acceptance of the notion of an 'obesity crisis', as well as their own dislocation from this 'crisis' and its impending risks. The 'obesity epidemic' was clearly conceptualised in this context as a 'crisis', one step removed from the lives of all at Westwood – staff, pupils, parents – as well as the wider middle-class village community which the school served. Yet, 'knowledge' of the "crisis out there" was readily available to, and routinely accessed by, staff through public health pedagogies concerned with the 'obesity epidemic'. For example, Jess explained: "It's what you read in the paper […] you hear it all on the news, don't you?", which again reinforced their dislocated position in relation to the 'epidemic'. This 'knowledge' was simultaneously drawn upon and affirmed when reading the bodies of 'others' in wider society, for example "seeing people in the streets" (Jess) shaped the way health education was then organised and delivered within the school:

> I mean it's a very affluent area and the parents are well educated so that has a knock-on effect I think with the children… I think these children generally are quite healthy. (Jess, PE Coordinator)

In this situation, Westwood's staff, pupils and parents are defined as privileged by virtue of their social class and are positioned positively in relation to dominant health discourses.

Considering pupils and their families to be 'wealthy' and 'healthy' with 'well educated' parents, staff at Westwood reported that they were "not aware of anything standing out [or] any huge issues on [body] size" (Claire, Healthy Schools Coordinator). Clearly, then, 'health' was to be read through the embodiment of their pupils' (and parents') size, shape and appearance as well as their ability to buy into the dominant health related behaviours (largely concerning diet and exercise) prescribed by the school. The relatively privileged, embodied class position of those at Westwood in relation to obesity discourse might begin to explain why pupils at this school felt particularly positive about their weight/size compared with other pupils in this research; they were 'emboldened' by obesity discourse simply by virtue of their class position (affording them the resources to be able – or at least to appear to be able – to make the 'right choices' and therefore adhere to the health imperatives of obesity discourse), educated parents (reinforcing the above), and their extant embodiment (their physical presence as slim, 'healthy' bodies). Nevertheless, in line with dominant, neo-liberal health and obesity discourses discussed in Chapter 2, the acceptance of a 'causal' relationship between a lack of education, poor lifestyle choices and obesity by staff at Westwood positions themselves and their pupils, regardless of their privileged subjectivities and extant embodiments, as perpetually 'at risk' of obesity. Intervention in the form of education by government, schools and parents to encourage pupils to make the "right choices" was therefore considered to be necessary "from very young" (Claire) and all staff at Westwood appeared to fully embrace their role in this endeavour.

5.3.2 Behaviourism in a 'Totally Pedagogised Micro Society'

'Health', focusing on promoting physical activity and a 'healthy' diet, was a clear priority for staff at Westwood, both in their own lives outside of school (e.g., Claire says: "I'm a fairly healthy person anyway and I believe you should try and eat healthily and be active, so things I do personally") and in the context of their role as educators within the school:

> I think it's a responsibility that we have to inform children and give them as much knowledge as possible so they can choose when they get older, we give them a curriculum and it's their choice what they do. (Claire, Healthy Schools Coordinator)

In line with a behaviourist approach to health education, whereby learning occurs through direct instruction and the subsequent performance of desired behaviours (Chambers, 2011), commitment to health thus had to be enacted and embodied (performed and displayed) by pupils at Westwood. Responsibility was placed on the individual child to make the 'right'

choice, informed by the knowledge they have been provided with at school. In effect, pupils at Westwood were expected to become good 'biocitizens' (Halse et al., 2007) (see Chapter 2), taking responsibility for their own health, not only for their own good but also for that of their school and wider society. A 'whole school approach' to the delivery of health education was thus operationalised to ensure that pupils were being equipped with "as much knowledge as possible" (Claire) for their own and the school's sake. Claire explains:

> health is not a subject on its own, it's the PSHE, it's the PE, it's everything […] It's throughout the whole school, it's in everything that we do within the school, the ethos that we have […] it's very difficult just to pin down and say 'we do this' because it's throughout the whole ethos of what we do and in everything we're teaching. (Claire, Healthy Schools Coordinator)

Westwood, therefore, in many respects exemplified the kind of 'totally pedagogised micro society' (TPMS) discussed in Evans et al. (2008, p.79) (see Chapter 2), where pupils are inescapably located in a culture in which a plethora of imperatives throughout the school prescribes the 'choices' they *should* make (predominantly around diet and exercise) in order to avoid becoming like those "out there" in the midst of the obesity 'crisis'. At Westwood, however, the potentially harmful and destructive nature of totally pedagogised approaches to the health of pupils reported in earlier work (Evans et al., 2008) does not seem to materialise. Westwood appears to be a TPMS comprised largely of emboldened bodies; why is this so? These data seem to clearly highlight the significance of social class location and pupil intake to totally pedagogised schools in relation to the way teachers and pupils enact and embody obesity discourse. At Westwood, health education reinforces and indeed amplifies the school's and pupils' sense of separation, distinction and 'well-being' in relation to obesity imperatives, whilst also constantly reminding pupils of the 'need' for action to 'be healthy'. But why, then, are not all middle-class pupils in this research so 'emboldened'? Grange Park High School was referred to in Chapter 4 for its high proportion of 'insouciant' bodies, and indeed there are pupils at Westwood, albeit in relatively small proportions, who reported 'insouciant' and sometimes 'troubled' relationships with their weight/size. Evidently pupils, including those in the same school context, do not experience dominant discourse in a uniform way. The voices of teachers and pupils at Westwood drawn upon later in this chapter further suggest reasons for the disproportionately large number of 'emboldened' bodies found at this school.

5.3.3 A Healthy Curriculum?

It is evident that individual interpretations of 'health' by staff at Westwood are brought into the enactment of their health education. The uncritical acceptance of health imperatives concerned with diet and exercise in their personal lives, coupled with the UK government's drive to prescribe specific behaviours around these two domains to young people (e.g., through the NHSP), shapes the design and delivery of health at the school. Thus, within this TPMS, an emphasis is placed on 'healthy eating' and PE, each of which will be briefly explored in the context of Westwood before examining the impact of these curricular on the pupils' understandings of health and their own weight/size.

Healthy Eating

Of all the schools in our study, Westwood, through their whole school approach to health education, appears to adopt the most integrated and prescriptive approach to 'healthy eating'. Health imperatives concerned with the pupils' diets dominate the TPMS at Westwood, particularly around snacks because "on the whole they were [previously eating only] crisps or cake" (Claire). In consultation with pupils, the school implemented a healthy snack scheme 18 months prior to data collection for this research project. The scheme was described by Claire as "a small guide to see that they eat healthily" and therefore involved the identification of unhealthy snacks, which were to be avoided by pupils. Claire explains:

> We kept it very simple, and it was crisps, chocolate and cake that are the three things we consider not to be as healthy, so all other things are considered to be generally OK.

In practice, the scheme involved a daily snack register taken alongside the attendance register whereby each child was required to name the snack they had brought with them to school each day. Those who brought a 'healthy snack' to school 80% of the time (4 of the 5 days a week) or more were awarded certificates along with a "healthy prize at the end of the year […] last year they got a Frisbee" (Claire). The scheme was therefore designed to both survey and govern the actions of pupils towards their diet, ensuring that unhealthy, 'risky' foods ("crisps, chocolate and cake") were avoided by rewarding pupils for bringing in 'healthy [safe] snacks'. The use of rewards in this way was clearly intended to have both emotional 'affect' and behavioural effect on the pupils; it aimed to 'condition' the pupils' behaviour in line with the health imperatives the school promoted around diet, and pupils were said to 'enjoy' participating in this scheme. However, the reason given for this (by Claire) was, first

and foremost, the rewards rather than the supposed health benefits. The scheme enforced a clear distinction between 'healthy', 'good', 'safe' foods and 'unhealthy', 'bad', 'risky' foods (see Welch, McMahon and Wright, 2012) and this, perhaps unsurprisingly, was further refracted in pupils' judgement of their peers' behaviour and choices regarding diet:

> Jess: The children will notice if one of the others is eating too many crisps or [drinking too much] coke. We get the odd few that will come in with crisps in their bags and things like that, and I think especially in this school it is noticed.
>
> Researcher: Right, and it's noticed because you have a focus on healthy eating?
>
> Jess: Yeah.

The classification of food in this way meant that those 'odd few' in possession of 'unhealthy', risky foods were destined to stand out as deviant in the TPMS at Westwood, thus creating limited scope for the acceptance of alternative behaviours in this setting. Indeed, further research might reveal whether the 'insouciant' or 'troubled' bodies at this school were considered to be 'deviant' or 'failing' pupils.

Physical Education

In addition to the promotion of healthy eating, staff at Westwood invested significantly more time and financial resources in PE (compared with other schools in this study). Again, this appeared to stem from the personal values of staff at Westwood:

> Personally I come from a very sporty background; my family are quite sporty so personally I think it's important, that's why I've taken on the PE role […] I'm very PE, I love PE. (Jess, PE Coordinator)

Jess' definition of health, in keeping with government policy edict and wider discourse on obesity, is reduced to one primarily concerned with exercise, as means of "tackling the obesity crisis out there". She goes on to explain how her own investment in sport is not representative of the majority, however:

> People don't exercise as much anymore. People have got busy lives now with workload, family, and they may not fit it in […] society in general I don't think is a sporty culture necessarily. (Jess, PE Coordinator).

Jess speaks of the ways Westwood's PE curriculum had benefited financially from the UK government's investment in health education and the promotion of physical activity in particular had raised the profile and importance of PE and school sport in the school:[7]

> I've got a lot of funding so I think the government are putting a lot of money into providing high quality PE for schools. I mean we have a lot of PE, a range on offer right throughout the year [and] we've got all this money coming in and lots of people wanting to come and offer us free clubs […] We've got a lot outside of school so our children are getting what I think is high quality and a lot of sport that's there available to them […] without the government's interest in PE I wouldn't have had all this money really […] We've even got the Sports Development people that come in for the little ones so it's open to them as well, and we've got a dance lady coming in now. Again, that's for Key Stage One as well. (Jess, PE Coordinator)

Jess also reported that a wide range of extra-curricular sports clubs were available to all of their pupils and that "the majority of them" do participate. Furthermore, additional money, collected through supermarket voucher schemes[8], had allowed her to buy PE and playground equipment:

> Now we're quite well resourced in the PE store for curriculum PE. So I spend usually half the money on the curriculum side of it and then half the money on our playground box so they get lots of games in there, they get skipping ropes, balls, all sorts of things that they can play with at play times and lunchtimes. They get a lot from it and we try to keep it topped up so they do use it. (Jess, PE Coordinator)

The value placed on physical activity by both the staff at Westwood and the UK government had clearly privileged PE (and those who teach it) in this context and as a result, "they [pupils at Westwood] are getting a lot [of physical activity] compared to other schools". (Jess)

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[7] Such funding has been cut significantly by the UK coalition government e.g., with the demise of School Sport Partnerships (SSPs).

[8] Many supermarkets in the UK have been running voucher schemes in recent years (e.g., Sainsbury's 'Active Kids' scheme and Tesco's 'For Schools & Clubs' scheme) whereby members of the public, namely parents, can earn vouchers as they pay for their shopping which schools can exchange for teaching resources (e.g., PE and school sports equipment).

The following section draws on quantitative pupil questionnaire data and qualitative data from the pupil questionnaires and interviews to explore in detail how health policy, when emplaced and enacted at Westwood, was experienced and embodied by pupils.

5.4 Emboldened Bodies

Given the strong emphasis placed on healthy eating and PE in dominant obesity discourse circulated both outside of the school (e.g., through public pedagogies and government policy) and through the enactment of health policy in the school, it is perhaps unsurprising that all of the pupils who participated in this study at Westwood (n = 25) defined health in terms of diet (commonly involving words such as 'healthy', 'balanced' and '5 A DAY') and exercise (with reference to specific types of exercise, e.g., 'going for a run' or 'playing football' as well as quantity of exercise e.g., 'a lot' or 'daily'), i.e., terms which conceptualise weight as an indicator of 'health'. Furthermore, all of the 'emboldened' bodies at Westwood (n = 17) defined 'being healthy' in these terms. For example, when asked in the questionnaire 'what are the most important things someone can do to stay healthy?', Nicholas (aged 10) stated "eat healthy food, play sport, start getting fit" and Emily (aged 9) reported "do some exercise and eat a balanced diet", and when asked what pupils learn about health in school, Christopher (aged 9) responded: "to eat healthy foods and get exercise". Of particular interest, however, is the role such interpretations of health played in the formation of different kinds of 'emboldened' bodies at Westwood.

5.4.1 Natured Bodies

Of the 17 pupils who reported in their questionnaires that they were happy with their weight/size 'all the time', 35% (n = 6) continued with an explanation that this was simply by virtue of already being the 'right' weight:

> I am not too heavy or not too light. (Daniel, aged 9)
>
> I am not overweight. (Emily, aged 9)
>
> I am always the right size for my age. (Jessica, aged 10)
>
> There's nothing bad about it. (James, aged 10)
>
> I am not overweight. (Joanne, aged 11)
>
> It is average for my age. (Anna, aged 10)

These pupils considered themselves already 'naturally' 'privileged' in relation to obesity discourse (and were therefore 'emboldened' by it) simply by virtue of their extant embodiment as slim, 'healthy', 'right size' bodies. Whilst these pupils were not required (by virtue of their extant corporeal status) to comply with the imperatives of obesity discourse to reduce their weight, they were, none the less, not exempt from and could not escape its imperatives, which prescribed the choices they should be making around diet and exercise. Thus, these pupils, like all others, were required to maintain their 'healthy' weight by eating the 'right' foods and doing 'regular' exercise; they did not escape the governing gaze of obesity discourse. In certain respects, then, these pupils emerged as the most 'privileged' of all the pupils in our research for not only 'naturally' conforming to the ideal weight/size promoted through dominant obesity discourse, but coming from relatively privileged economic backgrounds, they also had access to the required resources ('healthy' foods and a wide variety of sports facilities and clubs) which allowed them to sustain their healthy lifestyle and profile. For example, Anna and Christopher, 9-year-old pupils at Westwood, reported in their interviews that they ate a range of fruit and vegetables and attended a variety of clubs in and out of school including football, tap dancing, swimming and golf. This was in stark contrast to pupils such as Rory (aged 14) at Fielding Community College (see Chapter 7) who reported

> [t]he government says that we need to get healthier but if people like want to eat more healthy it tends to cost more. I mean, apples are 50p and I think that's a rip off!

And whilst pupils at Fielding participated in the limited range of sports clubs their school had to offer, their 'disadvantaged' class position restricted them from being able to participate in clubs outside of school such as those attended by Anna and Christopher at Westwood:

> People round here, they can't pay for enough like sports, yeah, you just go onto the field, but it's dangerous these days, so most parents don't want them going out on the streets and then so… the only safe thing to do is to go to an actual place that's indoors or something and then play there, but children pretty much have to pay for themselves. If you get a paper round you can do it, it's just, you're just not rich enough to be able to do it these days. Everything's going up in price so you can't do it. (Rory, aged 14, Fielding Community College)

5.4.2 Nurtured Bodies

Another 3 (18%) of the 17 'emboldened' bodies at Westwood reported in their questionnaire that they were happy with their weight/size 'all the time', not because of a naturally privileged embodiment, as was the case with other 'emboldened' pupils discussed earlier, but because of their compliance with the imperatives of obesity discourse around diet and exercise. They were happy with their weight/size 'all the time' because:

> I do exercise all the time. (Nicholas, aged 10)
>
> I have lost a bit [of weight]. (Jack, aged 9)
>
> I play loads of sport. (Oliver, aged 10)

Thus, whilst these pupils did not necessarily conform to the ideal and privileged 'slim', 'healthy' weight/size, they were 'emboldened' by obesity discourse through their actions, that is, by making the 'right' choices, doing the correct things. These young people were seen to be actively engaging with 'health' (performing risk avoidance) which itself provided them with a sense of achievement and indeed allegiance to their school. The imperatives of obesity discourse had, then, demonstrably entered into the thoughts, feelings and actions of all these young people, influencing the decisions they made around health. Again, coming from 'affluent' backgrounds with 'well educated parents', these decisions/achievements were enabled by their class position providing opportunities to participate in 'health', which other pupils in this study (e.g., at Fielding, in particular) simply did not have.

5.5 Conclusion

Whilst many pupils at Westwood appear to have an 'emboldened' relationship with their weight/size, further critical exploration of their voices in this context reveals a yet more nuanced and less positive picture; one that leads me to question the degree to which 'emboldened' bodies can be considered 'healthy' bodies. Just over half (53%, n = 9) of pupil participants at Westwood who reported that they were happy with their weight/size 'all the time', did not provide a reason for this in their questionnaires. There is, of course, any number of plausible reasons for this silence, amongst them, that these 'emboldened' bodies were perhaps unaware of (or could not yet articulate) the reasons why. This data does, however, lend some support and add nuance to the earlier claim that children of this young age perhaps reflect less frequently and/or less negatively on their weight/size than do older children. However, this case also lends support to the earlier theorisation that age is not a solitary factor here; rather what influences the number of 'emboldened' bodies at Westwood

appears to derive from an intersection of a child's age with other aspects of their subjectivity: their gender, social class, ethnicity and school health education. Combined with these factors, then, it could be argued that the young age of participants at Westwood contributed significantly to the disproportionately large number of 'emboldened' bodies in this school setting. Whilst a privileged class position may, perhaps, prevent many of these pupils from developing negative relationships with their bodies as they mature and progress to secondary schooling, the fluid nature of young people's subjectivities means that this may not be the case for all pupils, as shall be reported in the following chapter.

6. Insouciant Bodies

6.1 Introduction

It was revealed in Chapter 4 that Grange Park High School was one of four schools in this diverse sample of eight schools to reveal a below-average percentage of 'troubled' bodies (14%, n = 20). This finding reflects a class and cultural distinction across these eight schools, whereby lower than average percentages of 'troubled' bodies were generally found among pupils attending schools largely populated by white, middle class young people (Bentley, Grange Park, Westwood and Fraser), and higher than average percentages of 'troubled' bodies were found at the four schools catering for ethnically diverse and/or lower-middle and working class pupils (Rosehill, Longcliffe, Fielding and Huntington). As mentioned previously, these findings appear to belie previous literature discussed in Chapter 2 which suggests that 'troubled' bodies are predominantly white, middle class and female (Evans et al., 2008).

In light of the above-mentioned finding, Grange Park was, like Bentley, Westwood and Fraser, expected to reveal an above-average number of 'emboldened' bodies. This does not appear to be the case, however. With a below-average percentage of 'emboldened' bodies (32%, n = 46), and an above-average percentage of 'insouciant' bodies (52%, n = 75 - by far the highest proportion of 'insouciant' bodies in the sample), Grange Park appears to add further complexity to the apparent association between the social class and ethnic composition of a school and the relationships the pupils therein form with their body's weight/size. Being a girls' school, a below-average percentage of 'emboldened' bodies at Grange Park was perhaps to be expected in light of literature discussed in Chapter 2 concerned with the negative effects of obesity discourse on the relationships young females form with their body's weight/size (Allwood, 2010; Evans et al., 2008; Halse et al., 2007). However, rather than forming 'troubled' relationships, or indeed 'emboldened' relationships in line with the emerging pattern in the current data, many of the girls at Grange Park appear to have developed a less exact, 'insouciant' (ambivalent or indifferent) relationship with their weight/size, as illustrated in Fig. 6.1 below.

Fig. 6.1 Distribution of Young People's Relationships with their Weight/Size at Grange Park High School
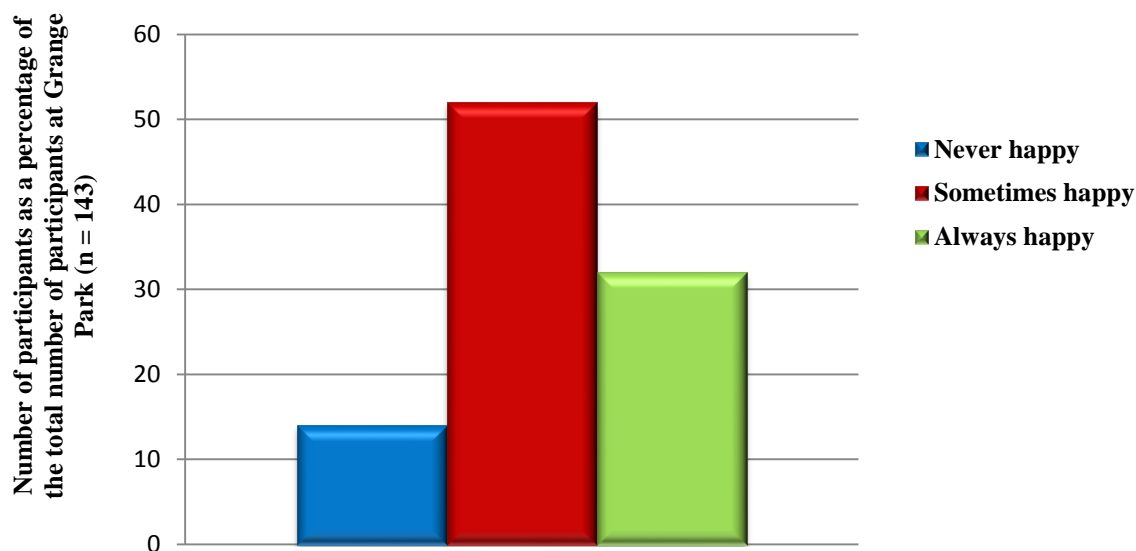
Drawing on qualitative questionnaire and interview data provided by staff and pupils at Grange Park, the remainder of this chapter attempts to explore *why* this might be the case.

So *why* did such a large number of pupils at Grange Park express an ambivalence or indifference towards their body's weight/size compared with pupils at the other schools in this study? In Chapter 4 it was suggested that low percentages of 'troubled' bodies and high percentages of 'emboldened' bodies reside in predominantly white, middle class schools (Bentley, Westwood and Fraser) and Chapter 5 attempted to shed some light on this finding, suggesting that some young people are better positioned than others (through an intersection of their class, culture and school context) to develop a positive relationship with their weight/size. Whilst pupils at Grange Park come from a similar social class and cultural background to those found at Westwood (see Chapter 5), i.e., those who were privileged by obesity discourses due to being able to afford (financially) to successfully engage with and enact associated health imperatives (e.g., a healthy diet and regular physical activity), the large number of 'insouciant' bodies at this school adds complexity to the relationship between obesity discourse, a young person's subjectivity, and the way they think and feel about their weight/size. This chapter therefore adds nuance to this relationship, exploring why pupils at Grange Park are more likely to develop an 'insouciant' relationship with their weight/size compared with other schools in this study.

6.2 The School Context

As mentioned in Chapter 4, Grange Park High School is a large, suburban, independent, secondary school for girls aged 11 to 18 years (the participants were aged 12 to 13 years and 15 to 16 years), from predominantly white, middle-class backgrounds. The school prides itself on its "rich history" (school website, 2012), which appears to play a significant role in contemporary school life; the school website includes information about the founding of the school and its traditions as well as the ways in which its historic buildings are being used and adapted to "mirror the educational challenges of today…to keep up to date with new developments and technologies" (school website, 2012). Other 'situated' and 'material' dimensions of the school (Braun, Ball, Maguire and Hoskins, 2011; Ball et al., 2012), particularly its locale, buildings and pupil intake, were among the first observations to be made upon entering the school:

> *We soon left the hustle and bustle of the town centre behind us as we walked further down a wide but quiet street which, on one side was lined with old trees and 19th century school buildings, and on the other, a new Arts Centre and netball court. The girls were on their way to their next lesson – all smartly dressed in uniform and chatting with each other as they walked; many carrying books and files. We were greeted with smiles as we passed a small group of girls on the steps leading up to a bright and airy school reception.*

<div align="right">(Field notes, 18th February 2008)</div>

Furthermore, the teaching staff we interviewed made several references to their pupil intake. For example, Zara, Head of PE referred to the girls as "very intelligent", "well educated", "high achieving" and "confident"… "They've got good nutrition, the majority of them, they've got parental back up and also they've got a lot of money".

Zara also made reference to the school's facilities: "we're really lucky that we've got an astro, it's great that we've got a playing field and brilliant that we've got a netball court". Nevertheless, the professional culture of the school was heavily influenced by its 'academic' reputation and the girls' academic achievement was a clear priority for staff, pupils and their parents. However, according to the school website, teachers are committed to helping their pupils to "realise their full potential in all aspects of life; physical, social and academic" (school website, 2010). The school places an emphasis on "the value of each girl as an

individual, and the importance of nurturing every aspect of her personality – intellectual, creative, emotional, physical and spiritual" (school website, 2010) and aims to provide an excellent academic education in a caring and supportive atmosphere" (school website, 2010).

The quality of education and personal development provided by the school is described by the Independent Schools Inspectorate (ISI) as 'exceptional' and the ability level of pupils in years 7 to 11 (aged 11 to 16) is far above national average (ISI, 2010). The girls' "achievements, learning, attitudes and skills" are said to be "exceptional and fully reflect the school's aim to provide an excellent academic education in a caring and supportive atmosphere" (ISI, 2010, p.4). Furthermore, with a focus on "each girl as an individual", and the inclusion of all pupils, irrespective of ability, the school provides learning support and a "wide curriculum" as required (ISI, 2010, p.1). There are seventeen pupils reported as "having learning difficulties and/or disability (LDD), of whom eleven receive specialist support. No pupil has a statement of special educational need and one pupil received support for English as an additional language (EAL)" (ibid.).

Like Westwood, Grange Park had established strong links with its pupils' families and parents were "overwhelmingly satisfied with the education and support provided for their children" (ISI, 2010, p.11). The ISI also reported that the school "handle[s] the concerns of parents with care" (ibid.). The school website, particularly the parents' portal, facilitates these positive links by providing a forum for regular communication between the school and the pupils' families. No official complaints or concerns had been logged by the school between 2008 and 2010 (ibid.). Pupils are challenged academically by a range of subjects beyond those of the national curriculum and are well equipped with careers education and guidance, to help fulfill their aspirations upon leaving Grange Park.

The girls are reported to have "excellent" relationships with the staff at Grange Park which ensures that "pupils feel valued and cared for" (ISI, 2010, p.8). Equally, the relationship between pupils is said to be "characterized by mutual respect and warmth" (ibid., p.7). During a recent inspection, a number of informal examples were noted of "pupils working together, sitting quietly talking to one another, being civilized and responding well to the trust they are offered" (ibid.). The older pupils in the school assume a range of roles to support the younger pupils e.g., mentoring (every Year 7 pupil has a mentor) and running extra-curricular clubs.

A strong emphasis is placed on promoting moral behaviour throughout the school and "effective procedures" are in place to "promote good behaviour and acknowledge good performance" (ISI, 2010, p.8) as well as deter undesirable behaviour.

UK government health policy and associated imperatives were therefore being emplaced in a context which values and prioritises academic performance as well as positive relationships between school staff, pupils and their families. The ways in which these key 'contextual dimensions' (Braun, Ball, Maguire and Hoskins, 2011) enabled or constrained the enactment of health policy at Grange Park is considered in the next section.

6.3 Health Education at Grange Park

Despite their first class sports facilities, health education is not a priority in the performance-driven culture of Grange Park High School. In line with the school's aims, outlined above, an emphasis is placed on providing "an excellent academic education in a caring and supportive atmosphere" (ISI, 2010, p.1). An emphasis was therefore placed on providing emotional support to the girls through their health education (particularly PSHE education) and imperatives concerning diet and exercise were confined to and comprised a marginal component of the PE and Food Technology curricular.

6.3.1 Physical Education (PE)

At the time of interview, Zara had been Head of PE at Grange Park for six years. During this time, she claims to have witnessed a decline in fitness levels and a rise in obesity in society generally, but also at Grange Park: "the girls here have not only got less fit, but you've got obesity issues coming in". Zara's views are not reflective of other members of staff we interviewed, however, and she later admits, "[m]aybe I think they're the major ones [health issues] because I think that something could be done about them". Here Zara is referring to the role she believes PE could have in improving young people's health (despite there being no obvious obesity issues in the school), however, she spoke of the ways in which her own values concerning young people's health and physical activity are undermined by the academic, performance-driven culture of the school. She explained that despite having first class facilities, they are "not fulfilling government recommendations" to provide pupils with at least two hours of high quality PE per week and this was exacerbated by a recent revision to the school timetable, from an eight-period day to a ten-period day, therefore shortening the duration of each lesson. Zara explained:

[I]t was almost thrown into the bag; there wasn't any 'this is the government recommendation for this' it was like 'this is our priority' and at the end of the day it is an academic school. (Zara, Head of PE)

Zara spoke of her frustration around the school's reluctance to devote the English government's recommended curriculum time to PE. In light of the value Zara placed on health-related PE, she considered the school's approach to it as "shocking" and "outrageous" and as a result she, along with colleagues in the PE department, was "always thinking about ways to get them more active".

Furthermore, Zara expressed additional frustrations brought about by the school's ineligibility, as a private school, to receive funding to participate in the English government's PE and school sport initiatives e.g., the 5 Hour Challenge, whereby each pupil was required to have access to a minimum of two hours of high quality PE per week and a further three hours of physical activity outside of curriculum time:

Obviously the initiatives in state schools to help combat [obesity], particularly from the PE side, are huge; we don't get any of that because there's a funding issue. I mean we've tried to get in and say we want to be part of it and we'll fund ourselves but we're not allowed to. (Zara, Head of PE)

In Year 9, the girls take a 'Health Related PE' module and it is here that the strongest links can be found between PE and health. Zara explained that she drew on 'British Heart Foundation literature' in delivering this module:

It's very much you've had the message before, now you're Year 9, let's really look at it. We go as far as to analyse their fitness levels to really shock some of them into action; to say actually what you're doing, what you consider to be an activity isn't really getting your heart rate going etcetera, etcetera; you know, this is what you should be doing instead and it's actually quote an enjoyable module, they quite like it.

However, Zara believes that her efforts are redundant without support from the girls' parents:

I think if it doesn't come from home then you're never going to address it is what I

think… it's the same with everything. It's the same with increasing activity levels; if you haven't got the parents' support at home, you're just not going anywhere. I think it's very hard; you can inspire, you can motivate, you can set them on the right path, but if their role models at home aren't providing them with, or are providing them with a different message, then that's really hard I think.

Hence, Zara's enactment of health at Grange Park relies on the strong links the school has with the girls' parents, as discussed earlier in this chapter.

Furthermore, and despite not being a priority amid the academic culture of the school, Zara affirmed that sport is valued highly at Grange Park, particularly in terms of the school's reputation and success in sport (i.e., winning medals), and this is heavily promoted in the marketing of the school. Zara, however, strongly believes that the performance of the PE department at Grange Park has little impact on the number of prospective pupils applying to the school. This, coupled with the fact that Grange Park does not have to follow the National Curriculum, highlights Zara's genuine passion for and dedication to ensuring that the girls receive high quality physical education.

Nevertheless, the girls are said to 'enjoy' participating in PE and school sport at Grange Park. With such tenuous links between PE and health, however, it is perhaps unsurprising that the reasons Zara provides for this are unrelated to health. She explains,

because we achieve at a high level, we get a lot of marketing, a lot of advertising of achieving, you know, winning things and that has a knock-on effect because the girls want to be a part of that so that's one of the reasons some of the girls are participating. You also got a range of girls who are intelligent and want to do an activity because they want to have some fun. We don't have dropout rates in PE, if girls are injured, they come and get their kit and they get on with it.

In summary, the competitive, performative nature of the school shapes the design and delivery of PE as a marginalized subject alongside 'privileged', academic subjects such as English, Maths and Science, for example. This is in stark contrast to the approach Westwood Primary School adopts to PE, discussed in Chapter 5. This finding will be further explored later in this chapter, particularly in relation to the high percentage of 'insouciant' bodies

found at Grange Park.

6.3.2 Healthy Eating

Zara discusses a conflict between the school ethos, the value placed on giving to charity and the imperative to ensure the girls are eating healthily:

> there's a drive on charity here… if you don't raise money for charity then your form is frowned upon, well the easiest way to raise money for charity is a cake sale or sweet sale, mini tuck shops all the time, but then they go down this healthy food route with the vending machine.

These tensions and the at times contradictory messages the girls receive from the school may begin to explain why a large percentage of girls are 'sometimes' happy about their weight/size.

Despite the school's efforts to provide healthy lunches, Zara explains that the girls "don't perhaps choose as wisely as they once did… if there's potato wedges to be had, they'll have potato wedges". In explaining why this might be, Zara goes on to say

> I think they're a bit like me; I know what I should eat and 80% of the time I eat healthily but given a choice on a particularly rubbish day I'll opt for something rubbish and I think that's how people are.

Zara suggests that individuals' choices around health are influenced by daily experiences, and hence, despite knowing which choices they *should* be making, the girls sometimes make less healthy choices when other pressures prevail. Again, this points to the fluid nature of embodied experiences of 'health' and offers further possible explanation for the large percentage of 'insouciant' bodies at Grange Park, particularly in light of its performance driven culture.

6.3.3 Personal, Social, Health and Economic (PSHE) Education

An emphasis is placed on enacting the UK government's Social and Emotional Aspects of Learning (SEAL) Programme at Grange Park. SEAL is described by the government as:

> a comprehensive, whole-school approach to promoting the social and emotional skills that underpin effective learning, positive behaviour, regular attendance, staff effectiveness and the emotional health and well-being of all who learn and work in schools (DCSF, 2007, p.4).

A strong emphasis is therefore placed on attending to the girls' emotional health and well-being at Grange Park; what Ecclestone and Hayes (2009) refer to as 'therapeutic education'. The school has a nurse/counselor ('Matron') who regularly weighs the girls and is heavily relied upon by other staff in the school to support a number of girls with eating disorders:

> It's quite formal in the way that they try to deal with severe eating problems in this school because they [pupils] are weighed probably twice yearly, they do have their discussions with matron (Zara, Head of PE)

Furthermore, the Deputy Head Teacher is in charge of Pastoral Care and child protection and they have "good connections with outside agencies for emotional support" (Zara, Head of PE). Staff have also encouraged a support system between the girls:

> We put together a peer mentoring system where Year 13 go in and talk to Year 7 and Year 9 and give advice on how to look after themselves and that has worked really well. (Jenny, Head of PSHE education).

Furthermore, the school holds an annual 'Self-Esteem Day' involving external support:

> They have a day off timetable on the day after their exams and we say it's not all about work and we have a Life Coach who comes in to help them feel comfortable about themselves.

This emphasis on therapeutic education is manifested in the PSHE education curriculum also:

> I'm actually team teaching in Year 8 about their perception of a beautiful body and they do a nice collage from magazines and they talk about how they perceive themselves and what's normal and what isn't […] are they happy and then they put together a presentation about body image and how the pressure of the media affects body image. (Jenny, Head of PSHE education).

The therapeutic pedagogies at Grange Park may begin to explain why such a high proportion of pupils there reported 'insouciant' relationships with their weight/size, rather than 'emboldened' relationships as was the case with Westwood, the other middle class school in this study. Indeed, Ecclestone and Hayes (2009) have documented the 'dangerous rise of therapeutic education' and the ways in which "denying the intellectual and privileging the emotional" (p.xi) through this approach can encourage young people "to respond emotionally

to day to day challenges" and therefore promote a "diminished human subject" (p.xi). Ecclestone and Hayes (2009, p.xi) define the "diminished human subject" as one who

> finds exposure to uncertainty and adversity, including disappointment, despair and conflict simultaneously threatening to the 'integrity of the self' and inhibiting of it. A diminished sense of human potential denies the intellectual and privileges the emotional.

The data presented in this chapter offer some indication of these processes at work, albeit not always at the extremes of effect suggested by Ecclestone and Hayes (2009). This is reflected in what is referred to below as the 'insouciant' nature of the young people's subjectivities evident at this school.

In stark contrast to the ways in which 'health' was enacted at Westwood, imperatives concerning diet and exercise featured as small and isolated components of the PE, PSHE education and Food Technology curricular at Grange Park. Furthermore, Zara explained:

> I think the other thing we don't do very well is bring it all together because I think there's a lot of repetition; what's happening in one place, maybe science, PSE, particularly in PE there's a big crossover and so that's not as good as it should be really. I think sometimes, I'm quite shocked, and think why are we devoting that time? That's something we've done, we could have worked together at the time. We're busy people and that's quite hard.

Clearly then, the size of a school, its ethos, values and priorities have significant purchase on the extent to which a whole school/totally pedagogised approach to health can be adopted. The ways in which the health pedagogies and practices at Grange Park were experienced and embodied by their pupils are discussed in the following section.

6.4 Insouciant Bodies

Just over half of participants at Grange Park High School (52%, n = 75) reported that they are 'sometimes' happy with their current weight/size. These pupils are referred to here and elsewhere (see Evans et al., 2012) as 'insouciant' bodies. Whilst this label perhaps implies that participants in this group are somewhat nonchalant about their weight/size, it is also intended to capture those young people who had a less exact or fixed relationship with their weight/size. Of all three body typologies presented in Chapter 4 and discussed in Chapters 5

to 7, it is this 'insouciant' category of pupil which most clearly exemplifies the fluid nature of young people's relationships with their own bodies within and across time, place and/or space.

Of the 75 pupils at Grange Park who were happy with their weight/size 'sometimes', 15% (n = 11) expressed a rationalised or indifferent reasoning for this:

I don't think it's a problem and could still be growing (Anna, 13)

I'm satisfied with it (Chloe, 15)

I feel comfortable with how I look (Rosie, 13)

My friends have told me I don't need to lose weight and they are really supportive (Jessica, 13)

I'm a generally smaller sized person and I don't really mind although I do get teased sometimes (Vicky, 15)

I am tall so I am going to be heavier than a lot of my contemporaries anyway (Emma, 15)

Because it's fun being small but sometimes I can't reach stuff (Alice, 15)

I am not very thin. I am slightly chubby but I prefer it that way (Jenny, 12)

I don't mind my weight because I know I'm muscly but I do feel rather big at times which I don't like (Sally, 16)

It doesn't bother me most of the time. A lot of my friends are much smaller than me though (Yvonne, 12)

I sometimes feel I should diet but it's too hard so I quit and I don't mind, it's no biggy (Zoe, 13)

On the whole, these pupils do not appear to be particularly influenced by obesity discourses and have expressed an 'insouciant' relationship with their weight/size, whereby obesity discourses and associated health imperatives *effect* the ways they (like the majority of pupils) think and talk about weight generally, but do not deeply *affect* their thoughts, feelings and actions towards their own bodies in any clear or determinate ways. The comments of Vicky, Alice, Sally, Yvonne and Zoe all point to the transitory and fluid nature of their relationships with their weight/size, across time, place and space.

29% of the 75 'insouciant' bodies found at Grange Park (n = 22) provided a positive explanation for their relationship with their weight/size. These pupils reflected on their

compliance with obesity discourses and associated health imperatives in explaining that they are 'sometimes' happy with their weight/size because of a 'healthy', 'normal' or acceptable weight/size:

It is healthy (Sarah, 13)

I am healthy (Ruby, 15)

It's normal (Lauren, 15)

I'm about right (Jo, 13)

Sometimes I fluctuate but I'm average weight (Nisha, 12)

I'm about right, not perfect (Holly, 16)

It's an ok size (Jemma, 15)

I am about the same as my friends (Lucy, 12)

I feel I'm just about the right size for my height (Rosa, 13)

I think I have an ok figure (Harriet, 15)

They are both normal unlike some people's (Shona, 16)

I am at the weight I wanted (Martha, 12)

I feel slim (Rhiannon, 15)

I am a size 8/10 (Nina, 15)

I am not over/underweight (Amy, 16)

I'm not really fat or really thin (Rebecca, 16)

I'm not over or under weight (Hannah, 16)

I am not over or under weight (Priya, 16)

I am just right, not underweight or overweight (Natalie, 15)

I am not fat but not really skinny either (Claire, 13)

I am not obese or I don't think I'm underweight (Suzie, 12)

I am not too skinny but am not overweight (Rachel, 12)

With reference to their weight/size being "healthy", "about right", "the same as my friends" and within the two extremities of 'underweight, thin or skinny' and 'overweight, fat or obese', these 'insouciant' bodies are invoking notions of normality, conformity and perhaps, therefore, another form of indifference to that described above. These pupils are neither 'emboldened' nor 'troubled' about their weight/size, simply because their 'acceptable' weight, endorsed by obesity discourses, allows them to 'fit in' and be accepted. Here we are reminded of the 'emboldened', 'natured' bodies at Westwood Primary School, discussed in

Chapter 5, i.e., those pupils who are 'emboldened' and privileged by obesity discourses by virtue of being the 'right' weight. However, where those 'emboldened', 'natured' bodies at Westwood reported being happy about their 'virtuous' weight/size 'all the time', these 'insouciant', 'natured' bodies at Grange Park expressed a less exact relationship with their equally virtuous weight/size. Why is this so? There are obvious demographic differences between pupils at Westwood Primary School and Grange Park High School (a secondary school). Firstly, pupils at Grange Park were older than those at Westwood. It was discussed in Chapter 5 that high percentages of 'emboldened' bodies were found at all three of the primary schools in this study, suggesting that younger children (given their stage of maturation) perhaps reflect less frequently and/or negatively on their weight/size than older children. This theorization seems to be corroborated here, by the finding that older age pupils (e.g., those at Grange Park) regard their virtuous weight/size less positively than their younger, 'emboldened' counterparts (e.g., those at Westwood). The small age difference between the eldest participant at Westwood (11 years) and the youngest participant at Grange Park (12 years), however, calls this theorization into question. *Neither age nor maturation alone explains such differences*. Secondly, Westwood is a co-education state school and Grange Park a private school for girls. The culture of each of these schools discussed in Chapter 5 and here in Chapter 6 respectively may have a role to play in the value placed on a 'normal'/'acceptable'/'average' weight/size and/or the corresponding affective relations invoked in each of these contexts. For example, whilst a 'natured' body might be 'enough' to embolden a child at Westwood, it may only count for 'so much' in the competitive, academic performance-driven context of Grange Park. Despite placing an emphasis on encouraging a supportive and caring environment for its pupils, the competitive, performance driven culture of Grange Park appears to have a significant influence over the way the girls relate to their own bodies, especially their weight. Jenny, Head of PSHE education at Grange Park made reference to the girls' concerns with their body image:

> Concerns mainly that they don't conform to what they see in magazines and this endless, constant striving for perfection. That's perhaps as much to do with the environment in which they study, alongside the media. I'm not sure what the biggest pressure is for them, but yeah, to be perfect.

Here we are given some indication of how media pressures to look a certain way and 'strive for perfection' are amplified within the competitive, performance driven culture of Grange

Park. In light of this finding, we can perhaps begin to understand why having a 'normal', 'healthy' or 'acceptable' weight/size (which 'emboldened' many pupils at Westwood) only counts for 'so much' in the context of Grange Park and therefore leads to some of the girls developing a less positive, more fluid, 'insouciant' relationship with their weight/size. In short, 'normal' is not synonymous with 'perfect' for many of the girls in this context. For example, Holly affirms: I am happy with my weight/size 'sometimes' because "I'm about right, not perfect".

Cursory analysis of the Grange Park data would suggest that many of the girls are uncritically accepting of what they see and read in the media with respect to body image and health. However, Zara's comments call for caution if making such assumptions, her views offering further complexity and insight to this relationship:

> [W]hen you do try to have an intelligent conversation, for example, if you sit in here with the girls, they will say all the right things; that they are aware of what the media is doing, they're aware about it but they will know that that's not realistic and they know that the 'perfect body image' is not necessarily the perfect body because of airbrushing etcetera etcetera, but they're still aspiring to it […] they're definitely pressured by it, as all girls are.

An apparent distinction and contradiction emerges between the girls knowing how they *should* feel towards their own and others' bodies (especially those portrayed by the media) and how they *actually* feel about their own and others' bodies. Thus, the girls' insouciance toward their weight/size is reflective of the interminable tension between affect and effect.

A further 24% of the 75 'insouciant' bodies at Grange Park (n = 18) provided a negative explanation as to why they were 'sometimes' happy with their weight/size:

> I'm ok with my size but would not mind being a little less fat (Josie, 12)
>
> I am underweight but can't put the weight on (Sunita, 12)
>
> I sometimes feel I should weigh less (Annabelle, 13)
>
> I could be a lot bigger but I wish I was smaller (Alex, 15)
>
> I am very heavy I think (Anna, 13)
>
> I often think I could lose weight on thighs (Maisie, 15)
>
> I have fat days (Brooke, 16)
>
> I like my height but want to be thinner (Kirsty, 15)

Sometimes I lose my self-esteem (Carmen, 15)

I don't want to look too thin (Katie, 13)

I'm not huge but I know I could be thinner if I tried harder (Jen, 15)

I don't mind my top half but I hate the bottom (Jane, 16)

I know that the SEAL says I am healthy but I look fat to all my friends (Danielle, 15)

I would like to be a bit thinner (I won't eat too much fat) (Florence, 13)

When I look at other children in my class, nearly all of them are taller (Elizabeth, 15)

I don't want to be anorexic or obese but I am heading to the obese side (Susan, 15)

I know I am not fat but I want to be skinny (Louise, 12)

I am a good shape but again I think I am too thin (Isobelle, 15)

Unlike the other 'insouciant' bodies at Grange Park, these pupils appear to be both affected and effected by obesity discourses, and in contrast to the 'insouciant', 'natured' bodies discussed earlier, many of these pupils are negatively effected through a perception that their weight does not 'conform' to the 'ideal' or acceptable weight the 'natured' bodies appear to be uplifted by. Again, the fluidity of these pupils' relationships becomes apparent here, especially in the responses of Annabelle, Brooke, Carmen, Danielle and Elizabeth, above, whose relationships with their weight/size are time or context specific. Whilst Danielle and Elizabeth may feel indifferent to or indeed satisfied with their weight/size the majority of the time, their relationship with their weight/size appears to shift to a more negative stance when in the presence of their friends or peers (likely at school). It is interesting to note the conflict and transience experienced by Danielle as a result of being defined as 'healthy', by the *Social and Emotional Aspects of Learning* (SEAL) Programme at school (see DCSF, 2007) but 'fat' in the presence of her friends. This conflict illustrates the ways in which bodies become situated and 'emplaced' in time, place and space and is perhaps reflective of a broader tension between the rhetoric of the SEAL Programme and the competitive, performative culture of Grange Park referred to earlier, in which many of its pupils routinely compare themselves with one another in their quest for 'perfection'.

The final 32% of the 75 'insouciant' bodies at Grange Park (n = 24) did not provide a written explanation as to why they are 'sometimes' happy with their weight/size. As was discussed in Chapter 5, there could be any number of plausible reasons for this silence. Amongst them, however, it could be argued that the ambivalence and indifference characteristic of these 'insouciant' bodies resulted in these young people perhaps being unaware of or unable to

articulate the reasons why they are 'sometimes' happy with their weight/size.

6.5 Conclusion

Drawing on a school case study, this chapter has attempted to explore those pupils/subjectivities who are 'sometimes' happy with their weight/size. Engagement with dominant health and obesity discourse is not a priority in the academic, performance-driven context of Grange Park. Rather, an emphasis is placed on the pupils' emotional health and well-being and thus, 'therapeutic' pedagogies are drawn upon to assist the girls in maintaining a sense of balance in their busy and demanding lives. Whilst the pupils referred to are considered to be 'insouciant' bodies, there is evidently great variance at this one school alone, explaining *why* these pupils are only 'sometimes' happy with their weight/size. Based on this school case study, of all three body typologies, it is this 'insouciant' group of pupils, I would argue, which most clearly exemplifies the fluid and indeterminate nature of young people's relationships with their own bodies within and across time, place and space. The therapeutic approach to health education at Grange Park, which seemingly acts as a stabilizing force in the girls' lives, offers some indication as to why so many girls displayed a fluid and indeterminate relationship with their body's weight/size in this context. It was highlighted in Chapter 4 that 'insouciant' bodies can be found, in varying proportions, at all eight of the schools in this study. Thus, whilst Grange Park has provided the focus of this chapter, it has done so merely as an illustrative example of a school context in which a particularly high proportion of 'insouciant' bodies are located. Further investigation is required in order to explore the extent to which the 'insouciant' bodies found at Grange Park are representative of those other 'insouciant' bodies in this study. These data strongly suggest that these subjectivities are therefore to be viewed and understood as contingent subjectivities – inextricably connected to (are an affect/effect of) the curriculum, pedagogies and culture of the school – i.e., they are not arbitrary subjectivities but expressions of the intersection of class and cultural predispositions and a very particular set of circumstances unique to the school. They are 'in effect' embodiments of the emplacement and enactment of policy *in situ*, issues which will be explored and elaborated on in Chapter 8.

7. Troubled Bodies

7.1 Introduction

This third and final school case study aims to explore the lived, embodied experiences of some of the 'troubled' young people found in this research project. It was revealed in Chapter 4 that of all 8 schools in this study, Fielding Community College presented the highest percentage of 'troubled' bodies (23%, n = 43), a higher than average percentage of 'insouciant' bodies (40%, n = 75) and a below-average percentage of 'emboldened' bodies (37%, n = 68). In light of these statistics, Fielding is one of four schools in this study to reveal the most negative distribution of young people's relationships with their weight/size (see Fig. 7.1 below).

Fig. 7.1 Distribution of Young People's Relationships with their Weight/Size at Fielding Community College
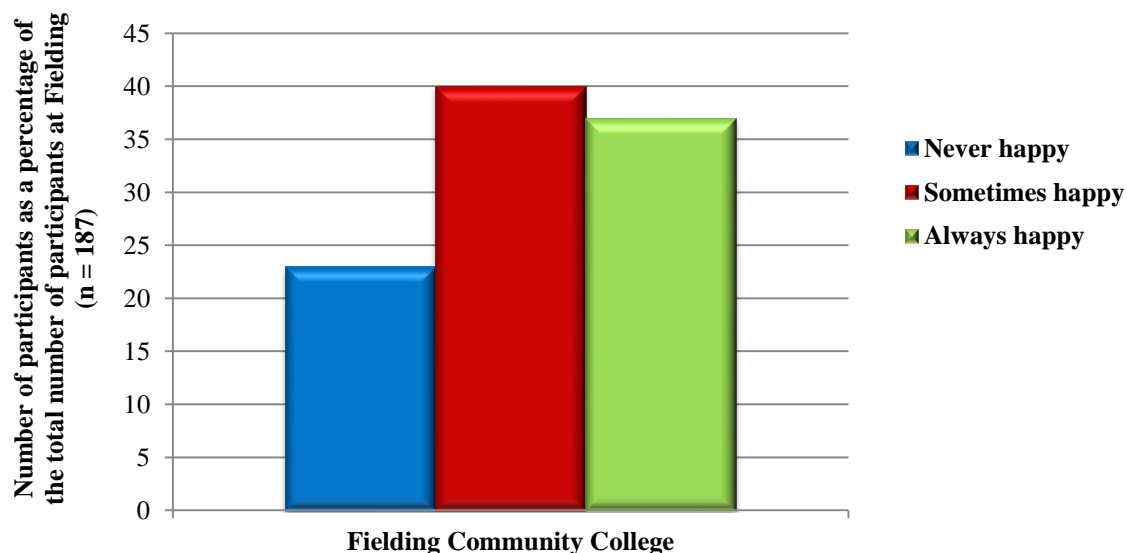
These findings further corroborate the class and cultural trend, which has been emerging from this research thus far. This trend has suggested that pupils from white, middle class backgrounds generally formed more positive relationships with their weight/size than pupils from culturally diverse, lower-middle and working clas backgrounds, such as those found at Fielding. As mentioned previously, these findings appear to belie extant literature discussed in Chapter 2, which suggests that 'troubled' bodies are predominantly white, middle class and

female (Evans et al., 2008). The remainder of this chapter seeks to understand why such a large proportion of 'troubled' bodies were found at Fielding. An insight will be gained into the embodied experiences of pupils attending this school, exploring in particular what it means to be a 'troubled' body in this context and the role Fielding's Health Education plays in the relationships its pupils form with their bodies' weight/size.

7.2 The School Context

> *After sitting in the inner-city morning rush-hour traffic, I was relieved to be approaching Fielding Community College. I was due to spend the day there and having limited experience of a large, inner-city comprehensive school, I felt a little apprehensive and unsure about what to expect. If I'm honest, the experience was a little intimidating. Groups of teenage students poured through the main gates and I felt self-conscious as I walked across the large, concrete playground to access the main school building. It felt extremely oppressive inside the building, the corridors were long corridors and gloomy and had various 'school rules' painted in big, bold letters along the top of the walls e.g., 'we will respect each other', 'we will act sensibly'. The doors to staff offices were re-enforced with steel sheets, which resulted in a dark and dreary environment and gave the impression that the school was not a happy place to either work or learn. I was amazed at how such a busy environment could feel so lonely and isolating, and instantly began to wonder if any of the students could relate to that feeling.*
>
> (Field notes, 11th July 2008)

Fielding Community College is a co-education secondary school for pupils aged 11 to 16. With a total of 882 pupils, the college is reported by the UK government inspectorate, Ofsted (2007), to be of average size compared with other secondary schools in the UK. The college serves an area of high socio-economic deprivation, which is reflected in the proportion of students eligible for free school meals being "well above the national average" (Ofsted, 2008, p.3). The proportions of pupils with learning difficulties and/or disabilities, from minority ethnic groups, and whose first language is not English are also higher than the national average (Ofsted, 2008). Fielding therefore caters for a more deprived and diverse population of young people than Westwood (see Chapter 5) and Grange Park (see Chapter 6). The extent

to which this has impacted the enactment of health education at Fielding will be explored later in the chapter.

At the time of this research, Fielding was given 'Notice to Improve' following an Ofsted inspection in 2007. The college was reported to be providing an 'inadequate' level of "effective, efficient and inclusive education, integrated care and extended services in meeting the needs of [its] learners" (Ofsted, 2008, p.10). This is in stark contrast to the 'outstanding' education and ethos reported to have been in place at Westwood (Chapter 5) and Grange Park (Chapter 6). Many of our pupil participants at Fielding were critical of the standard of education they were provided with. For example, Amy, a 14-year-old pupil commented:

> You've got some teachers that are 100 per cent but you've only got other teachers that are 50 per cent so like the person that's doing 100 per cent, the 50 per cent is letting that person down… I hate when we have supplies because you sit there, and you know the work you do is just going to be put in the bin anyway and so that kind of really annoys me. I like it when the teacher's there and they push you.

Nevertheless, Fielding was reported to be providing a "satisfactory curriculum" and pupils were said to enjoy school when engaged and taking an active part in lessons (Ofsted, 2008, p.4). Disruption was reported to occur when teaching styles were ineffective, however, which "leads to them [pupils] being inattentive or too passive in their learning" (Ofsted, 2008, p.6). This was evident in the experiences shared by Rory (also 14):

> Rory: I don't try as hard as I can do… Lessons are usually boring so I'm pretty much talking all the way, if not I'll just get bored and then you end up not actually doing any work at all, so you end up just sitting there.
>
> Researcher: What do you think is the reason behind that?
>
> Rory: The teachers… I don't even think the teachers have actually picked up on the fact that people are getting less grades.

Levels of disaffection appeared to be high at Fielding and in addition to an inadequate level of academic support discussed above, some of the pupils pointed to a lack of discipline from teachers:

> Researcher: How does this school encourage its pupils? Can you think of anything it does?

Rory: Not really, because say if someone hasn't got their PE kit, they just let them not do it and there's no discipline.

Researcher: So if they don't bring their PE kit they don't have to do PE?

Rory: No

Further highlighting a lack of support to effectively deal with disaffected pupils, Rory explains:

I think we shouldn't expel the children because, to be honest… it's not as bad as making them come to school because most of them try and get expelled so they don't have to come to school… because my mate, she got expelled and she was proper happy about it.

In light of the above, it is perhaps unsurprising that the overall progress of pupils during their time at Fielding was said to be "inadequate", with achievement and standards being "very low" (Ofsted, 2008, p.5). For example, Ofsted reported that "the proportion of pupils in Year 11 gaining the equivalent of at least five GCSEs at grades A* - C in 2006 and 2007 was well below the national average" (2008, p.5).

Rory commented:

Rory: In English, we're in mixed groups and apparently everyone's levels are supposed to be going down.

Researcher: Levels in achievement?

Rory: Yeah, like apparently my mate was on Level 6 last year, now she's on Level 4 because we can't go as fast as what they would like because we've got a lower set of people, then you just slow up and you don't get to learn as much.

Researcher: So do you think there are people in the group who perhaps could do Level 6 but they're not able to do it because of the lower level?

Rory: Yeah, but they're changing it because everyone's complaining.

Whilst the pupils appear to understand low levels of achievement to be a product of poor quality teaching at Fielding, Samantha, Food Technology Teacher/Health Education Coordinator, looked to external factors (largely their pupil intake) to explain this:

I think a lot of it comes down to the fact that a lot of girls have very, very low self-esteem… they don't see… very much from the point of view of job roles in future life, I think this comes down to the teenage pregnancy as well, it's seen as 'well that's what everybody does, isn't it?'… They don't have this concept that they can achieve, that they can go on, that they can do better… and it gets very wound up in their self-consciousness.

This not only suggests a lack of rapport but also mutual blame between teachers and pupils at Fielding which again is in stark contrast to the positive relationships reported between teachers and pupils at Westwood (Chapter 5) and Grange Park (Chapter 6). Pupils expressed a sense of feeling devalued by the education they were provided with, which alone may go some way to explaining the high proportion of 'troubled' bodies at Fielding (i.e., the way in which a school values/positions its pupils contributed to the shaping of their developing sense of self).

Although said to be improving, pupils' attendance, behaviour and attitudes to school were reported to be "inadequate" and on-going issues (Ofsted, 2008, p.4) and bullying among the pupils was said to be a concern for a number of parents and pupils (Ofsted, 2008). This was also found to be the case in the pupil questionnaire and staff and pupil interview data collected for this research project, particularly in relation to pupils' weight/size. Just over half (55%, n = 103) of pupil participants at Fielding reported in their questionnaires that they had been 'picked on' because of their weight/size 'sometimes' or 'all the time' (compared with 20% (n = 5) at Westwood (see Chapter 5) and 38% (n = 53) at Grange Park (see Chapter 6)) and just under a third (29%, n = 54) of pupils at Fielding reported that they had been called names about their weight/size 'sometimes' or 'all the time' (compared with 16% (n = 4) at Westwood and 15% (n = 21) at Grange Park). Furthermore, in interview, when asked what came to mind when considering the four interview topics (health, body, school and obesity), Rory (aged 14) responded "bullying and obesity… and health, for like people eating bad food and then basically bullying; in school lessons you get bullied"… an issue which Rory explained is exacerbated by a pupil's weight being visibly outside of (but especially 'over') what is considered to be 'normal' and therefore 'acceptable' at Fielding. Samantha also highlighted the same issue:

Kids don't tend to be kind to each other… those that are overweight are being told, erm… by the other students, so they know, or they suspect themselves.

It would appear, then, that teaching standards at Fielding were low, pupils' self-esteem, ambition and attainment levels were also generally low and levels of disaffection and bullying among pupils were high. These factors may all offer some initial insight into possible reasons contributing to the high proportion of 'troubled' bodies found at Fielding, further highlighting the significance of a school's context and culture as well as the transactions between teachers and pupils and within peer groups in the relationships pupils form with their own bodies. The extent to which these experiences featured in the lives of the 'troubled' bodies found at Fielding will be explored later in the chapter.

7.3 Health Education at Fielding

Educating the pupils about healthy eating was a priority for staff at Fielding, but unlike at Westwood and Grange Park, the pupils' diets sat alongside other pressing pathologies in their lives which the school was attempting to address. Samantha, Fielding's Health Education Coordinator reported that teenage pregnancy rates at the school were higher than the national average and smoking, alcohol consumption and drug use were also reported to be particular issues among the pupils. Thus, in stark contrast to the totally pedagogised micro society (TPMS) found at Westwood (see Chapter 5), obesity discourse concerning healthy eating and physical education, was neither a privileged nor privileging text and rarely extended beyond the formal curriculum time it was accorded. Rather, Health Education at Fielding was determined by immediate class and cultural considerations, thus, providing culturally specific knowledge/s to help young people to deal with and avoid such problems was prioritised over teaching the pupils about healthy eating and physical education. For example, the school facilitated a health shop run by school nurses, which involved the recruitment of an external team to deliver guidance around sexual health, and a smoking cessation group had recently formed within the college at the time of this research.

7.3.1 Healthy Eating

Compared with the other schools in this research, a relatively low amount of curriculum time was accorded to healthy eating. Samantha explains:

> The present national curriculum putting us [food technology] within technology has almost forgotten about healthy eating… The national curriculum gives lip service to it but it doesn't give you the opportunity to develop much around healthy eating and lifting the profile of healthy eating.

The teachers' own recontextualisation of the Food Technology curriculum at Fielding comes into play, however, whereby their personal values and Home Economics backgrounds built upon this 'lip service' to place a greater (but still relatively limited) emphasis on nutrition within Food Technology:

> The nutrition and that side of it was very important to us and so we've kept it running despite the National Curriculum.

Thus, the limited amount of time accorded to nutrition lessons at Fielding derived from an informal, rather than formal, curriculum context which was based on traditional values of cookery and focused on equipping pupils with skills to cook a range of foods with little attention paid to 'healthy eating'. During the period of research, however, a new initiative entitled 'Let's Cook' had been introduced at the college:

> It's literally cooking skills using recipes that have been adapted by the British Nutrition Foundation so that they're actually healthier recipes whereas, you know, the traditional recipes that we did in food weren't necessarily the healthiest way of going about things.

Eighteen months prior to interview, Samantha had taken on the role of Health Education Coordinator, which had also informed her teaching of Food Technology:

> We do a lot about healthy eating and working on the 5 A Day in Year 7. In Year 8 we tend to widen it out and look more at the carbohydrate based foods and… you know… trying to extend the range of the healthy eating guidelines that we're using – we're using the Eat Well 8. In Year 9 we go more into how health affects our person, in the broadest sense; we look at pollution, drugs… you know, just tiny little bits we give lip service to but put that all into a big context and then we take out much more of a nutrition theme.

Whilst Samantha believes that they "do a lot about healthy eating" this is relatively limited in comparison with the practices found at the other schools in this research. And although attempts were made to extend pedagogies concerning healthy eating beyond formal teaching and learning contexts at Fielding, not least into an improvement of school dinners, they were, it seems, met with little success. For example, Amy explained in interview why she chose not to have school dinners:

Amy: Well, for one, my mum used to work in the canteen

Researcher: Oh right

Amy: And she never, I suppose, liked what she's seen in there, so I suppose that don't help like… she says "why go and eat in there when we've got the stuff at home" and she gives me a packed lunch and she knows what I'm eating then. Like, if I go in there, I suppose whatever they eat I could just eat that, but then my mum knows what I'm eating so she can actually monitor it.

Unlike at the other case study schools it would appear that there is a lack of trust among parents towards the college ensuring that their children eat 'healthily' (or receive food that couldn't be provided more economically by the home). Samantha spoke about a healthy tuck shop at the school, i.e., an attempt to extend healthy eating practices, informally, across the school, but it appeared that not all of the pupils were aware of this: "I didn't even know that there was one… I knew they did it last year but I've never seen it done this year" (Rory). Samantha had also recently introduced a 'Healthy Lifestyles Day' to the college, to "try and get the parents involved in health issues as well" but again, this was with limited success. This was all in stark contrast to the totally pedagogised micro society (TPMS) found at Westwood (see Chapter 5) whereby healthy eating practices were everybody's concern, including staff, pupils and parents; shaping health practices within and beyond the school.

Healthy eating education at Fielding was therefore somewhat limited in comparison to the other schools in this research and was generally confined to formal curriculum time. Samantha drew upon several examples of public (televised) health pedagogies in her delivery of this and explained how this seemed to be a useful and effective way to tap into the lives of her pupils and engage the young people in learning about a healthy diet:

We don't go down the idea of the old deficiency diseases… we do go down the idea of things that they have seen, we do talk about diverticular disease… I have a lovely lecture that the children thoroughly enjoy about going to the toilet, they think that's really quite an interesting concept… we do a certain amount of visual images, but yes, they think that's really fun, and we do also link in when we're talking about things like that to Gillian McKeith on the television; in *You Are What You Eat* she makes them poo in a box and take it away, so you know, it is the end product of the diet and so we do a fair bit on that. We have some lovely little bits of videos that we use about

the relationship between diet and behaviour. There was a very good Trevor McDonald Tonight that followed some children and altered their diet and got some quite drastic changes and they're quite interested in that as well, because you know, they put up a list of things that are… a sugar junky, and all the behaviours you'd expect from somebody who's a sugar junky, and yeah, they all sit there 'yeah yeah yeah yeah yeah' [laughs] and so they can really relate to that quite nicely and that works really well with them.

The pupils (and their parents) here, then, are being positioned and 'pathologised' as in need of 'compensatory' health knowledge (through their college education) to alter their current health practices and thus improve their health.

7.3.2 Physical Activity

Although students were encouraged to adopt healthy lifestyles, participation in extra-curricular sporting activities was low in Years 10 and 11. This was particularly so for girls, who also had limited opportunities for physical activity outside school. For example, Amy and Erica's physical activity consists of informal, unstructured, recreational and family-based activities such as walking the dogs, walking to and from school each day, preparing for their Duke of Edinburgh award (walks in the park), collecting their brother (on foot) and whatever their parents want to do. They take part in PE at school but they are not part of any structured lunchtime or after school clubs. This points to a lack of provision at Fielding, compared with Westwood and Grange Park, both of which had a 'range of sports on offer' to their pupils.

7.3.3 Knowledge-Practice Gap

The school had clearly addressed health provisions within the parameters of its own context, but this doesn't always appear to align with practices within the family homes of the children. Samantha has run a Healthy Lifestyle Day once a year in which they try to involve parents. The actual involvement of parents, however, appears to have been minimal, although it is to be acknowledged that at the time of this research the initiative was only in its second year. In light of the attendant dislocations and competing messages between school and home, it is evident that although the children often 'know' how to be healthy, this wasn't then reflected in the children's agency; Samantha explains:

They have a concept about what they should be doing but they don't seem to think that they need to necessarily do anything about that. If you ask them the question 'what should you be eating?' they'll tell you the answer but that isn't what they're

actually doing… they won't then relate that to the fact that well maybe you ought to change your diet, maybe you ought to do something about that.

According to Samantha, then, there is a significant disjuncture between ('official/useful') health knowledge and practice in the lives of pupils at Fielding, such that the notion of the good biocitizen (Halse, 2009) making and taking responsible 'healthy' decisions for long term health is not evident. Rather, according to Samantha, her pupils' health decisions are driven by 'desire' and made on an individual basis for immediate gratification:

Everything's down to their own personal enjoyment, you know, the way computer games work and everything, it's all high intensity, it's all individual one-on-one and it's not so much, you know, that they have any sense that they're part of a community… you know, that they have a responsibility there for the long term health of the nation… what's important is whether I like it and that's all that is in any way bothering them… they're not using that information, they seem to somehow package the information different to what they've actually got to do themselves, they don't relate the two things together.

Samantha interprets this knowledge-practice tension as a bi-product of the pupils' personal choices and/or misrecognition of what they need to do to 'be healthy'. There is no reflexive consideration of the pupils' relative lack of economic resource or of the conflicts between health knowledge endorsed by teachers at Fielding and the practices and knowledge/s which feature in the pupils' lives at home. Here, the latter (health knowledge and practice at home) appears to determine the extent to which pupils at Fielding *can* engage with and enact the former (health knowledge transmitted across their school). Samantha does, however, touch on this tension in her own explanation of why children at Fielding fail to enact healthy ideals:

It's a subculture thing… I do think because of the levels of social deprivation in this area, we're probably a bit more extreme [in lifestyle choices] than other schools… … We do have a fair number of our children who do fall into the obese category.

Interestingly, in interview, when asked what they would do differently if they were the Head Teacher at Fielding, many of the pupils described a TPMS such as that found at Westwood:

Amy: I'd probably put more advertisements up, like posters around the school and like encourage them more to eat healthier.

Erica: Having to do more events like, I know we done a food event the other month, but that was on a day when everyone was off and it was only the parents coming in so to me it was like making the parents aware but I think it's us that needs to be made aware of it.

Some of the pupils also referred to their school and the media as the main influences on their learning about health:

Jordan: You get taught about it in school and you see it in the magazines; 'oh this person's got an eating disorder, this person's gained so much…'

Dominant health and obesity discourses, consumed by the pupils informally, through the media, and outside of their school day, are therefore reinforced through their formal learning about health in school, creating some (albeit limited) consistency and alignment in the neo-liberal messages pupils at Fielding receive about health within and beyond school.

In interview, many pupils discussed the ways in which messages conveyed by the media prompt them to think about their own bodies. Amy explains:

I suppose in some ways it's good because it makes you think 'I want to be healthier' but in some ways it's bad because people go to the extreme of eating hardly anything at all.

In the context of a health education which prioritises local issues concerned with drug and alcohol abuse, teenage pregnancy and smoking, there none the less appeared to be a significant presence in the pupils' perspectives of dominant health and obesity discourses. The extent to which pupils at Fielding can adhere to and materialise such messages, however, was somewhat restricted by the strictures of their economic circumstances and this perhaps begins to explain the high proportion of 'troubled' bodies at Fielding:

Researcher: What do you both think to 5 A DAY?

Amy: Yeah, I think it's good

Researcher: Do you manage it?

Amy: No

Researcher: Why is that do you think?

> Amy: I think because healthier food is more expensive, people don't tend to get a lot of it…

> Jordan: on a Thursday I'll go with my mum to the gym but only if she can afford to take me.

> Jordan: I know this sounds really horrible but my mum can't cook, but she cooks it and I'll just sit there and I'm prodding the peas around. I don't like it and then I'll probably eat more in the day, more junk and everything and then get home and not be hungry.

This, however, becomes problematic for Jordan in terms of the relationship she has developed with her own body:

> Jordan: You know when like you eat a McDonalds or something and it makes you feel proper bloated, and it makes me feel fat so I don't eat one again.

It is perhaps unsurprising, then, that Jordan was critical of the options available to her in her working class community:

> Jordan: I don't think it's a wise option to put a KFC right near a school because if you're allowed out, then clearly everyone's going to go there and there's quite a few chippies around isn't there and if the options were healthier then the children would be more willing to eat healthier.

7.4 Troubled Bodies

7.4.1 Finding Somewhere to Fit

In light of Samantha's intensely affective health pedagogies and many of the pupils feeling devalued by staff and peers, it is perhaps unsurprising, that all pupils (male and female, across all ages) spoke in interview about their desire to be 'normal'. Samantha linked this desire to the age of the pupils at Fielding: "[it] is very much part of the teenage psyche", thereby psychologising the problem and absolving the school and its staff of any contingent part in it.

This disjuncture between ideal and actual body state was expressed particularly in the ways the girls related to other women in magazines and at school:

I suppose when you see pictures of like say other women or like there's other girls in the school, like you look at them and then you look at yourself and you think 'well am I or should I be that size or perhaps I should be thinner'.

In Samantha's view, the conflicting messages concerning body weight conveyed through the media played a detrimental role in the pupils' quest to 'find somewhere to fit':

What they're getting is at one end you've got to be as skinny as anything so you can be like a celebrity but then the media's telling you all teenagers eat junk food so you must be obese.

Researcher: Right, so there are competing messages there that you think the young people are finding it difficult to work their way through?

Samantha: Yeah…

In light of the limited attention given to obesity issues at Fielding, and Samantha's amplification of dominant obesity discourse, it is unsurprising that some of the pupils did not feel they were being sufficiently supported to enact the healthy eating practices they were being taught in school and through the media. For pupils like Jordan, this generated an acute sense of frustration and, moreover, a 'troubled' relationship with their weight/size, which found expression and was endorsed across a number of different contexts. For example:

In her peer group:

Jordan: You know when you're with your friends and you're just having a big chat with them and then they'll come out with "oh yeah, you're fat", and you're like "oh my God, I can't believe you just said that", it really affects you.

Whilst clothes shopping:

Jordan: You know when you walk into a shop and you think, 'right, I'll have that, it's well nice' and they haven't got your size, I'm like 'oh God, I wish I was smaller', and then waist belts as well, when you put one of them on and it makes you look fat out here, it's really embarrassing.

In a bikini/swimming costume:

Say if you're a celebrity or something and they [magazine editors] pick people out 'oh look at her in that dress, she looks so fat', and then imagine if you went swimming or something and you had to wear a bikini or one of them costumes you'd feel fat.

And lastly, when discussing why people develop eating disorders, Jordan explained:

It's all about your confidence and things in yourself, and if say, someone calls you fat, and you think you are fat, and you're going to think 'oh well, I'll go and do something about it', and you think 'well my parents will have a go if I don't eat, so I'll eat' and then say "I need to go to the toilet" and then you make yourself throw up.

Although disconcerting, it is interesting to note the direct relationship Jordan makes between comments other people make and the 'troubled' relationship one might form with their own weight/size. The resultant 'troubled' behaviour Jordan describes (i.e., making herself sick after eating) resonates with some of the practices girls were engaged in, in earlier work concerned with the development of eating disorders (see Evans et al., 2008). The main difference in this case, however, is the class and culture of the young people involved. These behaviours appear to derive from an assemblage of tensions between a lack of academic and pastoral support for pupils, a lack of rapport between teachers and pupils and peer groups within the school, pupils' learning about health and their bodies and these pupils' inability to enact such knowledge/s.

7.4.2 Health Related Behaviours

Amy and Erica neither engage in nor appear to agree with behaviours to monitor their own weight/size:

Researcher: Do you do anything to monitor your own body, shape, size, weight or whatever, like weighing regularly or calculating your BMI or… you know, I forget the name of them, you know those clippy things where you can grab hold of your body fat?

Amy: No

Erica: I don't know anyone like that

Amy: I think weighing yourself is stupid because you could be perfect size but you can weigh more than what you want to weigh, so I think it's misleading

Researcher: So you would never weigh yourself because you don't think it's a good thing to do?

Amy: No

Erica's only use of a monitoring device (a pedometer) appears to be for 'fun' rather than reasons related to health:

Erica: I used to think it was like fascinating to be able to know how many steps you'd done and I just thought it was amusing.

Researcher: So for fun really more than anything?

Erica: Yeah

Erica's remark that she doesn't know anyone like that suggests that within her social network, these health-promoting behaviours are rarely if ever apparent. Amy's reasons for being critical about weighing herself are grounded in her own experiences; in her opinion she is an acceptable, desirable size, particularly in the context of her family, but when abstracted into numerical data, her weight represents something less desirable, something that is easily compared with and judged by others. This may have been brought to the fore in a pedagogical encounter at school during Samantha's health education lessons whereby pupils are asked to calculate their own BMI and compare this against the standard BMI chart to determine whether they are 'underweight', 'normal weight', 'overweight' or 'obese'. It was mentioned earlier in this chapter that this practice, whereby data about the body is extracted and projected into decontextualised categories, has the potential to marginalize and pathologise those bodies that do not conform to the 'normal' BMI/weight and Amy appears to be one such body.

This seemed to be a common sentiment in Amy and Erica's social network where larger bodies are more prevalent, and are valued and accepted as a norm. Amy and Erica's narratives are indeed representative of many of the others provided by pupils at Fielding.

7.4.3 (Un)Natured Bodies

Samantha reported in interview that a large proportion of pupils at Fielding are overweight or obese and explained this with reference to their social class position:

> Samantha: It's a subculture thing… I do think because of the levels of social deprivation in this area, we're probably a bit more extreme [in lifestyle choices] than other schools… … We do have a fair number of our children who do fall into the obese category.
>
> Researcher: A fair number being what sort of percentage would you say?
>
> Samantha: If I'm talking about a class of about twenty-five kids, probably five of them are getting to the overweight to obese category, erm, I think a lot of that comes from the fact that we are… our catchment area is essentially white, working class and the subcultures that go along with that really do predominate the obesity thing.
>
> Researcher: What do you mean by that, the subcultures that go along with that?
>
> Samantha: Well, the going down to the football and eating your Pukka Pies… the fish and chips or the, you know, that sort of thing, the amount of alcohol that's consumed contributes to it as well.

A significant proportion of pupils at Fielding were also reported by Samantha to be 'underweight' and these pupils' reading of health and obesity discourses transmitted via mass media (namely television and magazines) appears to add further insight into the large proportion of 'troubled' bodies at Fielding:

> Samantha: At the minute everything's about obesity and that's in some instances making an extra problem because the kids that are at the bottom end of the weight spectrum are taking obesity…. [imitates pupils] 'Oh everybody's obese, therefore I must be obese as well' and I think you'll find it may be increasing some of the eating disorders... we're certainly getting a lot more kids at the minute who are saying "I'm obese, I'm obese. I'm a teenager, I eat McDonalds, I must be obese" and that's where that concept is coming from. (Samantha).

Whereas at Westwood, the 'obesity crisis' was constructed by staff, parents and pupils to be "out there", one step removed from their middle class lives, at Fielding, obesity was experienced first-hand by many pupils and their families. Thus, whereas pupils at Westwood were 'privileged' and subsequently 'emboldened' through their apparent dislocation from obesity, pupils at Fielding, regardless of their weight/size, were instantly pathologised and positioned by obesity and health discourses as a problematic population. This may offer

further insight into the large proportion of 'troubled' bodies at Fielding; the moral panic around the 'obesity epidemic', fuelled largely by the media, appears to nurture 'troubled' subject positions which are taken up by a large proportion of pupils at Fielding, regardless of whether they are underweight, 'normal' weight, overweight or obese.

Samantha goes on to highlight the sensitivities associated with addressing issues relating to weight and obesity in particular at Fielding: "it's a difficult one to approach in the classroom because there is a certain political correctness". Whilst general messages and guidance around how to adopt a healthy lifestyle appear to be easily communicated to pupils, discussions about individual pupils' weight become much more personal and sensitive and further highlight the tensions between the pupils' home lives and the practices endorsed at school:

> The powers that be do not particularly like us turning round to children and saying 'do you realise that you're overweight?' you know, because you've got a certain amount of parental kickback from it… but personally it's something that I do.

In light of an apparent misalignment between teaching about health in school and the pupils' ability to enact these messages beyond their school context, e.g., within their family homes, and therefore find 'somewhere to fit in' pupils at Fielding appear to turn to and be more heavily influenced by the media in their learning about health and the body, than pupils at Westwood (see Chapter 5) and Grange Park (see Chapter 6).

> Researcher: And just lastly, what do you think is the biggest influence over the children's health?
>
> Samantha: The media… by far.
>
> Researcher: What makes you say the media?
>
> Samantha: When we stand up and talk to them about anything, they'll always come back with something that they've heard from the television… very much so.
>
> Researcher: And will that be through programmes like You Are What You Eat and things like that rather than news bulletins?
>
> Samantha: It's a mixture of both… you know, very much at the moment these sensational programmes that you get on err… cable television, these extraordinary

people… you know [imitating pupils] 'on the television last night there was somebody who was forty-seven stone' and these really sensational things, you know, this almost freak show mentality they seem to be quite into.

Thus, whereas many of the 'emboldened' bodies at Westwood (see chapter 5) were privileged by obesity discourses in the context of their TPMS for having a 'natured' (naturally slim) body, it may be the case that many of the 'natured' bodies at Fielding relied upon the media as their primary source of learning about health and the body which created more damaging subject positions for the pupils to take up. Samantha explains:

A lot of girls have very, very low self-esteem… very much from the point of view of job roles in future life, I think this comes down to the teenage pregnancy as well, it's seen as 'well that's what everybody does isn't it?'… they don't have this concept that they can achieve, that they can go on, that they can do better and it gets very wound up in their self-consciousness and 'I've got to fit in with something' and the celebrities are all so skinny… they've got to find somewhere to fit, which is very much part of the teenage psyche anyway, and you know, what they're getting is at one end you've got to be as skinny as anything so you can be like a celebrity but then the media's telling you all teenagers eat junk food so you must be obese.

Hence, pupils experience an apparent contradiction in the messages they received about their weight, at a time when they are likely negotiating their own identities and striving to "fit in". This could go some way to explaining the high percentage of 'troubled' bodies at Fielding.

They know how to use a microwave to heat up ready meals but they've never stood in a kitchen and prepared food to cook themselves.

As part of their Food Technology curriculum, pupils are taught how to prepare and cook their own meals. The extent to which these practices are sustained beyond the school gates and carried out in their own homes appears to be minimal, however.

Researcher: Have another look at the pictures quickly and tell us what you prefer to eat? What's your favourite? It might not be on there…

Abbas: It's not on there.

Researcher: Would Maryland [fast food] be one of your favourites?

Abbas: Yeah, chips mate, because it's nice... it's better than healthy food. It tastes nicer.

According to Samantha, pupils at Fielding span a wide range of weights particularly at the two extremes of overweight and underweight and she expresses a particular concern over how underweight pupils at Fielding are interpreting messages deriving from obesity discourse:

> Kids at the bottom end of the weight spectrum are taking obesity… oh everybody's obese therefore I must be obese as well and it… I think you'll find it may be increasing some of the eating disorders… we're certainly getting a lot more kids at the minute who are… we do their heights and weights in lessons and really skinny kids who are saying "I'm obese; I'm a teenager, I eat McDonalds, I must be obese!".

In reality, Samantha believes that approximately one quarter of pupils at Fielding are overweight/obese:

> If I'm talking about a class of twenty-five kids, probably five of them are getting to the overweight to obese category.

Samantha attributes this to the class and cultural background of pupils at Fielding:

> I think a lot of that comes from the fact that our catchment area is essentially white working class and the subcultures that go along with that really do predominate the obesity thing… going down to the football and eating your Pukka Pies… the fish and chips… you know, that sort of thing. The amount of alcohol that's consumed contributes to it as well.

Hence, unlike at Westwood and Grange Park, obesity is very much a part of the lives of the pupils at Fielding as it is experienced either first-hand, through their own weight, or second hand, through the weight of family members or other pupils in the school.

But given the large number of underweight children at the school, Samantha's pedagogies around weight attempt to address both ends of the spectrum, rather than focusing solely on obesity which she fears will be negatively interpreted and embodied by underweight children:

> We do the heights and weights with the kids. I say to them that I know some of you are very sensitive about your weight and I'm not going to ask any of you to talk in public about what your weight is, that's entirely your business, but what I will do is I

will project an ideal height and weight or if we're doing it with [year] seven and eight, we use the centile charts, but with year nine and ten we use just the general adult ones, I'll project that and we'll go through and say to them what they need… that, you know, their height and get them to do the weight in the store room and send them in so that they can do it individually, but only they need to know their weight and then they can look at it and compare and then they can come to us if they think they have an issue and at that point we say either you can talk to me about it but we do warn them that I will be straight with you because I think that it's important to teenagers to be able to turn round to them and say actually you do look very skinny.

The health education curriculum delivered by Samantha encourages the pupils to compare their own height and weight/BMI against what is considered to be 'normal and acceptable'. Whilst Samantha's pedagogies around weight might serve as a reality check for these pupils, i.e., using the BMI to inform pupils as to whether they are in fact 'underweight', 'normal', 'overweight' or 'obese', the implications of this appear to be overlooked, i.e., the extent to which those pupils whose BMI falls outside of the 'normal' range are marginalised and pathologised. Furthermore, the imperative to be 'normal' extends beyond the formal pedagogies at Fielding as it is reinforced through the various forms of informal, public pedagogy the pupils consume outside of the classroom. According to the pupils, these are mainly TV programmes (such as You Are What You Eat, 40 Ton Mum) but also magazines such as "Heat" and "Love It".

Thus, the pupils' turn to the media for guidance concerning the parameters between right and wrong, acceptable and unacceptable, normal and abnormal, healthy and unhealthy. Yet their ability to act in accordance with these messages is somewhat limited due to their economically disadvantaged backgrounds, thus placing them in a position of turmoil, 'knowing' what they *should* be doing but more often than not being *unable* to put this knowledge into practice. This potentially sheds some light on the high percentage of 'troubled' bodies at Fielding. With reference to the previous case studies, there are indeed pupils at Fielding who naturally conform to the 'ideal', 'healthy' body and are therefore not required to do anything in order to be deemed 'acceptable' ('natured' bodies). These pupils are therefore better placed than those who fall outside of this category to feel 'emboldened' by obesity discourses or at least are 'insouciant' towards it. Similarly, those few who may not necessarily naturally conform but can and do put this knowledge into practice (the 'exercised'

bodies) are often 'emboldened' as a consequence of their ability and successful attempts to engage with health imperatives associated with obesity discourse. A high percentage of pupils, however, who are neither 'natured' nor 'exercised' bodies, are engulfed by a miasma of despair, longing but unable to 'conform'.

Amy, a white, British, 14 year old female is one such pupil who expresses in her questionnaire responses the 'troubled' relationship she has with her body (quotation marks (") denote Amy's own words, apostrophes (') denote the selections she made in her questionnaire):

> I am 'never' happy about my current weight/size because "I'm fat". I am 'sometimes' called names about my weight/size – I have been called "fatty, fat bitch, ugly…". I am 'sometimes' picked on because of my weight/size and "I became depressed but got treated". I have 'never' tried to put weight on, "NEVER" - 'I have never thought that I needed to' and I have tried to lose weight 'all the time' because 'someone told me to', 'I feel fat', 'I had stopped exercising', 'I think it makes me healthier' and 'I don't like the way I look'. "I just want to be happy". My 'friends', my 'dad',' 'people I don't like' and 'people that don't like me' have made comments about my weight/size. There isn't a famous person I would like to look like; "I just want to be healthy".

Amy defines being healthy along the lines of a 'natured' and 'exercised' body: "having a varied diet, exercising and being skinny".

Here we gain an insight into the experiences of a pupil at Fielding who is neither 'natured' nor 'exercised'. Although Amy has attempted to lose weight 'all the time', the 'troubled' relationship she reports to have with her weight/size indicates that her efforts to do so may not have been successful. Amy is bullied and 'picked on' for neither conforming nor appearing to be remedying her 'problematic' and unacceptable body. As she slips further down the social spiral, her exasperation becomes all the more apparent: "I just want to be happy", "I just want to be healthy".

When asked what makes young people think about their bodies in terms of weight, size and shape, Amy responds:

> I suppose when you see pictures of like say other women… I know that when you're going through the catalogue and you're looking at the clothes and you've got the women, you never see, like for me anyway, you never see plus size, you always see

women that are like size 10s and stuff like that and you never see what for me I call 'real women', so in a way I think they're fake because they're not me, they watch what they're eating, although you've got to watch what you eat to a certain extent, they like scrutinize over everything where for me, like just to enjoy yourself while you live, watch what you do eat and like eat healthily but like do it in a way so that you're comfortable and not like… I think that's another thing that gets me like looking through catalogues and you always see like really thin people.

For Amy, the "really thin people" she sees in magazines are not real; she understands these bodies as having gone to extreme lengths to become 'thin' i.e., they have "scrutinised over everything" at the expense of their own enjoyment and comfort. However, the presence of other girls' bodies at school also has powerful affect on Amy. She explains:

there's other girls in the school, like you look at them and then you look at yourself and you think 'well am I, should I be that size or perhaps I should be thinner or perhaps I should wear make-up or something like that' […] I've always been, all my aunties and stuff, none of them were like what I would call skinny people, they were all quite nice built people and so when you look around the school and you see like really skinny people, it kind of like questions it.

When prompted by images of celebrities in magazines, and asked which celebrity she would most like to look like, Amy explains:

Amy: I'd like to look like her [pointing to an image]

Researcher: OK, she's one of the Sugababes, isn't she?

Amy: Yeah

Researcher: Why her?

Amy: Because she's a nice size and she's got curves to her as well and she's not, like for me, Victoria Beckham, you can see all her bones and I think that's nasty, but you look at her [points to Sugababe], although she's got a top on that can cover it up, she's not as like skinny and she don't, to me she don't put across like that, she's a nice size and she's got curves and she shows them off.

Researcher: OK, so being curvy is nice. And you said that Victoria Beckham's look is 'nasty'. What do you mean by that? Nasty?

Amy: You can see all her bones and I don't think that's right, you've got like, literally her skin's going round her bones and I think that's horrible

Erica also expresses similar feelings towards Paula Radcliffe's body:

She's really skinny as well and I've seen her when she's running and her legs are just like twigs, they might snap.

This further illustrates the powerful affective reactions Amy and Erica experience as they view other (celebrity) women's bodies in magazines through their own corporeality. The desirable bodies to Amy are those "curvy bodies" which are "a nice size" and would allow her to 'fit in'. Amy contrasts this with the 'skinny' body of Victoria Beckham which she describes as "nasty", "horrible" and "wrong".

Media and interactive (real life) encounters with other people's bodies appear to play a significant role in how some girls at Fielding understand their own bodies. Visual reminders of the 'skinny' body trigger 'affective' reactions for Amy as she is reminded of her own corporeality through viewing other females' corporealities. She struggles to relate to the 'skinny' models in the catalogues she reads, for example, and explains that "it gets her" and thus she interprets these bodies as 'fake' because they're not like her; she is unable to relate to them. She also refers to the ambivalence she experiences when presented with skinny bodies at school as it 'questions' the bodily 'norms' she is used to outside of her school context; through her own size 14 body and her aunties' bodies, none of whom are 'skinny people'. Amy's reference to her aunties' bodies as 'quite nice built' (i.e., desirable) indicates that for Amy, 'skinny bodies' are 'abnormal' and 'other' to her and her own family.

As soon as you say "I'm in a size 14" or something it's like "wooooaaahh!" but if it's like "I'm a size 10" or something like that, it seems alright. (Amy)

Despite being 'abnormal' and 'other' to Amy outside of school, the 'skinny' body is clearly the 'accepted' body in her school context, and all other bodies are read and judged *in relation to* this ideal, as Amy reveals above.

When asked how she feels about her experiences of her own body in relation to others' (celebrities') bodies, Amy responds:

I suppose in some ways it's good because it makes you think 'I want to be healthier' but in some ways it's bad because people go to the extreme of eating hardly anything at all.

Researcher: Do you know anybody who hardly eats?

Amy: Not really

Amy makes associations between celebrity bodies and health, and that seeing these bodies motivates her to be 'healthier' is deeply interesting. Amy remains critical of the lengths she believes some celebrities go to in order to achieve a 'skinny' body, and she notes the difference in experiences between bodies in the media and bodies around her. Whilst Amy is aware that some celebrities eat "hardly anything at all", she doesn't personally know anybody who does this, despite there being a number of 'skinny' bodies in her school. This points to a disparity between Amy's pedagogic encounters with the media and those she experiences in her every day interactive life.

7.5 Conclusion

Dominant health discourse and the government's knowledge-deficit model for health education (outlined in Chapter 1) are uncritically accepted at Fielding. Thus, Samantha adopts the government's oversimplified view of 'health' which assumes that "if we have knowledge we can change our behaviour" (Leahy, 2009, p.175). Whilst Samantha appears to demonstrate an awareness of her pupils' relative lack of economic resource, she doesn't apply this to her understanding of the pupils' experiences of dominant health discourse and the health pedagogies and practices she employs at Fielding. Hence, Samantha attributes her pupils' 'poor lifestyle choices' to a lack of responsibility and self-interested attitudes; she believes her pupils' health decisions are driven by 'desire' and made on an individual basis for immediate gratification. Samantha therefore interprets the knowledge-practice tension among the pupils as a bi-product of the pupils' personal choices and/or misrecognition of what they need to do to 'be healthy'. There is no reflexive consideration of the pupils' relative lack of economic resource or of the conflicts between health knowledge endorsed by teachers at Fielding and the practices and knowledge/s which feature in the pupils' lives at home. In light of this, Samantha strategically employs pedagogic practices which are designed to highlight who and what the pupils *are* in relation to who and what they *should be,* thus generating particular affective responses in her pupils; shame, guilt, anxiety, for

example, in an attempt to urge them to change their behaviour. Thus, many of the pupils at Fielding become 'troubled' about their body's weight/size as their lack of economic resource to achieve and perform 'health' counteracts their desire to 'be healthy'. Consumed by dominant health discourse and unaware of/unfamiliar with an alternative discourse through which to relate to their body's weight/size, these pupils constantly strive to find 'somewhere to fit'.

The following chapter draws on and discusses key findings presented in the preceding case studies in relation to existing literature discussed in Chapter 2, thus offering nuance to the relationship between policy, pedagogy and pupil subjectivity, and adding complexity to the notion of 'the neoliberal body' (Heywood, 2007; Rizvi and Lingard, 2010; Rose, 1999).

8. Discussion: Whose Knowledge Deficit?

8.1 Introduction

The UK government's knowledge deficit model of health education was discussed in detail in Chapters 1 and 2 and highlighted an assumed relationship between knowledge, behaviour and 'health', along with the neoliberal principles underpinning this approach. The model below was used to depict the hierarchical nature of this approach, whereby 'correct' knowledge is assumed to be a prerequisite for government-prescribed behaviours, which are, in turn, a requirement for the achievement of 'health':
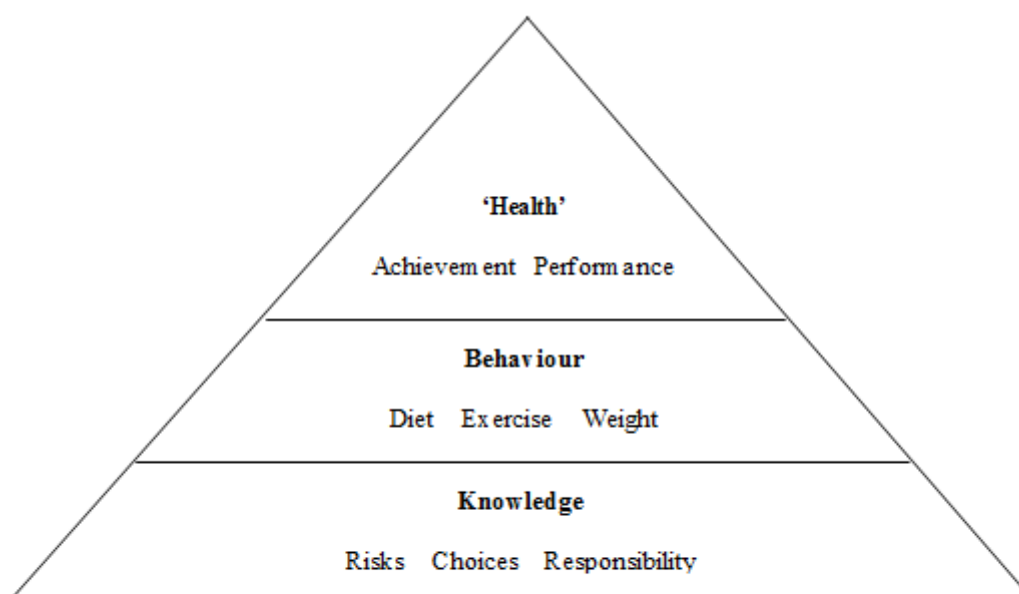
Fig. 1.1 Knowledge-Deficit Model for Health Education

Thus, government endorsed definitions of health emphasise individual responsibility which requires 'correct' knowledge about 'healthy' lifestyle choices and risk avoidance. 'Health' is therefore constructed by government and dominant discourse as an entity to be 'achieved' and routinely performed through an appropriate diet, exercise regime and body weight. Government school health policy clearly reflects these notions of 'health', focusing on weight management strategies largely involving 'healthy eating', physical activity and measurement

of pupils' weight and in recent years has been regarded as a form of biopower or 'biopedagogy' (Harwood, 2009). Existing literature has drawn attention to the damaging effects of such policies and associated pedagogies in school contexts, particularly for young girls (see Allwood, 2010; Evans et al., 2008; Halse et al., 2007, for example) in so far as they have encouraged them to think reductively and negatively about their bodies, essentially as objects to be relentlessly monitored, displayed, worked on and improved in the interest of achieving an imaginary (but for most) unattainable ideal. Furthermore, a growing body of research in the sociology of education, which has begun to challenge conventional writing about education policy 'implementation', was introduced in Chapter 2. This literature argues that if we are to fully and more accurately understand policy (what it is and how it functions), then it must be regarded as 'a process' (Braun, Ball, Maguire and Hoskins, 2011; Ball et al., 2012; Evans et al., 2008) taking account of the various ways in which policy both shapes and is shaped by a multitude of situational and contextual factors as it is enacted in specific school settings. Furthermore, Ball et al. (2012, p.20) argue that conventional school-based policy implementation studies "rarely convey any sense of the built environment from which the 'data' are elicited or the financial or human resources available – policy is dematerialised". Thus, while highlighting the deleterious and indeed ubiquitous effect of biopower on young people's sense of self, the preceding three chapters have attempted to build on this existing literature through in-depth case-study exploration of the *emplacement* and *enactment* of health policy in three schools. Drawing on policy artefacts, pupil questionnaires and teacher and pupil interviews, this project has focused on unveiling young people's uneven, subjective, embodied experiences of their school health education (specifically the ways their experiences shape the relationships they develop with their weight/size) and the implications of this for their developing embodied identities.

In this chapter, I return to the key aims and research questions guiding this study, as outlined in Chapter 1 and below, to draw on and discuss key findings in relation to existing literature highlighted above and discussed in Chapter 2, thus offering nuance to the relationship between policy, pedagogy and pupil subjectivity, and adding complexity to the notion of 'the neoliberal body' (Heywood, 2007; Rizvi and Lingard, 2010; Rose, 1999). The key aim of this study is to broaden current understanding of young people's subjective, embodied experiences of their school health education (specifically the ways their experiences shape the relationships they develop with their weight/size) and the implications of this for a young

person's developing sense of self. Hence, the key research questions guiding the study are (see also Chapter 1, section 1.6):

- *RQ 1: How do the unique 'contextual dimensions' of a school shape constructions of health/obesity in situ?*

- *RQ 2: Through which pedagogies and practices do young people learn about 'health' and 'obesity' in school?*

- *RQ 3: What role (if any) do school health education programmes play in the relationships young people develop with their own weight/size?*

- *RQ 4: How do the above processes of policy emplacement, enactment and embodiment shape a young person's sense of self?*

- *RQ5 5: What are the implications of this study for policy makers, health educators and researchers whose work is concerned with young people's embodied health and well-being?*

This chapter begins with an overview of the unique 'contextual dimensions' of the participating schools and how these shaped health policy, pedagogy and practice in each context (Research Question 1). The significance of *context* for young people's learning about health is therefore highlighted and discussed, illustrating the key ways in which ubiquitous health imperatives are interpreted and recontextualised through distinctive pedagogical relationships that are unique to each setting (Research Question 2). The various ways in which this enabled and/or constrained opportunities for the development of particular forms of embodiment and subjectivity are then discussed in response to Research Question 3, before highlighting the implications of this for a young person's sense of self (Research Question 4). The implications of this study for policy makers, health educators and researchers whose work is concerned with young people's health and well-being (Research Question 5) is discussed in Chapters 9 and 10.

8.2 'Emplacing' and 'Enacting' Health Policy

Chapter 2 discussed the importance of 'taking context seriously' (Braun, Ball, Maguire and Hoskins, 2011) when analysing the enactment of education policy in schools and Ball et al. (2012, p.21) highlight four contextual dimensions (see Box 2.1, section 2.3.1) which enable and/or constrain policy enactment in schools. Chapters 5 to 7 therefore began, first and foremost, with an exploration of the ways in which these contextual dimensions shaped the ways health policy was 'made sense of', mediated and struggled over, ignored or enacted in the case study schools (Ball et al., 2012) and the discussion below draws together key findings in theorising the emplacement of health policy in schools.

The contextual dimensions of the three case study schools in this study differed greatly. Westwood Primary School was a small, co-education, state-funded primary school for pupils aged 4 to 11 years, located in a rural, middle-class village in the Midlands region of England. The majority of Westwood's pupils therefore came from white, middle class backgrounds and no pupil was in the early stage of learning English as an additional language. Grange Park was a large, suburban, independent (private fees) secondary school for girls aged 11 to 18 years. Pupils were predominantly from white, middle-class backgrounds and the ability level of pupils in years 7 to 11 (aged 11 to 16) was reported to be "far above national average" (ISI, 2010, p.1). Conversely, Fielding Community College was a co-education secondary school for pupils aged 11 to 16. With a total of 882 pupils, the college was reported by the UK government inspectorate, Ofsted (2007), to be of average size compared with other secondary schools in the UK. The college served an area of high socio-economic deprivation, which was reflected in the proportion of pupils eligible for free school meals being "around double the national average" (Ofsted, 2008, p.3). The proportions of pupils with learning difficulties and/or disabilities, from minority ethnic groups, and whose first language was not English was also higher than the national average (Ofsted, 2008). Fielding therefore catered for a more deprived and diverse population of young people than Westwood and Grange Park. These divergent 'situated contexts' appeared to have significant purchase on how the health educators in each school conceptualised their pupils, and, more specifically, read their pupils' 'health'. Health educators at all three of the schools referred to their pupils, pupils' families and wider community setting when discussing health issues in interview. For example:

I don't think we have a problem personally, in this school or this village in particular… I mean it's a very affluent area and the parents are well educated so that has a knock-on effect I think with the children… I think these children generally are quite healthy. (Jess, Westwood)

I think a lot of that comes from the fact that our catchment area is essentially white working class and the subcultures that go along with that really do predominate the obesity thing… going down to the football and eating your Pukka Pies… the fish and chips… you know, that sort of thing. The amount of alcohol that's consumed contributes to it as well… It's a subculture thing… I do think because of the levels of social deprivation in this area, we're probably a bit more extreme [in lifestyle choices] than other schools. (Samantha, Fielding)

The problem we have here is within walking distance of the school we've got a KFC, we've got pizza places... we've got ... you know, everything is within easy walking distance of the school, we only have a forty-five minute lunch hour but they can get out to KFC and get something and... and I think particularly the older kids, that's what they do... that's what they do. (Samantha, Fielding)

Health education staff at Westwood and Fielding therefore drew uncritically on dominant health and obesity discourses in reading the 'health' of their pupil intake through their lifestyle choices and the options available to them in their locale. Furthermore, a clear relationship emerged between generalisations about pupil intake and their health, and the proximity of obesity to their lives, i.e., as either removed from (at Westwood) or an immediate part of their lived experiences (at Fielding). Thus, the teachers' personal values and commitments to 'health' were brought into effect:

Personally I come from a very sporty background; my family are quite sporty so personally I think it's important, that's why I've taken on the PE role […] I'm very PE, I love PE. (Jess, Westwood)

I'm a fairly healthy person anyway and I believe you should try and eat healthily and be active, so things I do personally. (Claire, Westwood)

The nutrition and that side of it was very important to us and so we've kept it running despite the National Curriculum. (Samantha, Fielding).

The powers that be do not particularly like us turning round to children and saying 'do you realise that you're overweight?' you know, because you've got a certain amount of parental kickback from it… but personally it's something that I do. (Samantha, Fielding).

However, the material contexts (staffing, budget, buildings, technology and infrastructure) of the schools either enabled or constrained the extent to which the health educators could enact government health policy in their school. For example, being a small, 'healthy' and successful school, staff at Westwood were able to afford the time and money to prioritise health education and adopt a 'whole school approach' as endorsed through the government's National Healthy Schools Programme (see Chapter 1, section 1.4) and this was reflected through the excess government funding, range of sports on offer and high quality sport available to Westwood's pupils. At Fielding, however, dominant health imperatives (concerning diet, exercise and weight) comprised several identified pathologies in the pupils' lives and resources to prioritise and enact health were somewhat limited.

Thus, the teachers' uncritical acceptance of dominant obesity discourse instantaneously positioned each of the schools – their staff and pupils – in relation to dominant health and obesity discourse. This appeared to privilege those at Westwood, pathologise those at Fielding and both privilege and pathologise those at Grange Park, depending on the context/pupil. Health policy was interpreted and 'recontextualised' as it was emplaced in relation to pupil intake albeit through teachers' generalised assumptions about their intake in relation to neoliberal principles of 'health'. Clear connections can therefore be made between teachers' conceptualisations of pupils, the locale, budgets and material dimensions of the school and the amount of time and money afforded to addressing the government's battle against obesity. The 'wealthy, well-educated and healthy' pupils attended schools located in affluent rural/suburban areas, which generally afforded ample time and funding to health-related resources and facilities (see Chapters 5 and 6). Conversely, the 'deprived, uneducated and unhealthy' pupils attended inner city schools, as in the case of Fielding (see Chapter 7), where time and funding for health-related resources and facilities were restricted due to weight and health more generally being considered but one of several pathologies in the pupils' lives which the school was attempting to address. Thus, health policy seeped into all corners of schooling, where time, money and teacher values and priorities permitted. Ironically, then, health education was most pervasive in schools where pupils were already

considered to be 'healthy', and was noticeably restricted where resources were limited, yet most seemingly needed.

A different process emerged at Grange Park, however (Chapter 6). Being a private school, health educators spoke of their struggles in accessing government initiatives and funding. Furthermore, whereas the situated and material contextual dimensions predominated the emplacement of 'health' at Westwood and Fielding, the professional culture (values and ethos) and external context (reputation and performance) appeared to have more significant bearing on the emplacement of health at Grange Park, such that these dimensions appeared to override dominant health and obesity discourses. Moreover, the development of eating disorders such as bulimia and anorexia caused Grange Park's health educators more concern than obesity. Thus, an emphasis was placed instead on providing a health education which enabled the girls to maintain their well-being and therefore their academic performance.

The necessity to enact health policy and the strict demands placed on schools to do so by the UK government were discussed in Chapter 2. It is therefore unsurprising that the two state schools in this study took seriously their role to educate their pupils about health in the government's battle against obesity, including Westwood, where pupils were considered to be relatively 'healthy'. This was due to perceived 'risk' associated with obesity (e.g., when an individual fails to make the right diet and/or exercise choices). Hence, all of Westwood's and Fielding's pupils, regardless of their socio-economic status, were required to conform to the health imperatives of their school. The government's knowledge-deficit model was evidently adopted by health education staff at both of these schools, either through the 'professional culture' of the school (health educators' own values (e.g., at Westwood) or through external pressures (e.g., from Ofsted, the government schools inspectorate) to deliver an appropriate health education (e.g., at Fielding).

Despite differences in the conceptualisation of health, health educators at all three of the schools frequently referred to notions such as 'a duty to educate and teach', 'raise awareness', 'reinforce messages', help pupils 'recognise' and 'realise' the 'value' and 'importance' of 'health', 'inform', 'guide' and 'encourage' pupils to 'make the right choices' in their justifications of their roles as health educators. Thus, teachers' efforts to educate their pupils about health at all three schools were replicating 'health' as an entity to be 'achieved' and routinely performed through an appropriate diet, exercise regime and body weight and were therefore geared towards (re)producing the government's self-governing, disciplined and

responsible imaginary neoliberal individual capable of making 'correct' choices. It was perhaps to be expected, then, that pupils at all three of the schools would define health by drawing on the same dominant notions of individual responsibility for the 'achievement' of health through enactment of an appropriate diet, exercise regime and body weight. All pupils were aware of what they *ought* to be doing in the name of achieving health, as endorsed by government guidelines and their school health pedagogies.

However, given the diverse class and cultural distinctions between the three schools, and the theorisation of emplacement in Chapter 2, it is no surprise that detailed exploration of the realities of health educators' tasks in Chapters 5 to 7 revealed stark differences in the way health policy became 'live' in each context (Ball et al., 2012). Indeed, as others (e.g., Ball et al., 2012; Braun, Ball, Maguire and Hoskins, 2011; Evans et al., 2008; Shilling, 2004) have previously suggested, policy is not merely implemented and experienced by all teachers and pupils in the same way. The findings from the three schools in this study suggest that possible tensions between initial responses to policy at Head or Senior Management level and the enactments of policy in classrooms arise from the nuanced microclimates throughout a school, which may include but are not restricted to classrooms (e.g., specific departments, dining halls, playgrounds etc.). What is key here is the notion that policy actors are "subjected differently and act differently" in relation to particular imperatives (Ball et al., 2012, p.69). Various pressures, levels of experience and different interests can all influence the enactment process within school contexts and hence Ball et al. (2012) speak of the incoherent and precarious nature of both policy and "the general functional demands on schooling" (p.70). For example, when emplaced in the middle class context of Westwood, the government's health policies aligned closely with existing values and behaviours of the staff, pupils and their families. Nevertheless, discursively positioned as perpetually 'at risk', health educators at Westwood enacted 'behaviourist' pedagogies (see Chambers, 2011) through the use of 'rewards' and 'prizes' to reinforce pupils' desires to eat healthily and thus sustain their exemplary position in relation to dominant constructions of health. At Grange Park, dominant discourses of health and obesity were secondary to the performative, anxiety-ridden culture of the school and health educators therefore focused on enacting cognitive-therapeutic pedagogies. Conversely, when emplaced in the working class context of Fielding, government health policy pronounced a significant mismatch between official and lay knowledge and practices, therefore highlighting a number of pathologies in the pupils' lives. Health educators at Fielding therefore enacted 'cognitive-remedial' pedagogies through the

use of popular media (namely television) and science (e.g., through the BMI) to evoke particular affective responses among pupils and shape their desires to 'be healthy', thus 'correcting' their position in relation to dominant constructions of health. Thus, the ways health policy was enacted (through artefacts, schemes, rules and the 'normalisation' of bodies) took various forms, depending on situated, professional, material and external factors (Ball et al., 2012, p.21), giving rise to specific signs and signifiers of 'health' in situ. Policy therefore took on a new form as it moulded to each school's unique context, and hence the different approaches and pedagogies related to health education across all three schools in this study. Ubiquitous health imperatives, even when driven and shaped by dominant political ideology, evidently generated very different curricular. Thus, the government's knowledge-deficit model was variously emplaced and enacted through different pedagogies which refracted each school's priorities, interests and values and therefore their position in relation to health discourse, whilst maintaining the neoliberal principles underpinning this approach. The preceding three chapters have therefore highlighted the dynamic and idiosyncratic nature of school contexts, each one providing a vastly different situated, material, professional and external environment for the emplacement and enactment of UK government health policies.

The case studies have therefore clearly demonstrated that whilst some schools may appear (at least on the surface) to be 'similar', they can never be considered 'the same' due to their own contextual make up, shaped by the class and cultural interests of staff, pupils and families. Each of the case study schools had thus either (re)created and/or privileged dominant (idealised) ways of perceiving, performing and embodying health in wider society i.e., as an entity to be achieved through regular exercise, healthy eating and celebrating the slender body as 'healthy'. The varying and contextualised capacities of each school to 'cope with' and 'enact' health policy imperatives in turn contributed to and reinforced the positioning of their pupils in relation to these dominant texts and therefore constituted pupils' bodies in particular ways. The four contextual dimensions (situated contexts, professional cultures, material contexts and external contexts) proposed by Braun, Ball, Maguire and Hoskins (2011), thus provide a useful starting point for the analysis of policy emplacement and enactment in the three case study schools in this research. Emplacing health thus creates relations between the local milieu of these schools and what it means to be '(un)healthy' in wider society.

The conceptualisation of 'health' as a product that can and should be quickly and easily achieved and maintained by individuals (given the correct knowledge) and schools (with the successful enactment of policy) has placed health educators under immense pressure to 'perform' and 'succeed' in the name of 'achieving health' in their school, encouraging them to employ prescriptive, instruction-based methods of teaching which promote surface-level learning (see Leahy, 2009 and Chapters 5 to 7 of this thesis).

8.2.1 Problematising a Knowledge-Deficit Model for Health Education

Fullagar (2009, p.113) argues that

> Despite their seemingly objective scientific claims about risk, health promotion discourses actually work to mobilise emotion, or affect, through 'fear' of bodily decline and 'guilt' about a lack of self-discipline or fitness (Bauman, 2005; Furedi, 1997).

It is clear that the emplaced pedagogies found at each school were deployed to do more than impart knowledge to pupils (as assumed by the government and discussed in Chapter 1 and above). Other (affective) 'forces and dynamics' (Leahy, 2009, p.174) were clearly at play to effect the government's prescribed behaviours among pupils, particularly at Fielding where a significant mismatch was identified between government ideals and pupil behaviour. Teachers were therefore enacting particular biopedagogies:

> normalising and regulating practices in schools and disseminated more widely through the web and other forms of media, which have been generated by escalating concerns over claims of global 'obesity epidemic' (Wright, 2009, p.1).

(Bio)pedagogy is, therefore, said to comprise more than knowledge alone:

> it gets right in there in your brain, your body, your heart, in your sense of self, of the world, of others, and of possibilities and impossibilities in all those realms (Ellsworth, 1997, p.6)

These biopedagogies had powerful potential, therefore, to not only educate pupils *about* 'health' but also shape their desires *toward achieving* 'health'. The subsequent emotions induced by health discourse and school biopedagogies are said to "shape the very surfaces of bodies […] through the repetition of actions over time, as well as through orientations towards and away from others" (Fullagar, 2009, p.113). Thus, these pedagogies, and

specifically the imperative to sculpt a 'slender' ideal, simultaneously set pupils' bodies apart, illuminating difference and non-compliance in the process, whilst also highlighting the affective relations *between* their bodies. Hence, these biopedagogies worked beyond

> enticing students to understand and relate to themselves' [as individuals in isolation, on the basis that] a body affects other bodies, or is affected by other bodies; it is this capacity for affecting and being affected that also defines a body in its individuality (Deleuze, 1992, p.625).

Embedded within health policy and these school-specific biopedagogies, therefore, is an imperative towards the appropriate presentation of the body and its affective potential *in relation to other bodies*, i.e.,

> not just to look and be looked at, but a body in movement, an affective body which is noticed and commands respect; a body which has the power to affect others; which possesses social force in the urban milieu and the spaces of sociability (Featherstone, 2010, p.196).

Furthermore, the imperative to perform/achieve 'health' when emplaced within these school contexts where "intense power relations" were at play (Tamboukou, 2003, p.209) constructed a series of dichotomous distinctions (e.g., healthy/unhealthy, normal/pathological) which

> necessarily hierarchizes and ranks the two polarised terms so that one becomes the privileged term and the other its suppressed, subordinated, negative counterpart (Grosz, 1994, p.3).

These distinctions replicated wider societal values, whereby "we make uniformity the criteria for belonging [and] we exclude people *because* of their diversity" (Kunc, 1992, p.32). Thus, conformity was 'privileged' and indeed celebrated through physical and social rewards (e.g., the healthy snack award at Westwood and achieving a sense of belonging at all three schools) and difference became its 'negative counterpart', maginalised or 'othered' in terms of diet and exercise behaviour and body weight/size (e.g., those 'odd few' in possession of 'unhealthy' snacks at Westwood, or those who are 'picked on' for being 'fat' at Fielding). This created an intense desire among most pupils to not only 'be healthy' but to be recognised as such by their teachers and peers and indeed wider society for being a responsible biocitizen. As such, pupils were required to (l)earn their right to belong, through displaying the 'correct' body weight/size and health behaviours, which would equip them

with a valuable passport to 'fit in' with their school's accepted 'healthy' normalised body ideal. However, through this process, pupils learnt that "their worth as individuals [was] contingent upon being able to jump through the prescribed hoops" (Kunc, 1992, p.32) and, hence, just as important as cultivating a slender physique was the imperative to command respect and a sense of belonging from teachers and peers.

This has significant bearing on how we can better understand the ways health knowledge circulates in schools and with what affect/effect on a pupil's developing sense of self. Thus, we must move beyond an understanding of the emplacement and enactment of health policy by school health educators to explore the ways in which health 'knowledge' takes on relevance and meaning in pupils' lives, particularly at school (e.g., through peer group interaction), and becomes 'embodied'.

8.3 'Embodying' Health Policy

The significance of *context* for young people's learning about health is highlighted and discussed above, illustrating the key ways in which ubiquitous health imperatives are interpreted and recontextualised through distinctive pedagogical relationships that are unique to each school setting. Of particular interest to the current study, however, is how these pedagogies materialised in the lives of the pupils at the three case study schools and the extent to which they may have contributed to the numbers of 'troubled', 'insouciant' or 'emboldened' bodies found at each school. Following Harwood (2009), I therefore want to draw attention to the complex 'processes of subjectification' involved in this biopedagogical work in schools. This involves turning to the work of Deleuze (1988) (specifically his theorisation of the productive capacities of affect for embodied human 'becomings'), and Simondon (1989), to better understand Foucault's later work on subjectification by asking

> how knowledges are folded into the students' understandings of themselves and others, [for] it is this folding action, where knowledge in this case is deliberately mobilised to entice students to understand and relate to themselves in particular ways that gives us the 'bio' of 'biopedagogy' (Leahy, 2009, p.176).

Hence, the various ways in which the biopedagogies found in these schools enable and/or constrain opportunities for the development of particular forms of embodiment and subjectivity are discussed below, before highlighting the implications of this for a young person's embodied sense of self.

8.3.1 Weighing Up 'Who I Am'

However, the affective force of the biopedagogies enacted at all three schools urged pupils to repeatedly assess their own bodies and diet and exercise 'choices' in relation to the 'expert knowledge' of their health educators, to understand *who they are* in relation to *who they should be* (the 'imaginary subject' discussed in Chapter 2) and to take responsibility for making appropriate modifications where necessary. Probyn (2004, p.29) describes this as 'The Goose Bump Effect': "that moment when a text sets off a frisson of feelings, remembrances, thoughts, and the bodily actions that accompany them". Drawing on the work of Simondon (1989) I extend existing work in this field through theorisation of pupils' bodies being prized into a pre-individual 'metastable' state in these moments, i.e.,

> a state that transcends the classical opposition between stability and instability (Barthélémy, 2012, p.217) and that is charged with potentials for a becoming … precipitous – on the edge of change… and ripe with tensions, potentials and energies that are resolved, actualized and used through processes of individuation (Fox, 2012, p.2).

The biopedagogies of these health education contexts therefore loosen pupils' emotions and cast their sense of self and agency to the fore. Here young people's experiences are interpolated by the Corporeal Device (Evans et al., 2008), whereby the body

> [a]s a material/physical conduit […] has an internal grammar and syntax given by the intersection of biology, culture and the predilections of class, which regulate (facilitate and constrain) embodied action and consciousness, including the way in which discursive messages (and all other social relations) are read and received (p.19-20).

Hence, these biopedagogies not only held individual pupils accountable for their own performance of 'health', but also their negotiation of tensions, potentials and energies in their processes of *becoming* 'healthy' through these biopedagogies. In this process, pupils

> read and critically reflect on the signs, select those that are meaningful, enjoy and recognize the achievable, whilst rejecting (or inverting), if *they can*, the patently unattainable, hurtful or bad (Evans et al., 2008, p.29).

Furthermore, the affective force of the biopedagogies explored in Chapters 5 to 7 left "little obvious space for resistance amongst the young people who [were] subjected to them" (Rich

and Evans, 2009, p.158). At Fielding, Samantha's biopedagogies continuously announced a significant mismatch between who the pupils were and who they should be, therefore invoking particularly powerful and troubling affects (e.g., anxiety) among pupils. However, pupils' agency at Fielding was never unrestrained as they had a limited range of resources (financial and material) to draw upon in their attempts to resolve such tensions (e.g., by walking more, getting outside more, calling on parents for limited practical support, monitoring behaviours etc.). Furthermore, there was little evidence of the health educators in any of the schools encouraging their pupils to think critically about dominant health and obesity discourses. This limited Westwood pupils' opportunities for resistance in particular, as their biopedagogies aligned closely with the values, practices and lifestyle 'choices' they were used to across other sites of influence outside of school (e.g., their family context), meaning their subjectivities as 'healthy', virtuous young people were brought into play, inducing uncritical conformity and compliance. As such, pupils and their teachers at all three schools were largely unaware of the processes of subjectification that were occurring through their passive engagement with the health imperatives of their school and wider society (outlined in Fig. 8.1 below).

Health Policy/Pedagogy   Pupil Subjectivity

↓   ↓

Affective Force   ⟶   Desire

↓   ↓

Invitation   ⟶   Acceptance
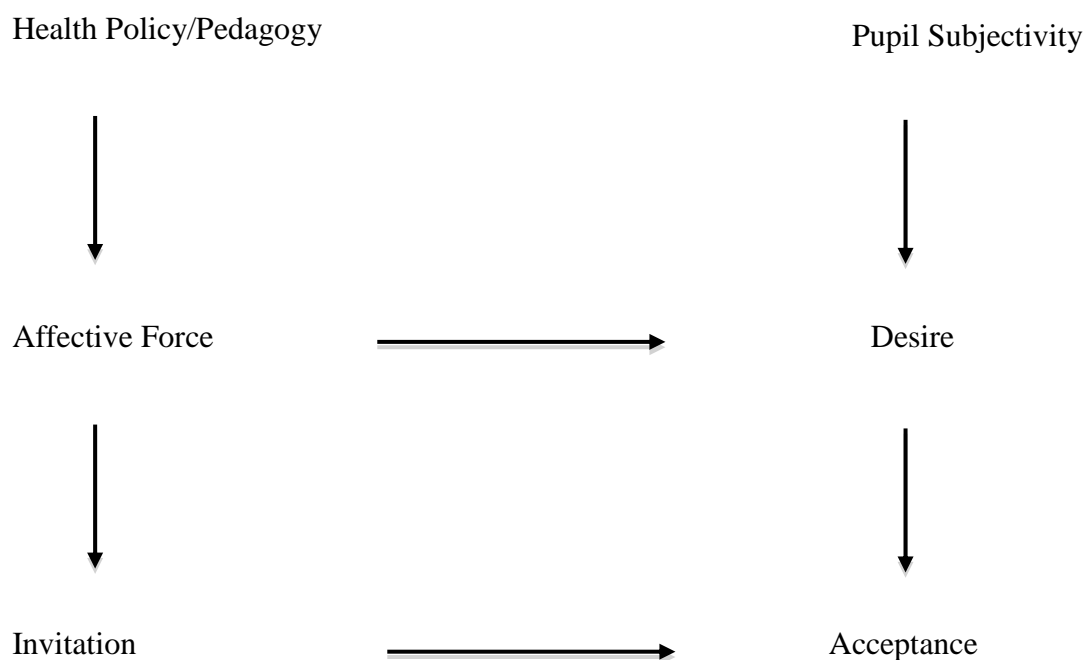
Fig. 8.1 Affective Dimensions of Health Policy/Pedagogy

8.3.2 Realising Pupils' Desires to be 'Healthy': The Troubled-Emboldened Affect Polarity

These, then, were bodies variously *affected* by the health pedagogies of their schools (all of which mediated their desires to 'achieve' health and 'fit in' with those around them). Pupils' responses to the health imperatives prescribed by the government and emplaced in their schools were not, therefore, determined by the amount or type of 'knowledge' they had, as assumed by the government and their schools. Rather conversely, data from pupil interviews suggested that (non)compliance was determined by the availability of resources (economic, physical, cultural) to *effect* health knowledge and thus fulfil their desires to 'be healthy'. For example, pupils' economic resources outside of school were often referred to by teachers and pupils at all three schools as key to pupils' 'performance' of health behaviours. At Westwood and Grange Park, pupils were considered to come from 'wealthy' and 'healthy' backgrounds, illustrated by the types of food and range of sports clubs they were used to. At Fielding, pupils were considered to come from stereotypical working class backgrounds because of their 'unhealthy' diets and sedentary lifestyles, and pupils spoke themselves about the barriers they faced in performing 'health' due to the cost of eating 'healthily' and securing safe spaces to be physically active. Pupils' desires to 'achieve' health, reinforced or shaped by school health pedagogies, combined with the apparent inequality in resources to effect these desires therefore offers a substantial explanation for the large percentages of 'troubled' and 'emboldened' bodies at Fielding and Westwood respectively. Essentially, at Westwood, Claire and Jess' biopedagogies reinforced their pupils' desires to 'be healthy' and the wide availability of resources to fulfil these desires through enactment of health, both within and beyond school, encouraged a sense of achievement among their pupils that was widely celebrated across the school. At Fielding, Samantha's biopedagogies similarly shaped her pupils' desires to 'be healthy', yet their lack of resources to enact health within and beyond school meant that the pupils' desires remained unfulfilled, tensions between ideal and actual bodies and lifestyles remained unresolved and a sense of failure was embodied by pupils.

These narratives point instead, then, to a knowledge-deficit among policy makers and health educators, regarding the resources available to pupils within and beyond school and the various types of knowledge and experience they themselves bring to their pedagogic encounters within school. In sum, in its cultivation of the performative body (Rich and Evans, 2009), the neoliberal 'healthy' ideal circulating across these schools and affecting pupils' relationships with their own bodies, has contributed to the reproduction of extant social hierarchies, resulting in health educators unwittingly inviting their pupils to become

particular 'class subjects' (O'Flynn, 2010). Such subjectivities are expressions of the intersections of biology and culture, and what Evans, Davies and Rich (2011) have elsewhere referred to as the interminable workings of the "corporeal device". Indeed, this reflects the assurgency of approaches which emphasise, "that social and natural phenomena are complex, processual, indeterminate, relational and constantly open to effects from contiguous processes" (Blackman and Venn, 2010, p.7).

Such subjectivities share common characteristics (not least a common way of thinking and talking about health risks and obesity—in this sense they are all, to a degree, bodies regulated by the principles of neoliberal governance), however, they also are uniquely idiosyncratic, expressing very different relationships of the body to the imperatives of obesity discourse (and therefore to neoliberalism itself) when meditated in and through their school cultures. These neoliberal *bodies* are not, then, mere reflections or effects of neoliberalism, but nuanced refractions of dominant (health) imperatives. They are, following Latour (2004), reflections of bodies as processes rather than entities; hence we have talked of '*troubled*', '*emboldened*' and '*insouciant*' bodies (De Pian 2012; Evans, Davies, Rich and De Pian, 2013), not only to signal the diversity of neoliberal bodies, but also their irreducible relationality (to each other and the environments they inhabit) and fluidity (it makes no sense to talk of being a 'troubled' body unless one simultaneously also has notion of what a non-troubled or privileged body would be in the same context). Such concepts are themselves highly problematic, as far as they, too, may appear to be reductive and suggestive of stasis and immutability. As discussed in Chapter 4, they are used here, and elsewhere, merely as heuristic devices which represent a continuum of embodied relationships to the imperatives of obesity discourse rather than fixed identities. They suggest that although some children may understand and constitute themselves at specific positions on a troubled–emboldened body spectrum (e.g., they may report that they feel 'troubled' or 'emboldened' by obesity discourse all of the time), even then they, like most others in our study, experience a somewhat fluid relationship with health imperatives. Such orientations are embodiments of affects, unresolved affects in the case of pupils at Fielding.

Insouciant Bodies

It is less apparent, however, why some pupils (e.g., those at Grange Park) reported that they are 'sometimes' happy about their weight/size. This orientation straddles the 'troubled-emboldened affect polarity' and captures the individual in transition. Drawing on Tomkins (1991), there are indeed a number of sub-continuums within this broader troubled-

emboldened continuum, whereby the intensity of affects between these orientations can be captured (distress-anguish may be one example of this). Thus, the 'insouciant' orientation represents a decline from being 'emboldened' towards becoming 'troubled' or indeed vice versa, whereby the intensity of affects associated with 'troubled' bodies is determined by the intensity of those associated with being 'emboldened', i.e., the level of intensity of feeling 'emboldened' enables or constrains feeling 'troubled'.

Hence, pupils whose weight and/or 'health' behaviours were considered to fall outside of the acceptable 'norm' (the lean, fit, active, weight-watching, diet-following, health-seeking body) were treated differently ('othered') by staff and their peers at a time when feeling as though they 'fitted in' and 'belonged' was of utmost importance for their development of a positive sense of self. Given that the schools had fulfilled the government's requirement to provide their pupils with appropriate knowledge, it was deemed to be the pupils' responsibility to resolve this tension, through compliance with the imperatives of their school health education. Thus, the neoliberal emphasis on individual responsibility for health is most evident at Fielding, as pupils' only option to resolve this tension was to themselves find the resources which enabled them to comply. The affects experienced are too intense for these pupils to simply resist this discourse, which highlights a need for health educators to critically appraise policy knowledge or to help equip their pupils with the skills to appraise the meaning and value of such knowledge in their lives (see Chapter 9 for a detailed discussion of this).

'Health', so narrowly defined, collided with the limitations of these pupils' working class lives, invoking a lack of achievement, recognition and belonging which was subsequently embodied by these pupils as a sense of failure on their part (positioning them as second class citizens). They therefore found themselves caught in a power struggle between their desires to be 'healthy' and therefore 'belong' in the 'normative' spaces their middle-class peers are able to occupy so readily, and their economically 'deprived' working class subjectivities, which were realised through performative neoliberal principles of health. Health educators at Fielding inadvertently did not mediate health for these pupils in a way that allowed them to fulfil the very desires they themselves had induced in their pupils; to 'be healthy'. Rather, their education encouraged desires which far exceeded pupils' financial and material resources, within and beyond school, resulting in these pupils 'never' feeling happy with their weight/size.

The relationship between health pedagogy and pupil subjectivity is therefore far more complex than it is assumed to be by government officials and health educators. Fig. 8.2, below, illustrates the consequences of this relationship for a young person's sense of self (particularly their relationship with their weight/size), whereby only those who conform to their school's health imperatives and 'achieve' health can experience a sense of belonging and therefore develop an 'emboldened' relationship with their weight/size.

Fulfilment

'Emboldened'

Belonging

Recognition   Respect

'Health'

Achievement   Performance

Behaviour

Diet   Exercise   Weight

Knowledge

Risks   Choices   Responsibility
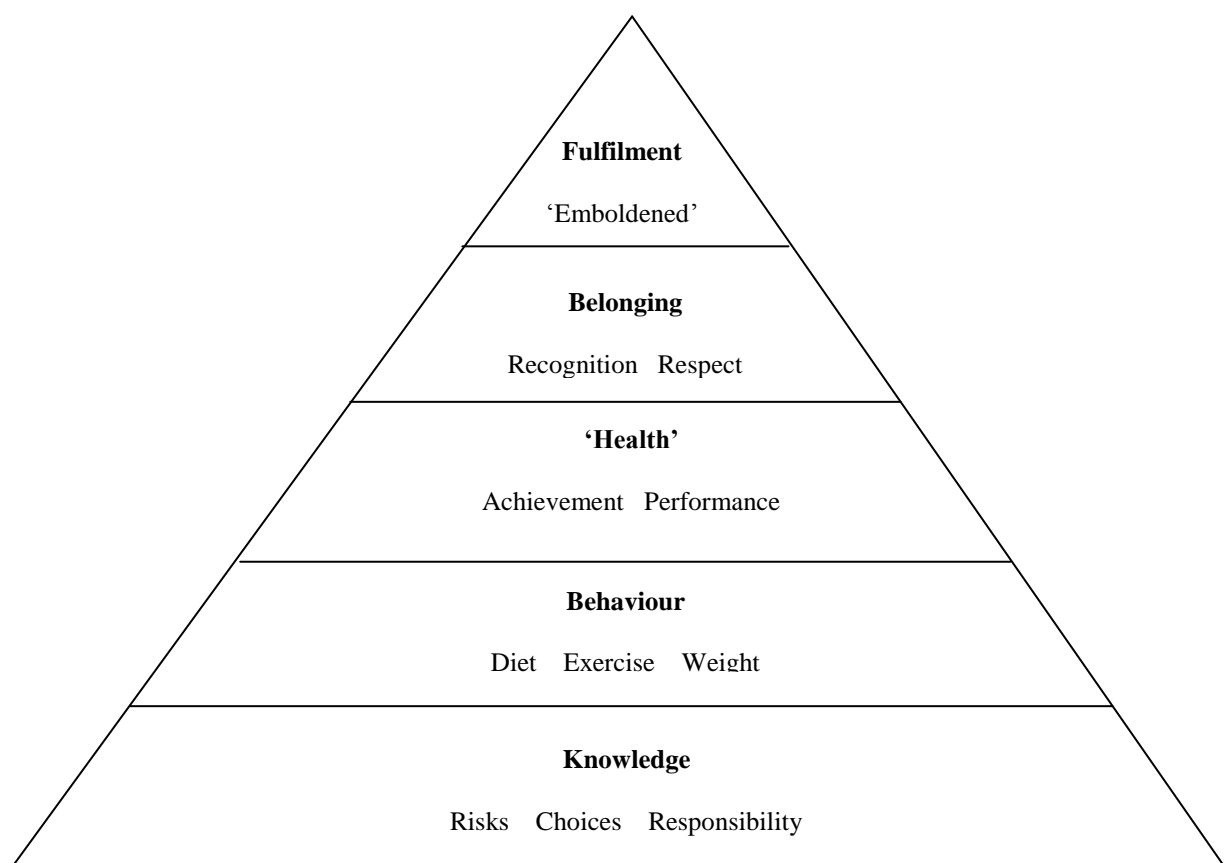
Fig. 8.2 Neoliberal Health Project

Policy makers' and health educators' constructions of 'health' as an entity to be 'achieved' is therefore particularly powerful in the lives of young people as they seek to define themselves, both as an individual in their own right whilst also 'belonging' to their social groups.

8.4 Metastable Bodies

Turning to the work of Ahmed (2004, p.27), it follows that "what moves us, what makes us feel, is also that which holds us in place, or gives us a dwelling place". Thus, children's

emotions are implicated as they are variously *affected* by obesity and health discourses within and across time, place and space, depending on the relationships, contingencies and materialities within the socio-cultural contexts in which they are located. Hence, the extent to which a young person feels happy about their weight/size does not simply derive from inside of them, "from some deep inner well and in accordance with its own mechanics", but is a product of the relations of which they are a part. According to Burkitt (1999, p.113), these relationships "are always social and cultural, specific to a particular place and time". Building on these theorisations, this thesis has not just been concerned with how a young person's feelings toward their own weight/size are shaped by their relationships with other people or cultural artefacts or discourses per se, but also by the value placed on health-related knowledge and practices which circulate within these relations. Hence, feelings are not only the result of relationships, but also the complex interactions and exchanges which take place within them.

Pupils' bodies are therefore considered to be 'metastable', i.e., neither stable nor unstable in the absence of certain conditions. Rather they are always in a process of individuation (becoming), and therefore on the edge of change. They are therefore bodies in situ, whose material and physical environments have significant bearing on their sense of self.

> [I]f the individual must be understood as an ongoing process of individuation, then the "individual" cannot be isolated from its surroundings, or from all other individuals. An individual can only be defined in relational terms, in contrast and connection to its "milieu", or to what it is not, but from which it has emerged. That which allows us to distinguish an individual, to see it as separate from everything else, also forces us to link it to everything else. I cannot be an individual at all, without the presence of that which is not me, not my individuality (Shaviro, 2003).

When the 'rational objective' (knowledge/discourse) collides with the 'emotional subjective' (pupils) in ways mediated by health educators, the response is entirely unpredictable and complex, based largely on "an embodied history to which and with which the body reacts" (Probyn, 2004, p.29). They are "the result of the moving arrangement of particles, histories and affects that are the bodies of teaching and learning" (Probyn, 2004, p.37). Hence, this is a complex biological, psychological and cultural interplay, captured previously by Tomkins' (1965) 'science of man' and more recently by Evans et al.'s corporeal device (see Evans et al., 2008).

8.5 Learning for Performance: A Class Act

In this thesis and elsewhere (see Rich and Evans, 2009, for example) it has been argued that class structures and social hierarchies are reproduced and reinforced through health educators' uncritical emplacement and enactment of the UK government's performative, neoliberal health imperatives inside schools. This has also been found to be the case in Australian schools (see O'Flynn, 2010, for example). This lack of critical engagement is perhaps surprising, given that, as Gard (2004, p.69) points out:

> a passive orientation towards scientific knowledge [seems] at least out of step with contemporary discussion about the need for students in universities to exercise a critical judgement when evaluating the knowledge claims of others.

However, Leahy (2009, p.174) offers insight into "the dominance of expert knowledges" in such schools with reference to the work of Dean (1999) which has underlined "the significance of expertise in governing populations" (ibid., p.175). Furthermore, Chapters 5 to 7 of this thesis have revealed how these expert knowledges, which privilege the measurable achievement and performance of health, leave little space for teachers and pupils to resist associated imperatives. As O'Flynn (2010, p.443) suggests, "[s]uch discourse shuts down critique of norms that position those as 'lacking', and structures that work to maintain inequality". Rarely are the public urged to think critically about the moral panic over obesity and "particularly its ability to harm health through shaming and stigmatisation" (Fraser, Maher and Wright, 2010, p.198). The neoliberal ideals underpinning these imperatives are rarely overt, and often are so embedded in social structures or patterns of interaction that they are taken for granted by health educators. This is particularly important for health educators, whose own values and understandings of their pupils in relation to dominant notions of health have been found throughout this project to have significant impact on how young people come to understand health and their own and others' bodies. Furthermore, the UK government's conceptualisation of 'health' as a product that can and should be quickly and easily achieved and maintained by individuals (given the correct knowledge) and schools (with the successful enactment of policy) has placed health educators under immense pressure to 'perform' and 'succeed' in the name of 'achieving health' in their school. It has encouraged them to employ prescriptive, instruction-based methods of teaching which promote surface-level learning (see Leahy, 2009 and Chapters 5 to 7 of this thesis). Such methods, characteristic of traditional, didactic, behaviourist ('input-output') pedagogy found

in performance-driven education environments have been criticised for encouraging restricted and passive forms of learning, and a lack of consideration of 'situated, material, professional and external' contextual factors (Braun, Ball, Maguire and Hoskins, 2011), as well as learners' individual needs, interests and desires (Armour, 2011). Findings presented in this thesis (see Chapters 5 to 7) lend support to this critique; suggesting that this method of teaching and learning disempowers both teachers and pupils when applied in a health education context in schools.

The emphasis such approaches place on 'behaviour modification' and, thus, on the notion that successful learning is determined through 'observable behaviour change' (Chambers, 2011) can be particularly damaging for young people when enacted in a health education environment where the focus is on body weight, diet and exercise. Hence, using behaviourist techniques such as affective stimuli and reinforcement (e.g., rewards for healthy eating at Westwood), the health educators in this study were seemingly 'conditioning' young people to passively adopt 'unhealthy' and, at times, destructive behaviours such as body measurement, comparison, monitoring and manipulation techniques, thus empowering those who complied (e.g., at Westwood) and troubling those who wished to comply but were unable to (e.g., at Fielding). Hence, with Evans (2014, n.p.) it seems fair to conclude that

> [a]s a social construct, reflecting socio-economic interests it [contemporary health policy] is, therefore, never going to be wholly inclusive or all-embracing, rather always nice for some people but never satisfying for all.

Thus, the neoliberal ideals underpinning health education in schools clearly prohibit "momentum toward potentially greater equity, democracy and inclusion" (De Pian et al., forthcoming, p.1) urging exploration of the scope for change. Moreover, these findings call into question the extent to which any of these young people's bodies – including those who, on the surface, appear to be 'emboldened' – can be considered 'healthy' bodies if their embodiment is determined merely by their successful compliance with imperatives which prescribe the ways they should 'be' or behave in the name of 'achieving' health. The notion that such compliance serves as a prerequisite for young people's sense of self and belonging in school further prompts urgent reconsideration of the ways in which policy makers and health educators respond to scientific claims and dominant constructions of 'health'. Thus, Wright and Dean (2007, p.90) highlight a need for physical and health educators to "critically examine the ideas about the body, health, physical activity and food that they promote and

consider the implications of their practices for the well-being of students" and Webb and Quennerstedt (2010, p.798) suggest that "this goes beyond and deconstructs calls for teachers to serve as healthy role models to improve students' learning".

8.6 Conclusion

In line with Braun, Ball, Maguire and Hoskins (2011) the complexities of policy "as a process" (p.586) have been captured and discussed through this study. These complexities clearly "set the work of policy within a framework of contingencies and materialities" (ibid., p.581) which are unique to each school setting. In agreement with Braun, Ball, Maguire and Hoskins, 2011, p.585), the emplacement of policy therefore enables and/or constrains policy enactments in schools, generating "differences in policy enactments between similar schools". The enactment of policy is, therefore, "intimately shaped and influenced by school-specific factors" (ibid.). However, this research has extended the work of Braun, Ball, Maguire and Hoskins (2011) and Ball et al. (2012) through illustration of the ways in which the emplacement of health policy enables and/or constrains not only policy enactments in schools but also young people's embodiment in these settings, i.e., the opportunities made available to them through their school health education to become some-'body'.

The obese body and associated behaviours were to be avoided at all three of the schools in this study, but the crisis surrounding this took slightly different forms in each context. For example, at Westwood the crisis was "out there", one step removed from their middle class lives, and hence their health education was concerned with maintaining their distance from this crisis and sustaining their privileged position. The obesity epidemic and the government's drive to tackle it therefore positioned staff at Westwood as 'privileged' and thus their responses to health policy (through pedagogy and practice) were formed on this basis. At Fielding, however, the obesity 'crisis' was considered to be one of several pathologies in the pupils' and their families' lives (along with teenage pregnancy, smoking, drinking and drug use), and their health education was focused on repairing these. The obesity epidemic and the government's drive to tackle this therefore further pathologised the lives of all at Fielding and marginalised them in relation to dominant notions of 'health'.

In their emplaced form, the enactment of health policy through oversimplified knowledge-behaviour associations (such as those discussed in Chapter 2), served to generate "particular politically articulated form[s] of order" (Fraser, Maher and Wright, 2010, p.206) in all three of the schools in this study and provoked imaginings of "particular subjects (such as the

healthy subject), objects (including the object of obesity itself) and collectivities (such as a responsible healthy citizenry)" (ibid.). The case studies presented in Chapters 5 to 7 illustrate not only the efficacy of the 'imagined neoliberal other' (Bernstein, 1996; Rich and Evans, 2013) in the lives of children, but also the relationality of such imaginings and how these help reproduce extant social class and cultural stereotypes and hierarchies. The young people in this study seemingly embodied these imagined relational positions, sometimes in particularly powerful ways, as reported in Chapters 5 to 7. Attending to the voices of pupils and their embodiment of health policy in situ therefore adds complexity to the realities of policy processes in schools.

The government's assumed model of health education, uncritically accepted by very many health educators, fails to account for the socio-cultural aspects of learning about 'health' and the affects/effects these can have on pupils. The findings discussed throughout this chapter therefore challenge contemporary health policy and practice in schools, pointing to a need for a new approach – one that avoids the promotion of health as an entity to be 'achieved' and 'performed' and which serves as a prerequisite for pupils' sense of self and belonging. Such an approach would need to incorporate a 'healthy' desire to learn among pupils, i.e., one which schools can help pupils fulfil, thus empowering all pupils rather than a fortunate few. Failing to address the complexity of young people's lives and the intersections of class and culture, health policies and their attendant pedagogies based on achievement and performance are likely to always induce class and culturally mediated relationships with the body and therefore reproduce social hierarchies. Through this approach, policy makers and educators will continue to blame the lack of compliance on individual pupils, therefore always marginalising those with least resource, 'the working classes' or 'single parent families', in the process. Research such as this can help to equip these professionals with the courage, knowledge and integrity to seriously question whether there is a more effective way to educate young people about 'health' – however it might be defined – and aid the relationships they might develop with their own bodies in the process.

Clearly not all pupils are hurt or damaged by health and obesity discourses. To the contrary, a significant number are 'emboldened' by it, at least initially so. However, even when this appears to be the case, such subjectivities cannot be taken at face value. That some of these 'emboldened' relationships are determined by a young person's compliance with imperatives which prescribe the ways they should 'be' or behave in the name of 'achieving' health, calls

to question the degree to which some of these 'emboldened' bodies can be considered 'healthy' bodies. Furthermore, over time, as the act of religiously and relentlessly maintaining or meeting (through persistent exercise and controlled diets) the imposed requirements of the 'healthy body' becomes more difficult to achieve, these individuals too may begin to become 'troubled' bodies or more 'insouciant' toward obesity ideals.

The neoliberal discourses of 'individual responsibility' and 'choice' discussed in Chapter 2 in relation to health implies that education can ensure that all children and young people are freely able to make the 'right' lifestyle 'choices' and failure to do so lies in a lack of responsibility of the individual child and their family. Chapters 5 to 7, however, highlight how the contingencies and materialities of a given context, combined with an individual's subjective potentialities, make it (im)possible to *be* 'healthy', if only momentarily. Hence, 'choice' is always mediated (enabled/constrained) by a young person's subjectivity – their age, gender, social class, ethnicity etc.

> As somatic selves we may well be urged to understand our embodied existence through the discourses of molecular science, but choices and desires are also mediated by relationships and emotions that connect us with each other (Fullagar, 2009, p.114).

9. Implications for Policy and Pedagogy

9.1 Introduction

This thesis began with a critique of the UK government's knowledge-deficit model of health education, which, in light of findings presented in this thesis, assumes an over-simplified and deterministic relationship between knowledge and behaviour and conceptualises 'health' as an entity to be achieved and continually performed by individuals, and particularly young people in schools. The case studies presented in Chapters 5 to 7 have illustrated the interminable workings of the neoliberal ideals embedded within this approach, which, when uncritically emplaced and enacted by health educators, promote the self-actualising, self-realising, disciplined, compliant, independent individual (Rizvi and Lingard, 2010; Rose, 1999), represented by the lean, fit, active, weight-watching, diet-following, health-seeking body. Drawing on data presented in these chapters, this thesis has attempted to add to and develop existing literature in this field by highlighting the complex micro processes this approach invokes in formal and informal health education contexts in schools, including the ways it has encouraged young people to understand and relate to their weight/size through measurable and therefore comparable outcomes (namely those concerning their weight, diet and exercise patterns) – an anxiety-ridden project for many of the young people in this study. The preceding chapter discussed the situated, affective and embodied dimensions of this approach, through which some (mainly middle class) children appear to fare better than other (mainly working class) children in the relationships they develop with their own weight/size. Thus, this thesis has highlighted "the way in which education fosters a particular view of what it means to be human" (Ecclestone and Hayes, 2009, p.viii) and the ways in which narrow definitions of health play out in young people's developing senses of self and belonging. This finding therefore challenges the medicalisation of weight and the clinical procedures of resulting policy which require health educators to somehow anaesthetise their pupils' emotions to avoid the damaging consequences current health policy and pedagogy can have for some young people. Thus, these findings indicate that the success of any alternative health education programme is likely to depend as much on what schools or teachers do as on what young people themselves bring to the learner encounter by way of cultural predispositions or propensities and levels of socio-economic, financial and political resource. Indeed, concepts drawn from Deleuze, Simondon and Bernstein have served to

"illustrate how individual pupils' needs, interests, abilities and desires are interrelated with, and affected by, the various cultural settings and pedagogies they experience" in time, place and space (Evans, De Pian, Rich and Davies, 2012, p.1).

The fluid, contingent and culturally induced nature of young people's embodiment is therefore conceptualised in the preceding chapter using Simondon's (1989) notion of 'metastable bodies' whereby an individual's potentialities to be some-'body' (Evans, Rich and Holroyd, 2004) may or may not be realised within the contexts in which they reside. Young people's opportunities to 'be healthy' may be enabled or constrained by the uncritical emplacement and enactment of contemporary UK government health policy in their schools. The finding that this has contributed to young people's uneven situated, affective and embodied experiences of health policy endorses Braun, Ball, Maguire and Hoskins' (2011) call to 'take context seriously' when researching and theorising policy enactment in schools (see Chapter 2). Furthermore, findings presented in this thesis call into question the extent to which any of these young people's bodies – including those who, on the surface, appear to be 'emboldened' – can be considered 'healthy' bodies if their embodiment is determined merely by their compliance with imperatives which prescribe the ways they should 'be' or behave in the name of 'achieving' health. Moreover, the notion that such compliance serves as a prerequisite for young people's sense of self and belonging in school prompts urgent reconsideration of the ways in which policy makers and health educators conceptualise 'health'. In this penultimate chapter, then, I move the discussion beyond the three schools presented in Chapters 5, 6 and 7, to consider the relevance and implications of themes discussed thus far for contemporary and future health policy, pedagogy and practice in all schools. Given that this research is not a policy evaluation per se, its implications for health policy are by no means taken for granted, nor are the views offered here to be taken as concrete or absolute. Rather, by focusing on the meaning and relevance of health policy when emplaced and enacted in different contexts, this chapter seeks only to provide information and *insights* that may contribute to debate and inform practice, especially those overly driven by narrow, reductive constructions of health (e.g., those concerned with individuals eating the right food, doing regular exercise and producing/maintaining a slender body). Consequently, this chapter suggests revisions to dominant conceptions of health and associated pedagogies in an attempt to highlight ways in which health education programmes can become more inclusive, empowering and sustainable for *all* young people, rather than a privileged few.

9.2 From 'Learning for Performance' to 'Learning for Sustainability'

> Pedagogy in relation to the body, exercise and weight, is not just about 'content', particular messages and belief systems prevailing locally, nationally or globally but entails a set of relationships affording teachers and pupils different levels and forms of responsibility and control (Evans et al., 2008, p.125).

Rather than focusing on behaviourist definitions of learning, such as those advocated by the UK government, which emphasise knowledge possession and observable behaviour change, findings presented in this thesis point towards a need to turn to alternative social theories of learning whereby

> [l]earning is [perceived] in the relationships between people [...] the conditions that bring people together and organise a point of contact that allows for particular pieces of information to take on a relevance; without the points of contact, without the system of relevancies, there is not learning, and there is little memory. Learning does not belong to individual persons, but to the various conversations of which they are a part (McDermott, in Murphy, 1999, p.17).

Such an approach would, therefore, invert the problematic and damaging ways in which dominant health discourse – when uncritically emplaced and enacted in schools – constructs a conditional sense of 'belonging' among young people in relation to their individual achievement and performance of 'health' (see Chapter 8 and above). Thus, rather than 'belonging' being an outcome of 'performative health', any alternative health education strategy must, first and foremost, be grounded in the positive relationships between young people. Thus, through a reconceptualisation of learning in health education contexts, as indicated above, the priority becomes 'the conditions that bring people together', (not what sets them apart) therefore fostering an inclusive, meaningful and culturally relevant health education and, moreover, an authentic and unconditional sense of belonging. Furthermore, Kunc (1992, p.37) attests that "when children are given the right to belong, they are given a right to their diversity", and hence I argue that such an approach to health education in schools would *educate* rather than merely *illuminate* difference, offering increased opportunities for young people's development of subjectivity.

9.3 Towards a Critical Health Education

Rather than attempting to challenge and override dominant obesity discourse altogether; an impossible task, some might argue, since "no 'body' escapes the evaluative gaze" (Evans et al. 2008, p.17), a growing number of academics suggest a need to develop pedagogies which foster teachers' and pupils' critical engagement with such discourses. For example, Evans et al. (2008, p.130) argue that

> professional health educators, teachers and teacher educators need to be vigilant, constantly seeking 'truth' as best we know it, sceptical of the assertions, ideologies and opinions that pass for knowledge and certainty in the official obesity field.

Drawing on this literature, I argue that we should not attempt to eradicate dominant obesity discourse from health education in schools; for this and other research (e.g., Allwood, 2010; Evans et al., 2008; Halse et al., 2007) has demonstrated the emotional resonance it has with very many young people outside of school. However, rather than urging pupils to understand their bodies in relation to questionable expert knowledge, this thesis makes a case for 'a critical pedagogy' that

> must help us to distinguish our real needs and those of our students from predatory fantasies in pursuit of artificial needs and to enunciate the demand for a new ethics of compassion and solidarity (McLaren, 1995, p.77).

In this light, health education should be helping young people to critique and negotiate 'expert' knowledge in relation to their everyday lives. Thus, rather than focusing on decontextualized knowledge acquisition for the enactment of government-prescribed behaviour, any alternative strategy must be grounded in young people's extant life experiences, needs and interests, some of which are indeed receptive to and supportive of dominant health imperatives in and outside school. If, as Ahmed (2004, p.27) puts it, "[w]hat moves us, what makes us feel, is also that which holds us in place, or gives us a dwelling place", then it seems necessary to turn to alternative, contemporary pedagogies which perhaps have greater potential to enable young people to think critically and reflexively about the affective dimension of obesity discourse and the ways this socially constructed phenomenon might contribute to their potential to be some-'body'. Hence, rather than "viewing the expert-lay discrepancy as a clash of objective expert knowledge and subjective lay distortions" (Hansen, Holm, Frewer, Robinson and Sandøe, 2003, p.111), which

constructs narrow and exclusive dualisms (e.g., right/wrong; fat/thin; healthy/unhealthy; good/bad; moral/immoral) and lays blame on individuals, I argue that government health officials should seek to empower health educators in schools with the space and autonomy to account for local experiences of 'expert' health knowledge, particularly where significant disparities exist between the two. This would require the development of an alternative (localised, culturally relevant) version of health education; one which prioritises young people's needs, interests, and cultural/economic resources.

Health educators could, therefore, critically and consciously contextualise health policies, particularly those which emphasise individual responsibility for their enactment, in relation to "the cultures and environments of their school" (Fox and Smith, 2011, p.403). As Probyn (2004, p.35) argues,

> [w]hile we offer material that potentially sets off lines of flight, we then have to continually re-territorialise the very bodies that have been set in motion through our teaching.

These suggestions merely offer a starting point for change in Initial Teacher Education (ITE) and highlight in particular the potential power of increased understanding among future health educators of "the part they are playing on a wider stage" (Apter and Garnsey, 1994, p.26). Apter and Garnsey (1994, p.22) further assert,

> [ch]oices are constrained, sometimes eliminated by circumstance, but understanding can expand our range of options; when awareness is widened more possibilities are envisaged and consequences better understood. Outlook can change the context of choice and action; some constraints remain immovable, but the nature of others can be reassessed.

This may indeed involve reconstructing and broadening definitions of 'health' itself. After all,

> the fundamental principle of inclusive education is the valuing of diversity within the human community. Every person has a contribution to offer to the world. Yet, in our society, we have drawn narrow parameters around what is valued and how one makes a contribution (Kunc, 1992, p.38).

The 'narrow parameters' Kunc (1992) refers to are particularly true of contemporary conceptualisations of 'health' and 'the body'; parameters which privilege white middle class ideals (e.g., sound physical fitness, healthy diets and a normative weight) and thus constrain the extent to which many (working class) young people can 'achieve health'. Through these constructions, 'health' is read through normalized, slender and fit bodies and thus, any deviations from this discursively constructed 'norm' constitute a health risk (Quennerstedt, 2008). Several academics have challenged these dominant constructions of 'health' in relation to physical education (e.g., Evans et al., 2004; Kirk, 2006; O'Sullivan, 2004 and Quennerstedt, 2008) and young females' bodies (e.g., Allwood, 2010; Evans et al., 2008 and Halse et al., 2007).

This thesis has added to this body of literature by highlighting the uneven and potentially damaging consequences it can have for *all* young people. Drawing on Simondon's (1989) theorisation of bodies as 'metastable', I argue that a more inclusive health education requires broader definitions of 'health' and alternative pedagogies in schools which increase young people's opportunities to experience 'health' by tapping into, realising and accepting their non-performative potentialities and desires to 'be healthy'. For example, by drawing on definitions and pedagogies which encourage young people to think about how their body *feels* rather than how it looks (Evans, B. 2006; Slater and Tiggemann, 2011). This further highlights a need for critical engagement with knowledge through health education, and more specifically, what Probyn (2004, p.30) refers to as "an ethics of the affective in the classroom". She suggests,

> [f]ocusing on how, as a text, it makes them feel… plays upon their bodies, can create a space of reflection outside of common judgements (p.29).

In this view, health educators need to acknowledge "the body and the 'live subject' either as a political or a pedagogical problematic" (ibid., p.33) and, in the process, avoid shying away from "the messiness of bodies, experience and affect, especially when they are expressed by their students" (ibid.). For example, Probyn (2004, p.33) suggests eliciting

> a moment of realisation that can be seen on their bodies, when the affect of memories of childhood or a forced recognition of their social position connects viscerally with the concept: 'Oh, that's why I do that. That's what it means when I do that.

Probyn (2004, p.30) also suggests that this should be accompanied by "consideration of the structure of the space in which affect is generated and experienced", in this case, how dominant obesity discourse permeates divergent class/cultural contexts, health education classrooms and the bodies of young people therein. However, such approaches are not without their pitfalls, and in adopting 'an ethics of the affective', Probyn (2004) warns

> [w]e need to ask what type of affective response is appropriate in the classroom context. In addition, careful consideration needs to be paid to providing safety structures for students for whom a triggered affective response may be deeply disturbing (p.29-30).

In this light, health educators must also avoid turning their classrooms into "the site of self-help groups" (Probyn, 2004, p.33), for this has been deemed "inappropriate and unprofessional" (Freedman, 1994, p.34). Indeed, Ecclestone and Hayes (2009) have documented the 'dangerous rise of therapeutic education' and the ways in which "denying the intellectual and privileging the emotional" (p.xi) through this approach can encourage young people 'to respond emotionally to day to day challenges' and therefore promote a "diminished human subject" (p.xi).

A growing number of academics have begun to consider alternative approaches to health education. For example, Quennerstedt (2008) quotes Haglund et al., (1991, p.3) in contending that

> health itself should be seen as a resource and an essential prerequisite of human life and social development rather than the ultimate aim of life. It is not a fixed end-point, a 'product' we can acquire, but rather something ever changing, always in the process of becoming.

This conception of health resonates with the conceptualisation throughout this thesis of young people's subjectivity as fluid and always in a process of becoming; it thus has the potential to enable all young people to individually experience 'health', i.e., in different ways and at different times which avoid measureable and comparative indicators (such as weight). The 'salutogenic' approach to health, advocated by Quennerstedt (2008), offers some indication as to how this might be enacted through Physical Education programmes. He speaks of

a health perspective… that draws attention to the qualities, abilities and knowledge that pupils can develop, and, in the name of *learning health*, point the way to the possible contribution of physical education in pupils' health development in terms of how physical education can enrich their lives, strengthen them as healthy citizens and contribute to a sustainable (health) development.

Less is known, however, about how this approach could be applied to health education beyond PE, thus pointing to a need for further research in this area.

Evans et al. (2008, p.128) advise that such considerations of alternative approaches to health education involve "not just a politics of health but a politics of pedagogy, since schools are now positioned as key institutions in the fight against obesity". We must therefore consider the ways in which new conceptualisations of health *and* associated pedagogies can become more inclusive, empowering and sustainable for *all* young people. Drawing together these two dimensions of change for contemporary health education brings us to a relatively new way of thinking about (health) pedagogy which is captured by a 'slow pedagogy' movement; one which

focuses on the importance of the body in education as a necessary balance to the "fast pedagogies" that threaten to overrun and exhaust teachers and students at every turn (Tooth and Renshaw, 2009, p.4).

The approaches adopted by the health educators in this research are considered to be examples of the "fast pedagogies" to which Tooth and Renshaw refer. Thus, a case is made for "slow pedagogies", which promote deep-level, reflective and culturally relevant learning about 'health' and empower young people *in the long-run*. Ballantyne and Packer's (2008) discussion of learning from environmental experiences for sustainability provides an example of this, and involves five key factors: 'being in the environment'; 'real life learning'; 'sensory engagement'; 'learning by doing' and 'local context'. This approach to learning, I argue, could foster the kind of deep-level, reflective and culturally relevant learning about 'health' discussed above, which would allow young people to engage with and understand their body's becoming in time, place and space. The current trend (Barker, 2012) in the adoption of such approaches by educators at some of the UK's wealthiest schools may lead some educators and academics to argue that slow pedagogies are merely another means by which the middle and upper classes are privileged through education and are, therefore, no more

helpful than existing health pedagogies in promoting equity and inclusion for all young people. However, the Headteacher of a UK comprehensive school with "well above average deprivation levels" (Barker, 2012) has spoken publicly about the benefits of this approach in diverse class and cultural education contexts. Furthermore, it is argued that an 'experiential education' can be meaningful for learners of all ages, including early years (Payne, 2006). Further research, which draws on 'real-life' enactments of this approach across a range of class and cultural contexts is therefore needed to build upon this preliminary literature and explore the ways in which this approach could offer a valuable and practical alternative to the potentially harmful health education methods discussed throughout this thesis.

The alternative health strategies mentioned above are, of course, not exhaustive, but merely indicative of the direction away from reductive (and potentially damaging) body pedagogies toward those that might better serve the health and well-being of all children and young people in and outside schools. Clearly these recommendations will also have implications for ITE, its knowledge base, what is to count as 'health education', and being and becoming a health 'professional'. The challenges this poses for ITE and the roles of future health educators are not to be underestimated and the alternative approaches to health education discussed in this chapter are merely a starting point for such considerations.

10. Conclusions

10.1 Introduction

The key aim of this study was to broaden current understanding of young people's subjective, embodied experiences of their school health education (specifically the ways their experiences shape the relationships they develop with their weight/size) and the implications of this for their developing sense of self. Through in-depth case study exploration of the emplacement, enactment and embodiment of health policy in three divergent school contexts, I have discussed the (potential) role schools can play in young people's embodiment and developing sense of self. Rather than attempting to position any of the schools referred to in this study as exemplary, this thesis has aimed to highlight the mediating effects of these three different schools for young people's developing sense of self. Drawing on affect theory to make sense of teachers' and pupils' experiences of health policy has revealed some of the uneven class and cultural mediations of 'health' in this process, thus adding nuance and complexity to both an understanding of biopedagogy and the notion of 'the neoliberal body' (Heywood, 2007; Rizvi and Lingard, 2010; Rose, 1999). Health education as it is currently enacted – at least in these three schools – appears to privilege white, middle class ideals, empowering those pupils who are recognised (by themselves and others) as conforming to these ideals and troubling those who are not. Hence, the young people in this study appear to understand their weight/size through dominant and narrow constructions of health found in the formal and informal contexts of their schools and more widely. Such constructions set pupils' bodies apart and illuminate difference, thus urging pupils to (l)earn their right to 'belong'. The damage this can do to young people's sense of well-being points to a need for policy makers and health educators to rethink health education in schools, if their goal is to empower _all_ young people rather than a privileged few. In this final section I conclude the thesis with a critical reflection on the research process itself and discussion of some of the limitations of this study, before making suggestions for future research concerned with health policy, pedagogy and young people's embodied subjectivity.

10.2 Reflections on the Research Process

10.2.1 Broadening Understandings

With reference to Ball et al. (2012), Chapters 2 and 3 of this thesis highlighted a lack of 'real life' analyses of education policy in schools, which involve 'real' and diverse school settings, policy actors (staff and students) and the various nuances which take shape in each specific context. In an attempt to address these lacunae, three schools were identified and selected for study by the initial quantitative analyses of the data gathered for the original ESRC project from which this thesis has stemmed (see section 1.5 for details) and detailed case studies were compiled involving descriptive quantitative and qualitative data collected via pupil questionnaires (n = 360) and qualitative data from semi-structured interviews with health/physical education staff (n = 7) and young people (n = 32) across the three schools. As discussed in Chapter 3, there are, of course, serious limitations to using (quantitative) questionnaire data to interrogate issues of subjectivity. It has been drawn on here, however, simply to demonstrate the demographic trends in the young people's relationships with their weight/size. Thus, the quantitative questionnaire data served as a starting point for the analysis with the intention to provide the most direct and straightforward illustration of how young people variously felt about their body's weight/size (albeit at a particular moment in time). The schools reflected a small range of socio-cultural settings in the UK, and specifically those that were typical of the Midlands county in which this study took place (see Table 3.1, Chapter 3, for details of each school). Whilst this offered sufficient contrast for the purposes of this study, the emplacement, enactment of embodiment of health policy in other socio-cultural settings (e.g., diverse primary schools, middle class boys' schools) remains under-explored. Furthermore, due to the busy schedules and pressures experienced by teachers and pupils in these schools, it was not possible to interview all health educators or pupils in each context. This was particularly the case in the largest and most diverse school in this study (Fielding Community College) where only one teacher (Head of Food Technology/Healthy Schools Coordinator) was available for interview. With more time to carry out data collection, it may have been possible to involve other health educators (e.g., PE and PSHE education teachers) in this context, therefore offering a broader and more detailed account of the emplacement and enactment of health policy in the school. Moreover, this study involved pupils between the ages of 9 and 16 and therefore scope remains to explore younger pupils' embodied experiences of their health education at school, particularly in light of recent studies (see Hutchinson and Calland, 2011, for example) which have started to

highlight the ways health and obesity discourse is affecting both boys and girls at a much younger age than has previously been recognised.

Whilst attempts have been made to provide 'real life' analyses of health policy in these schools, this research relied on teacher and pupil accounts of their own experiences, rather than employing potentially more intrusive and disruptive ethnographic methods, whereby the unique health practices, pedagogies and interactions in each setting could have been observed. Nevertheless, we were required by the University's Ethical Advisory Committee to obtain consent from school staff and parents for the young people's participation before commencing data collection in these schools which lays bare the notion that this was, to a degree, 'naturalistic' research whereby we were entering into the 'worlds' of those we were researching to understand their experiences of health policy. As a consequence, this research becomes unavoidably intrusive, despite our attempts to minimise this issue. The implications of this encountered through this research project are discussed below.

Furthermore, it was documented in Chapter 3 that due to the anonymous nature of the questionnaire, it was not possible to identify the questionnaires completed by the pupils who participated in the interview. Links between findings from the two datasets were made where possible and these revealed young people's experiences of their health education at a school level. However, it was not possible to analyse an individual pupils' questionnaire and interview data together which resulted in an uneven spread of pupil interview data across the three schools. As noted in Section 3.3, this has meant that the study has addressed research questions 1, 2 and 5 more successfully than it has 3 and 4. Nevertheless, the analyses presented in this thesis serve as a starting point for a more nuanced understanding of young people's experiences of 'health' within and beyond their schooling. Scope for future research to build on this is discussed later in the chapter.

10.2.2 Impression Management

Despite briefing the health educators and distributing an information letter to pupils' parents/carers (see Appendix 1) it appeared that our research may have been (mis)interpreted as a health promotion/surveillance project. For example, a small number of parents/carers opted their child/children out of the research project. Whilst there could be any number of reasons for this, some of the teachers' and pupils' (mis)interpretations of our research suggest that we were unable to remove ourselves from the health and obesity discourses we were researching and therefore inadvertently positioned parents, teachers and pupils as lacking and

inferior. For instance, it was clear that teachers at Westwood Primary School (Chapter 5) and Grange Park High School (Chapter 6) saw our presence in their school as an opportunity to showcase their health promotion work, e.g., teachers at Westwood were keen to report that they were enacting the criteria of the government's National Healthy Schools Programme long before the UK government had introduced the initiative and therefore little needed to be altered in their existing health practices to obtain 'Healthy School Status' and teachers at Grange Park High School enthusiastically offered to take us on a tour of their PE and Food Technology departments. In light of these responses to our research, it is perhaps unsurprising that many of the pupils in this research project were selected for participation by their teachers, rather than freely volunteering themselves, thus raising questions over the 'type' of pupils included in this study and the extent to which they were representative of the pupils in their school, i.e., were these pupils selected on the basis that they were considered by their teachers to be amongst the highest achieving, most confident and/or 'healthy' pupils in their school? Wyness (2006, p.194) points out that "for many researchers working with children, adult gatekeepers remain the last point at which access to a child population may or may not be granted". This highlights the importance of managing the perceptions and expectations of gatekeepers in order to meet the aims of a research project, without discouraging their participation. Whilst recognising that it is not possible to include all 'types' of pupil in a research project, this does point to a need for alternative sampling techniques which minimise gatekeepers' and participants' (mis)perception of future research projects to ensure the inclusion of other pupils whose experiences of their health education may have gone unheard.

The pupil participants also appeared to assume that our presence in their school meant that we were health promotion experts. For example, upon seeking clarification of the questionnaire prompt "I learned about health in school from…" a pupil at Westwood responded with "teachers, *people like you*", indicating that, to them, we were health 'experts'/proponents of the very discourse we had set out to critique. On other occasions, some of the young people sought our advice (e.g., about their weight loss), again emphasising the children's (mis)interpretation of us (the researchers) as health 'experts'.

Whilst these assumptions about who we were provide further insight into and confirmation of the pressures parents, teachers and pupils are under to 'perform' health, they could have influenced their responses to our research and specifically teachers' and pupils' answers to

our questions, therefore limiting our understanding of pupils' subjective, embodied experiences of their health education. The above scenarios raise pertinent questions regarding impression management in research projects, i.e., the way in which we, as researchers, do or do not influence the interpretations of those involved in the research process. This has prompted me to critically reflect on the role of a researcher in this process. Greene and Hill (2005) discuss the ethics of concealing particular aspects of research, for example, allowing participants and/or gatekeepers to assume our research intentions, rightly or wrongly, without correction where necessary. Hence, in order to meet the aims of a research project as fully as possible and to maintain an ethically sound research project, it seems imperative to ensure that all gatekeepers and participants have fully and accurately understood the purposes of the research they are participating in.

10.2.3 Researching Young People's Experience

Greene and Hill attest that those researching children's experience assume that it is possible to do so by "enquiring into their active engagement with their material and social worlds, *and* from their own reports on their subjective world" (2005, p.6). With an emphasis placed on subjective, embodied experience within this research, it is imperative to acknowledge the limitations in accessing the experiences of another person. For instance, there will always be elements of a child's (or adult's) experience that will remain, at least in part, "inaccessible to the outsider" (ibid., p.5). An individual's experience, in its entirety, always extends beyond our 'researchability', due to the researcher relying upon the participant's memory, awareness and willingness to disclose information. Nevertheless, Stainton-Rogers and Stainton-Rogers (1992, p.162) contend that "what we [researchers] are aiming for is an increased level of understanding, albeit a partial understanding, of children's experience and the ways in which they process it, mentally, physically and behaviourally". Moreover, contemporary understandings of experience as 'socially mediated' shift this view of experience, as partially inaccessible, away from the individual towards a shared concept which can be interpreted through language and discourse. Whilst it is acknowledged that not all experience is entirely constituted by discourse, (for example that which involves material and sensational foundations such as physical pain), discourse does remain a powerful source in creating and mediating meaning around health and the body.

Despite freely offering their thoughts around health in general and attitudes towards their school's attempts to promote health, several children displayed unease on varying levels when posed with questions about their own bodies. It was only at this stage of the interview

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process that the body language of some of the pupils altered; recoiling, looking down, speaking quieter and in shorter sentences than previously noted, for example. This was particularly the case with children who expressed 'troubled' relationships with their weight/size, particularly those who considered themselves to be 'overweight', despite our observation of no apparent weight issue. On one occasion, a 14-year-old girl was reduced to tears when talking about how she felt about her own body, highlighting the sensitivities this topic invokes. The way in which this situation was dealt with was imperative to the ethics of this research. In line with the informed consent process, the child in question was given the opportunity to withdraw from the interview, however, she declined and expressed a willingness to continue. As a result of this incident, relevant questions were 'depersonalised' without losing sight of what it was we were seeking to understand – why children feel the way they do about their bodies. Rather than asking "how do you feel about your body", we asked "what makes young people think about their bodies", to which the pupils, more often than not, responded with reference to a family member or friend.

Several questions arise when reflecting on this case. For example, would this child's parent/teacher have given consent for their participation in our research knowing that it would have affected them in this way? It is of course possible that this child's parent/teacher did not object to their child taking part because they were unaware of the issues the child expressed. This raises questions about the nature of parent/teacher consent, particularly when parents/teachers are unaware of any issues the child/children in their care may have with their bodies. Some weeks after collecting this data, we were given the opportunity to revisit the school in which this incident occurred, although contact was not made with pupils on this occasion. Through discussion with one of the teachers, we became aware that the teachers were unaware of this and any other negative impacts our research might have had on the children and it became apparent that a communication/knowledge gap existed between pupils and teachers in relation to such issues.

Hill (2005, p.80) reports "the Society for Research in Child Development (1991) advocates care in the reporting of findings and taking appropriate action if there are any undesirable consequences". It is therefore down to the researcher's judgement to decide what constitutes 'appropriate action' in the context of the 'undesirable consequences' in their own research. In order to obtain ethical approval for this research from the University's Ethical Advisory Committee, the committee requested that "protocols were in place to provide information,

support and guidance to parents should their children become unduly stressed by sensitive issues raised". In the case of this research project, this meant referring to an appropriate member of staff to make them aware of issues arising as a result of our research. However, having guaranteed the participants' confidentiality and anonymity, individual pupils' names could not be revealed. That said, there are occasions when there are limits to confidentiality offered to research participants and it is widely noted that researchers have a responsibility for 'disclosure' if a (child) participant reveals risk of harm (to themselves or others) or illegal behaviour (e.g., information on self-harm, evidence suggesting abuse) (British Educational Research Association, 2011). In such cases it is important that, where possible, the researcher discusses "their intentions and reasons for disclosure" with the child and/or their parents/guardians first (ibid., p.8; Morrow, 2008).

In addition to the adverse effects of the research process (e.g., unease, distress, etc.,) outlined above, some interview questions and questionnaire prompts sparked laughter amongst the pupils, indicating that perhaps the children felt embarrassed about answering such questions. Furthermore, during questionnaire completion, many children seemed anxious to find out what their friends had written in response to several of the questions, which may have reflected their unease with answering some of the questions, and therefore their desire to agree with their peers. This is, perhaps, indicative of pupils being conscious of what others and we as researchers think about them and/or their health as they seek to provide 'socially desirable' responses (Greene and Hill, 2005), particularly in light of their (mis)perception of us as 'health experts'. Alternatively their lack of understanding and/or familiarity with such questioning could also account for this.

Resistance

Hill (2005) discusses reasons for child participants' reluctance to engage with and respond to interview questions, and the extent to which the research can or should probe the child in an attempt to engage them with the questions posed to them. Hill (2005) also questions the extent to which the research can reflect on these "communication difficulties", i.e., why do they occur and to what extent can you read into or analyse their meaning? Williamson and Butler (1995, p.69) conclude "quite how one copes with the "dunnos", "all rights", "not sures" and "OKs", we dunno". This issue resonates with an encounter at Westwood Primary School (Chapter 5), whereby one of the pupil's answers were almost always monosyllabic and followed his interview partner's responses, hence he would respond with "same" and "yeah". This 'resistance' may be a result of the child being selected to participate in the

interview, rather than freely volunteering her/himself. This further problematises the role adults play when providing consent on behalf of children. It also draws attention to the way in which existing research methods tend to privilege the articulate, opinionated and extroverted child, when some children are inevitably quieter and more introverted than others. Consideration of alternative methods that can help to facilitate the thoughts and opinions of other (less articulate or extroverted) young people, e.g., photo voice and visual ethnography (Pink, 2007) is therefore required.

Compliance

Despite efforts to reduce children's compliance, e.g., through actively involving them in the interview process, a number of pupils displayed a tendency to provide responses that they believed we, as researchers, were seeking, rather than speaking freely and truthfully. Greene and Hill (2005) refer to this as 'social desirability', i.e., the impulse to present oneself in a way that is socially acceptable to others. Children are no exception here, which became apparent during data collection. Firstly, a number of children were hesitant to answer certain questions, particularly those enquiring into their own engagement with 'health' (levels of physical activity, diet etc.) whereby they may have felt that their efforts were perhaps inadequate and would therefore be unacceptable in the eyes of the researcher and/or fellow interviewees. Occasionally, children would wait for their interview partner to respond before offering their own accounts. Furthermore, compliance can involve lying and deceit, which may not always be apparent to the researcher who is relying on the participant to provide a reliable account of their lived experience. However, Kagan (1984, p.278 in Greene and Hill, 2005) asserts that whilst we must reflect upon subjective interpretations, 'we do not have to accept it in our objectively framed explanation'.

'Indifference'

Another response we encountered, but, admittedly, did not anticipate or account for came from a small number of children who had volunteered to participate in our research, not out of genuine interest it seemed, but as a means by which to be excused from their school lessons. It was noted that in such instances the pupils lacked interest and therefore offered data of little relevance and use to the project. It must be said, though, that this was not the case in every school and was, in fact, unique to the economically 'deprived' and ethnically diverse schools whereby pupils were given a greater sense of autonomy compared with those in the middle class schools who were selected by their teachers to participate. Other than to

point to pupils' individuality, we, as researchers and indeed outsiders, are in no position to offer further explanation as to why this indifference may have occurred.

'Storying' Health Messages

It is clear from the literature and empirical research outlined within this thesis that health is constantly 'storied' into existence through discourse and narrative. At times, it became apparent that this research inadvertently contributed to the 'storying' of health messages. For instance, by simply talking to the children about weight, for example, we were refreshing their minds with the messages and discourses they were exposed to around weight, i.e., the discourses we had set out to problematise through our research. An ethnographic study, whereby participants were unaware of our purpose would, perhaps, have helped overcome this issue through a more discrete approach to the enquiry, however, the intrusive nature of our research meant that we were entering into a specific setting to talk about a given subject in a less than subtle manner whereby it was very difficult to neutralise ourselves.

Self-Regulating Behaviours

A significant and alarming finding was that several children self-regulated their diets in order to 'avoid gaining weight' or 'becoming obese'. One girl, aged 10, claimed "I feel really happy with myself because I've gone on a bit of a diet. This morning I didn't have any breakfast". Questions arise, however, around a researcher's role in reporting such findings or dealing with certain types of data, i.e., such data prompts us to ask what the role of the researcher is beyond enquiry. What are the researcher's obligations? In this case, these questions are based upon health behaviours which are potentially harmful. But should we cross the boundary of confidentiality in order to safeguard such pupils from the self-destructing behaviours they are adopting at such young ages? The University Ethical Advisory Committee required appropriate protocols to be in place to deal with such cases, and bound by the anonymity and confidentiality we had assured our pupil participants with, we could only alert teachers to generalised comments from an unnamed pupil in their class.

The issues listed above, arising from one research project involving children, are by no means exhaustive and it is not always possible for a researcher to account for such issues. It is, however, essential for a researcher to be aware "and take account of their own position as an enquirer" (Davis, Watson and Cunningham-Burley, 2000, p.8), which is particularly applicable to research involving children whereby the adult researcher brings "a particular package of attitudes and feelings, constructed through our own personal childhood history

and our contemporary perspective on childhood" (Greene and Hill, 2005, p.8). Although it is not possible to enter into a research situation without this "package of attitudes and feelings" (ibid.), it is within the researcher's capabilities and responsibilities to minimise the impact of our position on the research process and subsequent generation of data. The active involvement of our child participants in the interviews contributed significantly to this.

10.3 Future Research

The findings presented in this thesis offer valuable contribution to understandings of young people's subjective, embodied experiences of their school health education and social class emerged as a key theme through teachers' and pupils' accounts of their experiences. However, this project is by no means *a fait accompli*. For example, further research and theorisation is needed to consider how dominant health discourses found in schools and the classed experiences featured in this project "intersect with, and work with, gendered and raced discourses in contemporary school physical and health education contexts" (O'Flynn, 2010, p.435-6). However, Flintoff, Fitzgerald and Scraton (2008) draw attention to some of the key issues that can arise when researching such 'intersections'. With reference to Penney (2002), they suggest in particular that

> how differences are conceived, which differences get noted and why some and not other differences are viewed as significant or relevant and by whom, are important questions for those wishing to make a difference in education (p.73).

Furthermore, in order to address the aims of the research, emphasis has been placed on *young people's* embodiment. However, recent research (e.g., Webb and Quennerstedt, 2010) has also underlined the significance of teachers' embodied experiences of health discourse. The implications of this for young people's experiences of health education could offer further lines of inquiry to better understand health policy processes as well as young people's situated and affective experiences of 'health'.

The analyses presented in this thesis have also pointed to a need for further exploration of how school health policies and associated pedagogies 'play out' in the lives of young people *beyond schooling*, and with what affect/effect on their developing sense of self. This resonates with the work of others (e.g., Holroyd, 2003) who have focused their attention on young people's identity and subjectivity formation across key sites of influence comprising home, school, peers, and media. Less is known, however, about the ways in which a young

person experiences and indeed embodies apparent synergies or tensions between health- (and specifically weight-) related pedagogies experienced in school and those found within these other key sites. Such research has the potential to advance current understanding of the relationships between pedagogy and subjectivity beyond schools and, more specifically, to contribute to nuanced understandings of the fluidity of young people's subjectivity and embodiment across time, place and space.

10.4 Closing Comments

This study has contributed to and broadened understandings of young people's subjective, embodied experiences of their school health education (specifically the ways their experiences shape the relationships they develop with their weight/size). It has highlighted in particular the complexity of the policy process itself as a product of the organisational and social relations of schooling, as well as the situated and affective dimensions of young people's embodied subjectivities in relation to this. Furthermore, the original contribution of this project lies with the implications of young people's experiences of dominant and narrow definitions of health for their developing sense of self, i.e., the ways in which this constructs young people's sense of belonging and empowerment as conditional upon their achievement and performance of narrowly defined health imperatives. Health educators' uncritical acceptance of this discourse and their subsequent enactment of didactic, behaviourist pedagogies have been found to contribute to the reproduction and reinforcement of class hierarchies. Thus, any alternative approaches to educating young people about 'health' in schools must, first and foremost, be grounded in young people's subjectivities; the resources and experiences they bring to their pedagogic encounters in schools. As mentioned previously, the challenges this poses for ITE and the roles of future health educators are not to be underestimated and this thesis is merely a starting point for such considerations.

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Appendices

Appendix 1: Parents' Informed Consent Form

Appendix 2: Semi-Structured Interview Guide – Teachers

Example Interview Transcript – Teachers

Appendix 3: Pupil Questionnaire

Appendix 4: Semi-Structured Interview Guide – Pupils

Example Interview Transcript – Pupils

Appendix 5: Example Field Notes – Fielding Community

College

Appendix 6: Nvivo Coding Example

Appendix 1

Parents' Informed Consent Form

Loughborough University

[Date]

Dear Parent/Carer

[Name of school] has agreed to participate in a research project that is being carried out by researchers at Loughborough University. This letter provides information about the project.

Who we are:
We are a team of researchers based at Loughborough University. Our names are:

Name	Role	Contact Details
Dr. Emma Rich	Principal Investigator	E.J.Rich@lboro.ac.uk
Prof. John Evans	Co-investigator	John.Evans@lboro.ac.uk
Dr. Tina Byrom	Research Associate	T.Byrom@lboro.ac.uk
Laura De Pian	PhD Research Student	L.De-Pian@lboro.ac.uk

What the project is about:
The project aims to investigate pupils' and teachers' understandings of health and physical activity, along with their views on current health and physical education initiatives. We will not be asking your child about their own personal health.

What we would like to do:
There are two parts to the project: a paper based questionnaire and an interview.

Questionnaire
The questionnaire will be used to explore how young people understand health related issues. Any information gathered from the questionnaire will be treated as confidential.

Interview
A small number of young people will be randomly selected by the school, although this may not include your child. Each interview would last approximately 30/40 minutes. Questions will be appropriate to the age of your child. Children will be interviewed in pairs and their views audibly recorded. This information will then be stored in a locked room at Loughborough University.

Further information:
Your child is free to withdraw from the research at any time if they choose to do so. We will not ask for any reason to be given. We will feedback results to your child's school. All children who take part in this research will remain anonymous. If you would like some further information about the project, please contact any member of the above team by e-mail, or telephone 01509 228451.

We would really value your child's participation in this project. However, if you do **not** wish your child to take part, please complete the tear-off slip below and return it to your child's school.

Thank you for taking the time to read this. Your child's participation will be invaluable to our ongoing research in this area.

With best wishes

Laura De Pian   *Tina Byrom*

Laura De Pian (PhD Research Student) and Dr. Tina Byrom (Research Associate)

Please complete this tear-off slip and return to school by [date].

I do **not** consent to my child/children taking part in this research

Name of child/children ....

Form/Class Teacher ....

Signed ....

Relationship to the child/children .... (Mother/Father/Carer)

Appendix 2

Semi-Structured Interview Guide – Teachers

Example Interview Transcript – Teachers

Semi-Structured Interview Guide – Teachers

[Explain the interview plan, ethical procedures etc.]

Topic 1: Young People's Health

What do you think they key issues are for young people's health?

    Where do those ideas come from?

Do you think we should be worried about the state of young people's health?

    Why?

What role do you see physical activity playing in young people's health?

What role do you see diet playing in young people's health?

Topic 2: Health/Obesity in Schools

What do you think about all the attention the government is giving to obesity at the moment?

Has the government's attention to obesity had an impact on the way you/school consider young people's health?

Do you think obesity is something you/the government should be paying attention to?

    Why?

Do you think the other teachers in the school share your view or offer different views on the role of schools in addressing young people's health/obesity?

Topic 3: Young People's Health in Your School

What do you think the purpose of health education is in your school?

    Does this differ between PE/PSHE?

What do you think the responsibility of the school is in addressing individuals' health issues?

Does your school focus on any particular health issues?

    Why?

    Does your school focus on fitness?

What are the keys messages your school delivers to the pupils?

    Check: Diet, physical activity, weight/obesity

How do you deliver these messages?

    Strategies, initiatives, policies, rules, curriculum, activities, facilities, events

    Check: Are any of these documents available to borrow/photocopy?

    Do you monitor the pupils' health/fitness in any way?

How does the school make decisions about which health initiatives to have in the school?

    Who makes these decisions?

Has the health focus within the school changed over time?

    What was the motivation behind these changes?

Topic 4: Pupils' Responses

Where do you think the pupils in your school get their ideas about health from?

How do you think young people in your school are dealing with all the attention on their health, diet, body shape and physical activity?

Do you think the pupils in this school worry about physical activity, diet and their weight?

    What sorts of things do they say?

Are you aware of any children being teased/bullied about their weight/size in this school?

    How is this dealt with?

Example Interview Transcript – Teachers (Jess, Westwood Primary School)

TB: Could we start by you saying your name, your role in this school and how long you've been in that post?

JESS: Right, I'm Jess: and I am Key Stage One teacher with Reception Year One and I've been here for six years

TB: And you're the PE Coordinator?

JESS: Yeah, I've got a few roles with it being a small school. So I'm PE Coordinator, Literacy Coordinator and International Schools Coordinator

TB: Right, so that sounds like quite a big amount of work?

JESS: Yes, it can be

TB: OK, so us being in here grabbing half an hour of your time is really annoying so we really appreciate your time

LDP: We just want to talk through a few questions on the health of young people

JESS: Right

LDP: So what do you think the key issues are for young peoples' health?

JESS: Obviously to keep fit and get their 15 minutes in a day. Our PE sessions are usually two hours a week and obviously tackling the obesity crisis there is out there

TB: Do you think there is an obesity crisis out there?

JESS: Yes, I think there is

TB: What makes you think that?

JESS: I don't think we have a problem, personally, in this school or this village in particular, but nationally I think we are going down the American route as it were. Just from what you read in the paper, seeing people in the streets. People don't exercise as much anymore. People have got busy lives now with work load, family, and they may not fit it in. Personally, I come from a very sporty background; my family are quite sporty, so personally I think it's important, that's why I've taken on the PE role. But society in general I don't think is a sporty culture necessarily

TB: Right, and do you see it as your role as a teacher to tackle that issue in school?

JESS: Not necessarily tackle the issue but just to, as a teacher, make the children aware of how their bodies change, how it's healthy for them, what it does for them and the enjoyment side of it, especially through the PE some of the children may find it a bit of a chore and the fun element of it really

TB: OK, can I just probe you a little bit more about the PE lessons themselves?

JESS: Yep

TB: What sorts of things do you do with the children in PE?

JESS: We have quite a lot of outside agencies coming in at the moment. I've got a lot of funding, so I think the Government are putting a lot of money into providing high quality PE for schools. I mean we have a lot of PE, a range on offer right throughout the year. We have two gentlemen come in to do the multisport and they do whatever you ask them to do really and they've got their own scheme of work as well, so, for example, they do netball with the older children, they've done hockey, they do all the children, they do all the classes, they do that on a Tuesday afternoon. And then one of the classes has got badminton happening and then we have dancing after school, I do cross-country after school, somebody else does netball so we've got a huge range and then in the summer I get funding for racket sports so I use that for tennis, and then we have golf lessons for the children, so we do offer a lot here

TB: There's a wide range of activities?

JESS: Yeah, and sometimes it's difficult for children to choose which one they do 'cause time, they have to choose things sometimes. But we mostly rely on outside agencies and funding that comes in because there's only four or five staff and I'm really the only PE

TB: You've talked a little bit about an obesity crisis and you've also talked a bit about the activities that are available for the young people in this school. Have you noticed any change in the young people in the way they feel about their bodies and the size or shape that they are because of this obesity crisis or the messages on obesity that are everywhere?

JESS: Yeah, I think you'd probably see it more in other schools than in ours. But I've noticed it with the older children

TB: What happens?

JESS: They're reading magazines and things like that and you can hear them in their little peer groups and I think they're more conscious about the way they look and fashion

TB: So what sorts of things do they say?

JESS: They're talking about fashion and what's in fashion and have they got this and there's that peer pressure to look good and have their hair cut and do it like this, you know?

TB: What sort of age are we talking about?

JESS: I've heard them in this room [points to Y5/6 classroom]

TB: So Year Fives and Sixes?

JESS: Yeah, sort of nine upwards, but it can start quite young with them talking about the way they look. Or, you know, somebody might call someone else fat and they're not. Like in my room with a four-year-old, but it has a lasting effect on a child. The chid that's said it may not even know what it actually means. For example, one of mine used it the other day completely out of context but the child who had the name called at them went home and had the parents in and obviously I was quite sympathetic because it can have a lasting effect. So I think things are starting young because they're hearing things on the news, out there. With the older children, I wasn't as fashion conscious and as conscious about my body as they are now, this young

TB: Do you think they're more conscious about things like fashion and dress sense rather than body size and shape?

JESS: I think it's both. The children will notice if one of the others is eating too many crisps or coke

TB: Right, why do you think they would notice that?

JESS: I think these children generally are quite healthy

TB: Right

JESS: I mean it's a very affluent area and the parents are well educated so that has a knock-on effect I think with the children. They do take Healthy Schools quite seriously; they will provide healthy snacks most of the time. We get the odd few that will come in with crisps in their bags and things like that and I think especially in this school it is noticed

TB: Right, and it's noticed because you have a focus on healthy eating?

JESS: Yeah

TB: Right, OK

LDP: What do you think about level of attention that's been directed towards young peoples' health?

JESS: It's difficult. Coming from a PE background myself, I'm very PE, I love PE and I think there's a lot of other curriculum things that could be done through PE, especially the children at my age, but staff find it hard to fit everything in, especially in Class Four with the Year Fives and Sixes so although we've got all this money coming in and lots of people wanting to come and offer us free clubs, it's difficult to fit it in curriculum time so we do the two hours a week and the staff are very good, they'll concentrate on it and we'll do it through PSHE and things like that but other than that it's difficult to address things, or to address everything

TB: So in your ideal world, if you were responsible for timetabling, how would you go about it?

JESS: I mean, you've got to weigh things up and the two hours a week is probably enough but I'm talking about our school and our setting

TB: Two hours curriculum time?

JESS: Yes

TB: So outside of that?

JESS: We've got a lot outside of school so our children are getting what I think is high quality and a lot of sport that's there available to them. They may not necessarily take it up. So every class does their two sessions a week, with the majority of time we're allowed up to two hours

TB: What proportion of young people in this school would you say take up the extra-curricular sports?

JESS: I have to fill a form out every year, I have to go round them all and there aren't many that don't do an after-school club to be honest. The majority do something, whether it's cross-country or netball, and we try to have a range 'cause some don't like running yet they like the netball, which seems to be popular with the girls. We've got football as well, so we've got clubs that are open to all sorts of children and the majority of them, I think, do participate. We've even got the sports development people that come in for the little ones so it's open to them as well and we've got a dance lady coming in now again, that's for Key Stage One as well. We did have an issue where Key Stage One weren't getting many after school clubs because you couldn't find the people for their age, and obviously, with only being four staff there's only so much we can do as well, but we've got the PE open to all of them so they are getting a lot compared to other schools

TB: You also mention something about the two hours curriculum time being enough for a school like this, it was almost as if you were going to go on to say for some schools that might not be enough, could you say a bit more about that?

JESS: Well it's a balance, isn't it? Being a PE person I think there's some schools that may have a lot of children that are overweight, they may need to do more PE and if it's a cross-curricular school then maybe other things could be brought into that PE session

TB: Have you ever worked in a school where a large percentage of the children were overweight?

JESS: I haven't, no, so then again they would argue they've got to fit in all these other curriculum things so...

TB: Time is really pressurised isn't it?

JESS: It is, yes, so I mean national average, two hours a week, I think's enough curriculum time, yeah

TB: OK

LDP: We've touched on the fact that some of the kids are aware of body shape and size. Do you think they have any major concerns about body shape and size?

JESS: Major concerns, not until they get to this age [points to Y5/6 classroom]. I think our children do lead quite a sheltered life to be quite honest and I think when they go to secondary school it hits them more, but as I say, you do hear them in the class

TB: OK, speaking with Claire we were talking about the key messages of health and what you think they would be. Have you got any ideas about what the key messages are about health?

JESS: I think just all the things we do through PE and science and PSHE about the healthy eating, why things are healthy, why are they not healthy for you? Eating in moderation, why we need to exercise, what it does for our bodies, making the children aware. Even at four years old, we put our hand on our heart and they recognise that exercise is good for you because it makes your heart beat, so all those messages are given out by the staff

TB: What do you think your specific role is in delivering those messages?

JESS: I think it's just to teach them basically, and be aware of. We can't push anything too much but to offer things that we do and to just make them aware really

TB: OK, great, thank you

LDP: We just want to talk a bit about obesity in schools. What impact do you think the current media and policy focus has had on this school, if any?

JESS: In terms of obesity, I'm not quite sure really. We've had no documents coming through or anything

TB: None on obesity?

JESS: No, not that I've seen

LDP: OK

JESS: Obviously I've noticed the funding, the amount of funding that's coming through and the amount of clubs and associations that are obviously being paid from the Government, or somewhere, to deliver PE in schools, and sometimes you have that many that are coming in that you have to select which ones you want to take up

TB: OK, so that has been a change recently?

JESS: Yeah, especially over the last couple of years. I mean I've been here for six years and definitely over the last two years there's a huge amount of money that's been pumped into schools. I mean I go on courses and people don't seem to be offered what we're offered and they must be, 'cause it's out there and I think either schools are deleting emails or the information is not getting to them from Heads or, I don't know

LDP: Is it ring-fenced money that's directed at something in particular?

JESS: There's a huge range. I often get emails coming through and I give my personal email out now so that people can contact me but our Head's very good at passing things on, she will pass them on and let you decide. So I have ring-fenced money yes, I have so much money for racket sport, I've got a range of money for different sports and then as I say you've got all these people emailing you saying we can come in for six weeks to deliver football and sometimes that carries on 'cause we've got a gentleman coming in now who's doing football. Key Stage One football they were focussing on and it was supposed to be just for six weeks because they've recognised that they're not getting at the Key Stage One, and where that's come from I don't know, maybe the Government, I don't know, it's the younger ones they're trying to target and I think they've got some more money and they're continuing it so we've now got another six weeks and that's open to the children in curriculum time and then out of school as well

LDP: OK

JESS: It's nice that I have that money and I have to use it for that because sometimes money comes into school that's supposed to be used for something but it doesn't always get used, so it's nice that that money's coming to me and it's for that, you can't use it for anything else

TB: Why do you think schools are being given such a large role in tackling the issue of obesity?

JESS: Probably because of the obesity crisis out there, young people on the streets. You hear it all on the news, don't you? Trying to tackle that side of it as well

TB: Do you think it's right that schools should have that role? What's your personal opinion on that?

JESS: Yes and no. I think we have a duty to educate the children, that's what we're here for. But in terms of pushing it, there's only so much we can do. So I personally think we do the best for the children in this school and, as I say, the amount of sport they get offered to them, both in and out of school, is great and we do teach healthy eating through the science, PSHE, assemblies, a lot of other things. Our topics are cross-curricular so lots of things come into that as well

TB: Do you advise them what they can bring in for their lunch?

JESS: I think that was the next thing that Claire was going to tackle

TB: Right

JESS: We spent a lot of time on the healthy snacks and that was a really big thing in school, so that's kind of been tackled, and the lunches is the next thing to be tackled

LDP: So what do you think about the fact that the Government's involved in children and young peoples' health?

JESS: Well, without the Government's interest in the PE I wouldn't have had all this funding really

TB: So it has had a direct impact on your role, hasn't it?

JESS: Yes, so I think in terms of the money coming in, its obviously been coming from the Government initiatives and I think it's great but I don't think, for whatever reason, it's getting into a lot of schools, I don't know why

TB: Is it available to all schools, the funding?

JESS: Not sure. I know my money comes from [funding body] and that's [county] so in terms of [county] schools, they will be getting what I get. Other counties I don't know what they get

LDP: What impact do you feel that recent Government initiatives to improve children's nutrition and physical activity have had in schools?

JESS: I think it's had a real positive effect in this school. The Government can do these things but it's filtered down, isn't it? And then it's up to other people to deliver them

TB: You've mentioned a whole host of physical activities, clubs and sports that the young people can get involved in. You've also mentioned the healthy snack focus and you've also mentioned that you're now going to be working on lunches. Is there anything else that's been introduced in the school as a result of the Government's attention to this issue or do you think that's it?

JESS: I don't think so

TB: No, OK

JESS: If you gave me some examples it might jog my memory

TB: No, I'm just wondering if there's anything else

JESS: We've got the fruit scheme

TB: Oh yes, that's for the Foundation Stage, isn't it?

JESS: Yes, and sometimes, if they don't eat it or we've got a lot left over, we get loads of fruit coming through, we offer it to the Key Stage Two

TB: Right, OK. Is there anything that you think should be introduced to schools, to promote young people's health and physical activity?

JESS: As I say, I don't know about other counties but [county] get a lot and we use it, so it depends on the school and if they use it, but I think we get enough and, I say, we use it and make use of it

TB: OK, thank you. I guess what I'm interested in is this balance and the focus in PE lessons. When you're talking to young people about physical activity, how is it packaged? What message is there for them? Are they taking part in these activities for fun, or for pleasure, to get fit or to lose weight? How is it put across to the young people?

JESS: You've got the keeping healthy side there and why we're doing that kind of thing but the kids have got to enjoy it. So yes, all those messages will be sent through

TB: Is one more of a key message than another?

JESS: I think my personal view is if they're not enjoying it, they're not going to get a lot from it, so enjoyment is at the heart of. The previous Head was very competitive, and yes, there was a lot of sport in school but his message was competitive, competitive, we've got to win, win and a lot of children were put off by that. So you're almost failing in the other messages because they've not got the enjoyment aspect, if you see what I mean. Whereas now it's more enjoyment and yes, it's good to win but I think the other messages are getting through

LDP: Is there anything else that you want to add about PE lessons in this school?

JESS: I don't think so

TB: So they do a range of activities, presumably they follow the statutory guidelines for PE, do they?

JESS: Yeah, they swim as well. They call it Top-Up Swim and if the children aren't swimming their 25 meters they are able to go and have some top-up training and I think that might be funded as well

TB: Right, where do they do that?

JESS: I think it may be [town], [town] swimming pool

LDP: Where do you think children in your class get their ideas about health from?

JESS: You mean out of school, or in school?

LDP: Both really

JESS: Obviously they get very positive messages from the teaching aspect here and I think it depends on their family. These children, most of them, most of the time get quite a positive image of food and I think parents are quite selective with media and things like that so I think they get quite a positive image. But yeah, I think it depends on background and families

TB: How would you be able to tell whether the children are actually listening to what you're saying about health?

JESS: I think they take those messages on board and you'd probably see it as they got older, if you see what I mean, in their day-to-day lunches, do they enjoy playing sport in their own time? Those kind of messages I think

TB: I saw on the door in the classroom food words and the children had written some quite complicated words about food. Could you tell us about that?

JESS: It might have been topic related. In literacy we're having a big focus on language and basically if children haven't got the language then they'll struggle to write it, if you see what I mean, and their topic may have been food related so we've got these food words coming through, so that might be where that's come from

TB: Right, OK. Have you noticed any changes in young peoples' attitudes or thoughts about health issues since your school has gone more towards Healthy School Status?

JESS: I think they're a lot more conscious, whether that's subconscious or... They do bring healthy snacks and they want to

TB: Right, why do they want to?

JESS: I think because of the rewards, and it's a big thing

TB: Whose idea was it to initiate the rewards? The healthy snack award...

JESS: I'm not quite sure to be quite honest. I think it must be something to do with Claire and the Healthy Schools Award, and raising the awareness. I can't remember

TB: Right, OK. So you don't know whether that came from the Head or whether it came from the children themselves?

JESS: To be quite honest, I think we had discussions, when this healthy award came out. I remember us having discussions as staff about how we're going to tackle it, what we're going to do and I think most of it was discussed as a staff, it wasn't any one person's particular decision to have done that. It was a while ago

TB: Could we just ask you also about playtimes? What sort of things do they get up to at playtime?

JESS: Again, we've got money coming through, you've got the Tesco and Asda vouchers so with that I get quite a lot so I can order a good few times a year. I order PE equipment. Now, we're quite well resourced in the PE store for curriculum PE. So I spend usually half the money on the curriculum side of it and then half the money on our playground box so they get lots of games in there, they get skipping ropes, balls, all sorts of things that they can play with at play time and lunchtimes. They get a lot from it and we try and keep it topped up so they do use it and they'll play football

TB: And is that just in the playground ready for them to use as and when they want?

JESS: Yeah

TB: Is there anything else you'd like to say?

JESS: No, I don't think so

TB: Thank you ever so much for your time

LDP: Thank you

[End of interview]

Appendix 3

Pupil Questionnaire

You and Your Ideas About Health

We would like to find out about what you think about health and where you get your information from. To do this, we need you to answer the questions below.

Before you do this, we need to let you know a little bit more about what you will be doing.

- Tina and Laura would like to find out what you think about health, physical activity, diet and weight.

- If you don't want to write anything down that is okay and you won't get into trouble.

- If you get stuck on any questions you can ask for help.

- There are no right or wrong answers. If you don't want to answer some of the questions, that will be okay.

- Tina and Laura are using the answers you give for a project at Loughborough University.

- Tina and Laura will write about some of the things that you have written but they will not use your name.

- Your answers will be kept private and in a safe place.

- If you have any worries about this survey you can contact Tina and Laura.

How to answer the questions:

When you choose an answer, fill in the bubble next to it like this 🌑 not this ⊘

If you make a mistake, rub it out or cross it out neatly.

Use a pencil if you can, they're easier to rub out!

Loughborough University

E·S·R·C
ECONOMIC & SOCIAL RESEARCH COUNCIL
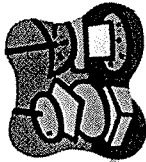
About You

1. **My age is:** *(please fill in the bubble next to your age)*

- ○ 9
- ○ 10
- ○ 11
- ○ 12
- ○ 13
- ○ 14
- ○ 15
- ○ 16

2. **I am:**

- ○ Male
- ○ Female

3. **I am** _____ **cm/ft tall** ○ Not sure

4. **I weigh** _____ **kg/stone** ○ Not sure

5. **I was born in the UK...**

- ○ Yes
- ○ No

6. **What jobs do the people who look after you do?**

Please write the job they do,
or fill in a bubble if they are not in paid work or if they are a student.

Mother

Job _____   ○ Not in paid work   ○ Student

Father

Job _____   ○ Not in paid work   ○ Student

Carer

Job _____   ○ Not in paid work   ○ Student

Other

(please state who looks after you: _____ *)*

Job _____   ○ Not in paid work   ○ Student

7. **I am:** *(please fill in a bubble next to the one that best describes you)*

White:

- ○ British
- ○ Irish
- ○ Other White

Mixed:

- ○ White and Black Caribbean
- ○ White and Black African
- ○ White and Asian
- ○ Other Mixed Background

Asian or Asian British:

- ○ Indian
- ○ Bangladeshi
- ○ Pakistani
- ○ Other Asian Background

Black or Black British:

- ○ Caribbean
- ○ African
- ○ Other Black Background

Chinese:

- ○ Chinese
- ○ Other Background

You and Your Body

Choose one bubble...

		Never	Sometimes	All the time	... and then write about it here
9.	I feel good about my body	○	○	○	I feel good about my body because:
10.	I like the way I look	○	○	○	I like the way I look because:
11.	I think about the way I look	○	○	○	When I think about the way I look I wish:
12.	I am happy about my current weight/size	○	○	○	I am happy about my current weight/size because:
13.	I have been called names about my weight or size	○	○	○	These are the names I have been called:
14.	I have been picked on because of my weight or size	○	○	○	This is what happened:
15.	I have tried to put weight on	○	○	○	I tried to put weight on by:
16.	I have tried to lose weight	○	○	○	I tried to lose weight by:

3

17. **The following people have made comments about my weight or size**
(please choose more than one if you need to)

- ○ Friends
- ○ Carers
- ○ Mum
- ○ Dad
- ○ Doctor
- ○ Teachers
- ○ Nobody
- ○ Sports Coach
- ○ Other family
- ○ People I don't like
- ○ People that don't like me
- ○ Other *(please say)*

18. **I have thought that I needed to lose weight because...**
(please choose more than one if you need to)

- ○ Someone told me to
- ○ Images in the media
- ○ I feel fat
- ○ Everyone else is thinner
- ○ I had stopped exercising
- ○ I don't like the way I look
- ○ I think it makes me healthier
- ○ Other *(please say)* _____

- ○ I have never thought that I needed to lose weight

19. **I have thought I needed to put weight on because...**
(please choose more than one if you need to)

- ○ I lost weight when ill
- ○ My body is too thin
- ○ I have been called skinny
- ○ My clothes didn't fit
- ○ Someone has told me to
- ○ Other *(please say)* _____
- ○ I think it makes me healthier

- ○ I have never thought I needed to put weight on

20. **A famous person I would like to look like is...**
(or fill in the bubble if you don't want to look like someone famous)

- ○ Nobody

_____

I would like to look like this person because

_____
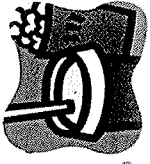
You and Your Ideas About Health

21. **Being healthy means...**
(list as many things as you can)

↑

22. **I can tell a person is healthy because...**
(finish the phrase)

↑

23. **The most important things that someone can do to stay healthy are...**
(list as many things as you can)

↑

24. **These are the things that stop people being healthy...**
(list as many things as you can)

↑

25. **A person's weight or size is linked to their health...**

⬆

    ◯   Yes

    ◯   No

I think this because: _____

_____

_____

26. **Being healthy is important to me because...**
(finish the phrase)

⬆

_____

_____

_____

27. **How healthy do you think you are?**
(fill in the bubble to say how healthy you think you are: 1=poor health, 10=fantastic health)

⬆

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

28. **I would be healthier if I...**
(finish the phrase)

⬆

_____

_____

_____

You and Learning About Health

29. I get my ideas about health from...
(please choose more than one if you need to)

- ○ Mum
- ○ Friends
- ○ Newspapers
- ○ TV
  (which programmes?) _____
- ○ Films
  (which films?) _____
- ○ Magazines
  (which ones?) _____
- ○ Books
  (which ones?) _____
- ○ Other
  (please say...) _____

- ○ Dad
- ○ Doctors
- ○ Health leaflets

- ○ Other family
- ○ Internet
- ○ Teachers

30. I learned about health in school from...
(please choose more than one if you need to)

- ○ Teachers
- ○ Visitors
- ○ Science lesson
- ○ Other
  (please say...) _____

- ○ Canteen staff
- ○ School nurse
- ○ PE lesson

- ○ Tutor
- ○ PSHE lesson
- ○ Leaflets

- ○ Friends
- ○ Posters
- ○ Special event

31. My school does these things to help young people stay healthy...
(please choose more than one if you need to)

- ○ Sports clubs
- ○ Fruit snacks
- ○ Weighing
- ○ Other *(please say...)* _____

- ○ Breakfast club
- ○ No fizzy drinks
- ○ Special event

- ○ Monitoring packed lunches
- ○ Healthy school meals
- ○ I don't know

32. I have been weighed at school...

○ Yes   ○ No

If YES: When I was weighed I felt *(please finish the phrase)*: _____

Could other young people see or hear your weight being recorded

○ Yes   ○ No

Please tell us who weighed you:

○ Teacher   ○ School nurse   ○ Tutor   ○ Other *(please say)*
_____

You and Your School Life

33. **I am doing well in these subjects at school**
(please choose all the ones you are doing well in)

○ English   ○ Maths   ○ Science   ○ Geography

○ History   ○ Music   ○ ICT   ○ PE

○ Languages   ○ RE   ○ PSHE   ○ Art & Design

○ Design & Technology   ○ Other

_____ *(please say...)*

34. **I know that I am doing well in these subjects because...**
(please choose as many as you need to)

○ My teacher says I am   ○ I get good grades   ○ I find the work easy

○ I am in top sets/groups   ○ I work hard at all subjects

○ I do better than friends   ○ I always finish first   ○ I have extra work

○ Other *(please say...)*

Choose one bubble...

	Never	**Sometimes**	**All the time**	*... and then write about it here*
35. Teachers say I have to do well at school	○	○	○	→ Teachers say this because:
36. The person who looks after me says I have to do well at school	○	○	○	→ They say this because:
37. I take part in sports clubs at school	○	○	○	→ I do this because:
38. I am in a sports team at school	○	○	○	→ I do this because:
39. I have school dinners at lunchtime	○	○	○	→ I do this because:
40. I bring in a packed lunch at lunctime	○	○	○	→ I do this because:

Your Ideas about Obesity

41. Being obese means

(please finish this phrase or fill in the bubble next to 'not sure' if you are unsure)

➔

_____

_____

O   Not sure

42. I have heard about obesity

(please choose more than one if you need to)

➔

O Mum	O Dad	O Other family
O Friends	O Doctors	O Internet
O Newspapers	O Health leaflets	O Teachers

O   TV _____
(which programmes?)

O   Films _____
(which films?)

O   Magazines _____
(which ones?)

O   Books _____
(which ones?)

O   Other _____
(please say…)

O   I haven't heard about obesity

43. **What does healthy eating mean to you?**
(please tell us your ideas about healthy eating)

➔

_____

_____

_____

44. **What does unhealthy eating mean to you?**
(please tell us your ideas about unhealthy eating)

➔

_____

_____

_____

45. **I know what an eating disorder is...**
(answer yes or no – if yes then say which eating disorders you know about)

➔

    ◯   Yes   ◯   No

These are the eating disorders I know about: _____

_____

_____

46. **I have heard about eating disorders from**
(please choose more than one if you need to)

↑

- ○ Mum
- ○ Friends
- ○ Newspapers

- ○ Dad
- ○ Doctors
- ○ Health leaflets

- ○ Other family
- ○ Internet
- ○ Teachers

- ○ TV
  (which programmes?) _____

- ○ Films
  (which films?) _____

- ○ Magazines
  (which ones?) _____

- ○ Books
  (which ones?) _____

- ○ Other
  (please say...) _____

- ○ I have never heard about eating disorders

Thank you so much for your help with this project

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Appendix 4
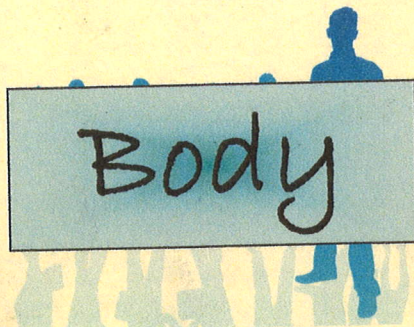
Semi-Structured Interview Guide – Pupils
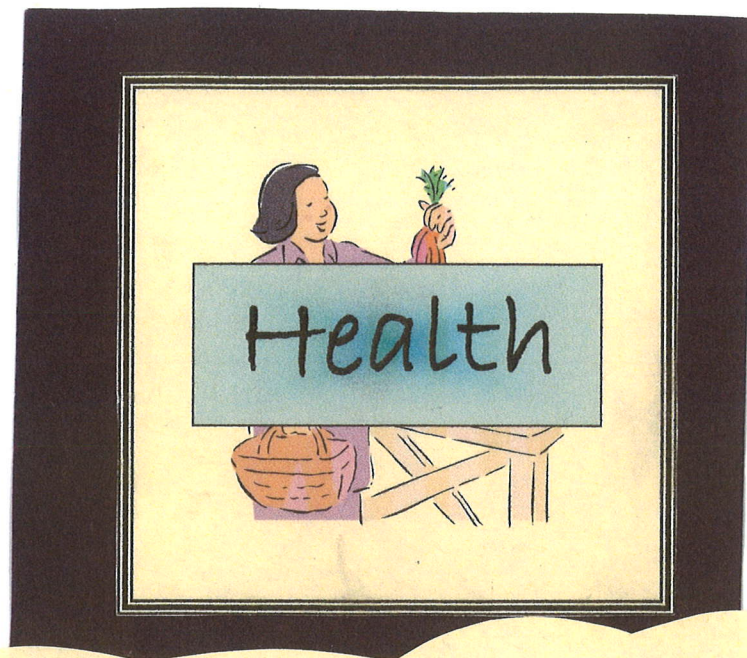
Example Interview Transcript – Pupils
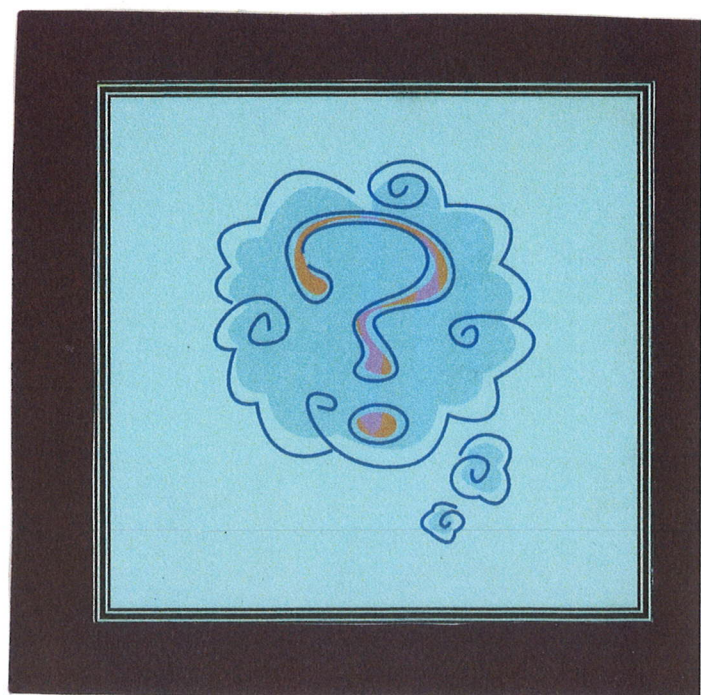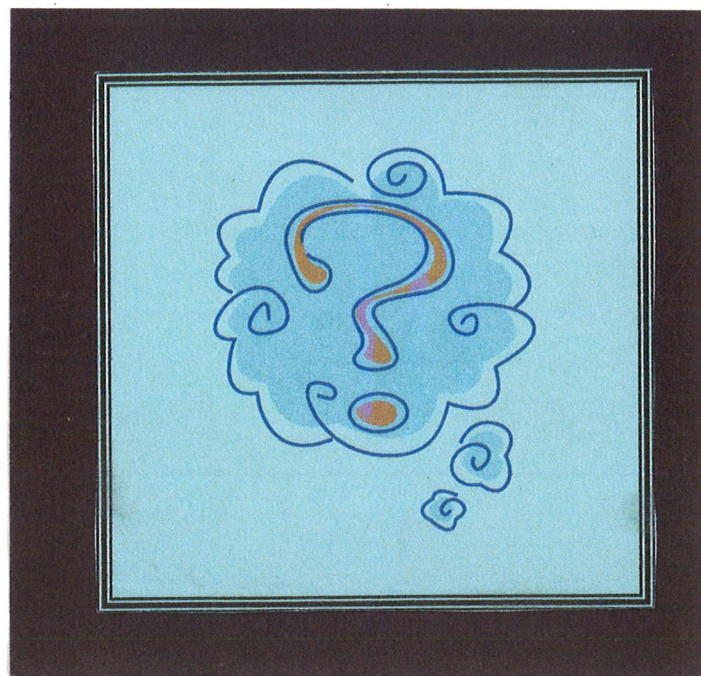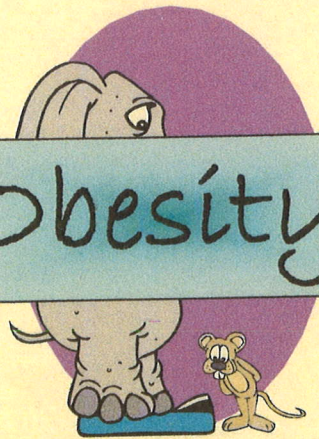
Health

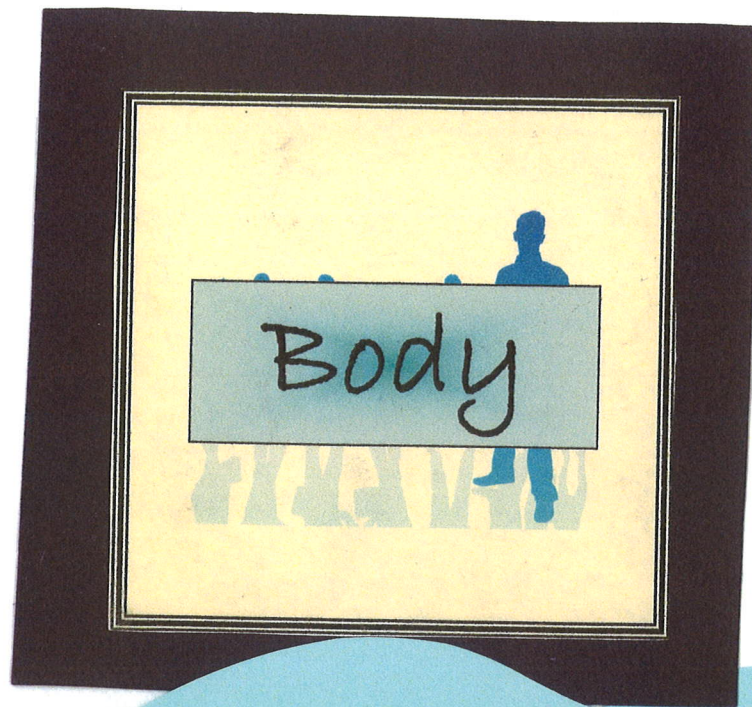Body

School

Obesity

Health

What do you think the key issues about health are?

What do you do to be healthy?

In what ways do your friends tell you that they are unhappy with their body size?
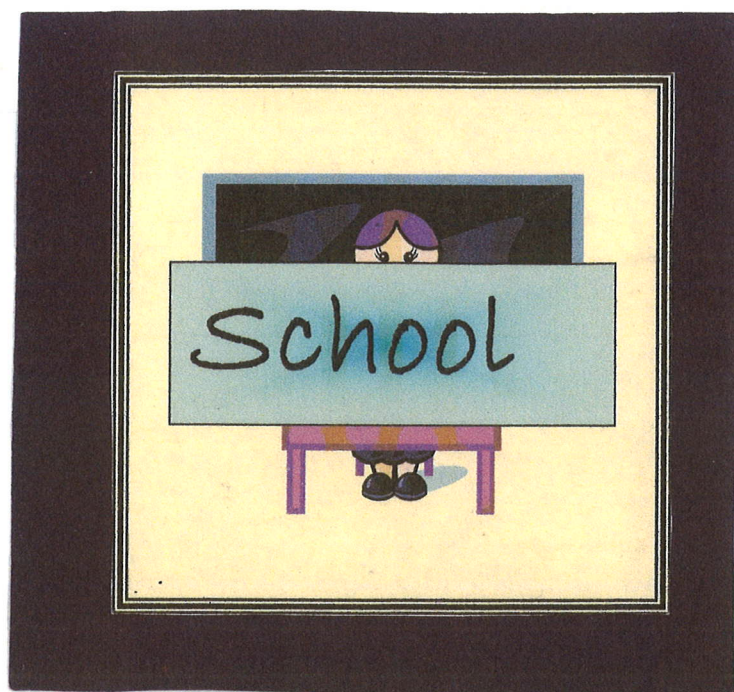
Where do you get most of your ideas about health from?

List three things you would put in a TV advert to give young people ideas about how to be healthy

Body

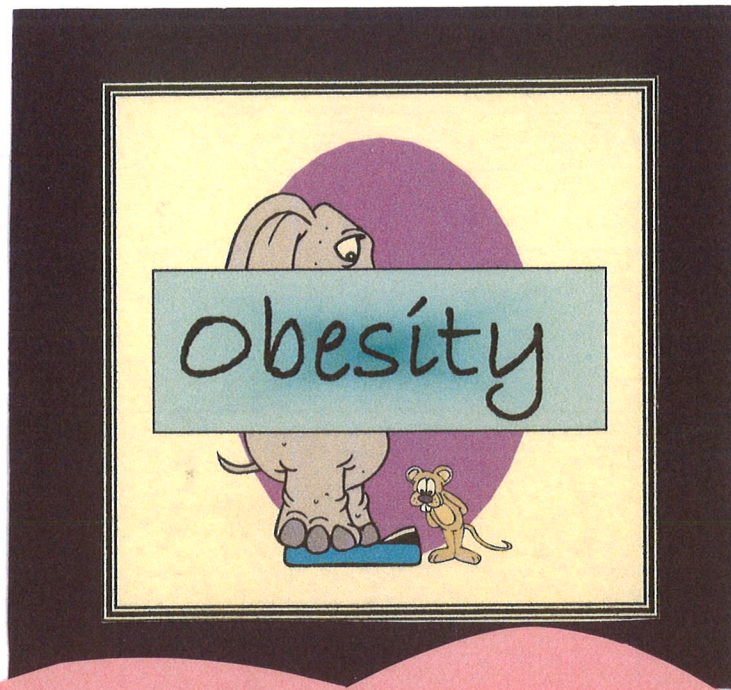Take a look at the celebrities – who would you most like to look like and why?

What sorts of things influence the way young people feel about their bodies?

School

What's it like for young people in this school?

How do you think you get on at school?

If you were headteacher of this school, what would you do to help young people stay healthy?
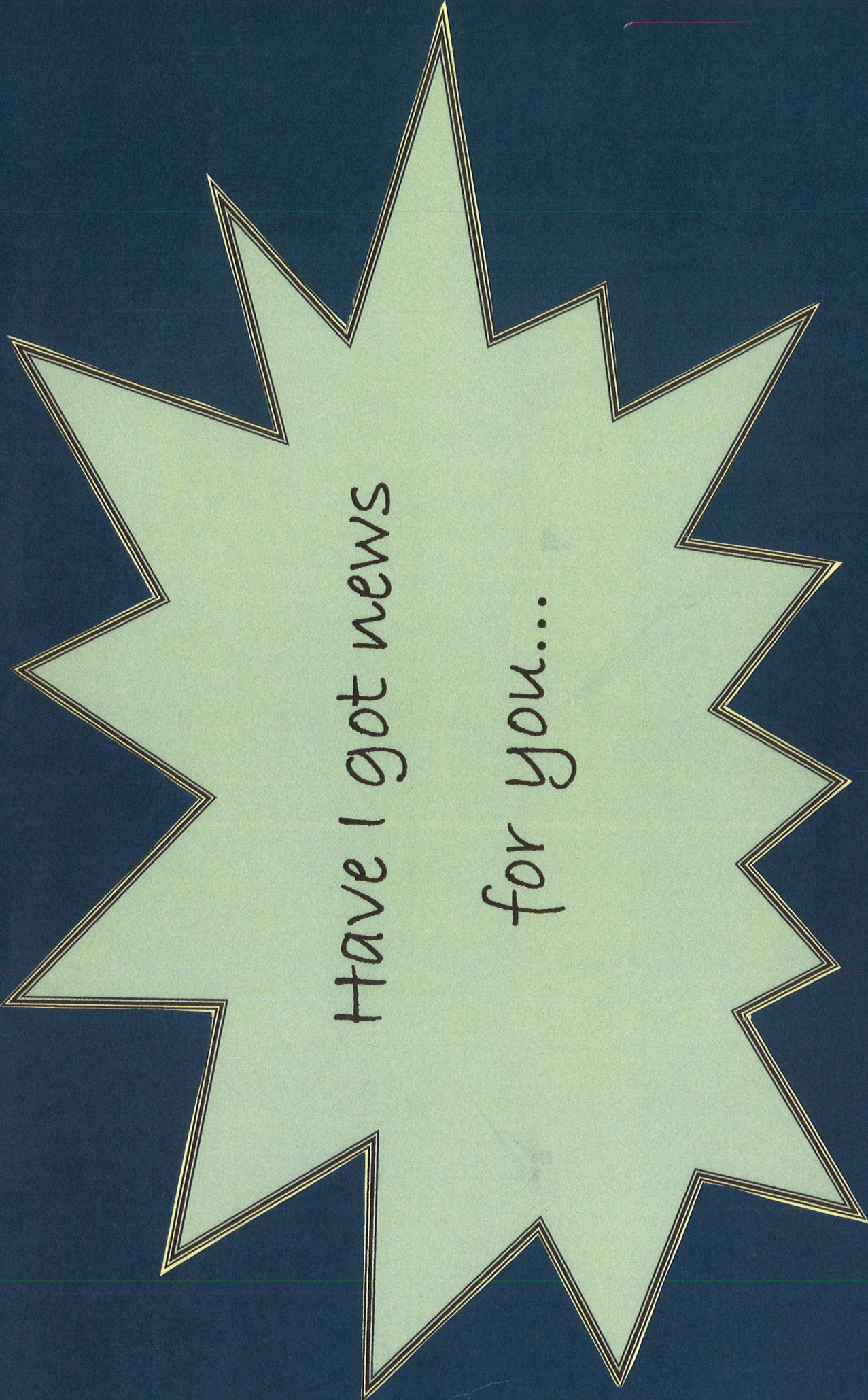
Obesity

What do you think the word obese means?

What sorts of things have you heard being said about obese people?

Tell us what you know about eating disorders

Describe what do you think life would be like if you were obese

Have I got news for you...

The rush to healthy eating initiatives could be getting out of control

HEALTH Secretary Patricia Hewitt insisted today that everyone should take responsibility for their own lives in the battle against obesity

Children should watch no more than two hours of TV a day to protect their future health

Child obesity has 'doubled in 10 years'

School meals are to undergo a major government review in an attempt to tackle obesity in children

The Government is planning to make cookery lessons compulsory for teenagers by 2011

INT: Okay, the four categories that we are looking, oh, no actually shall we start by saying your name and how old you are?

RES: Okay my name is Abbas and I'm 14.

RES1: My name is Rory and I'm 14.

INT: Okay so, Abbas and Rory, yeah? Okay. The four categories guys that we are looking at today are health, body, school and obesity. Does anything immediately spring to mind when you see those 4 categories?

RES: No.

RES1 Bullying and obesity.

INT: Bullying and obesity?

RES1: And health, for like people eating bad food and then basically bullying, school lessons you get bullied...

INT: So quite a bit about bullying there Rory. Abbas no, nothing, nothing comes to mind. Is there any category that you would feel slightly uncomfortable answering questions on?

RES1: No.

INT: Okay, you're happy. Let's start. The way its going to work is on the back of those cards is one of these categories, so when you turn it over that will be the category that you start with. So who's going to turn the first card over?

RES1: I will.

INT: Okay Rory, go for it. Obesity, right. Okay, Laura...I didn't introduce us did I? This is Laura, I'm Tina. We've got two categories each okay and obesity is one of mine. Okay. What does the word obese mean?

RES: Fat.

INT: Fat?

RES1: It don't mean overweight, it means a lot overweight.

INT: A lot overweight okay. So if it's a lot overweight, if obese means a lot overweight what do you think life would be like if you were overweight?

RES1: If you are you get bullied and erm, and you won't be a fit as most people.

INT: Okay, so it would be hard, you would get bullied, and you won't be as fit as most people. Abbas?

RES: People would take the mickey out of you.

INT: So, okay because you were a lot overweight people would call you names. Anything else, what life would be back? Have you seen any programmes about it? Which ones?

RES1: [unclear 02.11] my child at 16's obese, the thing is though some people they can't really help it because of their genes because some people, like me, I don't actually, I'm quite big, but I actually don't eat much, but I just put on weight, when some people like who are thin eat like no tomorrow, and they stay skinny.

INT: Yeah. Right, how does that make you feel?

RES1: It's just really who you are.

INT: Right so, it's who you are, you can't do anything about it? What about you Abbas, he's smiling there ... no? Okay, you've said that you would get picked on if you were obese, what sort of things have you heard being said about obese people?

RES1: Just about that they're fat...

RES: Just people taking the mickey that they're fat and say in jokes like oi, skinny come over here.

INT: Right okay.

RES1: Which is pretty horrible really.

INT: Not nice. Okay, look at these headlines for us and tell us which ones stand out to you and why....I think my recorders picking up that music, have your batteries gone?

INT1: Yeah.

INT: That just gives these guys a bit of extra time to read these through, because you can.... ah... is he being mean to you Abbas? Are you best mates?

RES: Yeah.

INT: So you're allowed to be slightly cruel to each other are you? Is that back on Laura? Okay, which one? The top one?

RES1: Yeah.

INT: Child obesity has doubled...why does that one stand out for you?

RES1: Because it's a big figure, especially in 10 years it's not that long, to double.

INT: Okay, so is that something that makes you worried, or what do you think about that?

RES1: It just basically means that we're making more fast foods and more people are doing it because like Maryland is nice and cheap...

INT: Where's...what's Maryland?

RES1: Maryland chicken, you know....

INT: Oh is it like KFC or something?

RES: Yeah.

RES1: And then Subway, Subway is nice but more expensive and a lot of more expensive and a lot more expensive and the government says that we need to get healthier but if people like to want to eat more healthy it tends to costs more, I mean apples are 50p and I think that's a rip off.

INT: Right, do you ever go to your food technology room and buy fruit at break time at all?

RES1: I didn't even know that there was one.

INT: You didn't know that they did that. Right okay.

RES1: I knew they did it last year, but I didn't, I've never seen it done there before... this year anyway.

INT: Okay, so tell us what you know about eating disorders, anything, if anything?

RES1: I know like some people they don't, if they eat a huge meal, they still don't get full up, they just digests slowly or something like that.

INT: Right okay. Any other eating disorders that you know of?

RES1: Anorexia.

INT: Anorexia, okay what do anorexics do?

RES1: They either want to be skinny to be models, or they just, they're bodies don't accept the food.

INT: Okay and why do you think people develop eating disorders?

RES1: From like when they're young.

INT: From when they're young, what do you think Abbas?

RES: The same.

INT: The same. Okay, next category then guys, who picked that, oh you picked that one Rory, it's your turn. School, that's Laura

RES1: He picked the worse one as well.

INT: Oh great so you're looking forward to the other two.

INT1: Okay guys, how does this school encourage the pupils? Can you think of anything it does, or does it not do anything?

RES1: Not really, not really, because say if someone haven't got their PE kit they just let them do it and there's no discipline.

INT1: So if they don't bring their PE kit they don't have to do PE?

RES1: No, they also the lessons, because in English we're in mixed groups and apparently everyone's levels are supposed to be going down.

INT1: Okay.

INT: Levels are going down in achievement?

RES1: Yeah, like

INT: In terms of what they get?

RES1: Apparently my mate was on level 6 last year, now she's on level 4, because we can't go as fast as what they would like, because we've got lower set of people than, then you just slow up and you don't get to learn as much.

INT: So do you think there are people in the group who perhaps could do level six but they're not able to do it because of the lower level....?

RES1: Mmmm, but they're changing it because everyone's complaining.

INT: Right. So what are they changing it to?

RES1: I don't really know, I think they're just doing it like set 1, set 2, set 3, set 4.

INT: Oh right okay, so at the moment are you not mixed up into sets?

RES1: No we're mixed up in English now, then next year they're changing it because apparently parents were complaining.

INT: Right, so you won't be mixed up next year. Right, okay....

INT1: So, if you were head teacher for example what would you do differently to try and encourage the pupils? Can you think of anything?

RES1: I would probably more... you get sweets and that if you do a good thing, it seems like the bad people they get all the good [unclear 08.22], know what I mean, say if you were bad they have stuff like a lot of schemes and that and then they go out on trips and then the good people they only get pretty much attendance, but if they're ill but they behave when they're at school and its not really their fault if they're ill and if their attendance is low then they don't get any trips or anything.

INT1: Right okay, so more rewards for the people that are good?

RES1: Yeah.

INT1: Okay, anything else?

RES1: A lot of people don't smoke at all [unclear 09.03]

RES: If I was head teacher and I would stop all the fat foods and stuff.

INT1: Okay so healthier eating. Do you guys have the school meals, hot dinners?

RES1: I do.

INT1: You do Abbas?

RES: [unclear 09.17] fast food, I mean a snack basket...

INT1: Oh okay what sort of things do they do there?

RES: Salad pots and stuff.

INT1: Oh okay, what makes you choose the snack pot things, the salad bar things as opposed the other food?

RES: I don't like the hot food at school, because it's not nice.

RES1: It's supposed to be from another school apparently, it's supposed to be left over or something.

RES: Every time when I have hot food I keep on finding hairs and stuff.

INT1: Nice...

RES1: That's probably your own...

INT1: I've forgotten what I was saying now, you distracted me with that.

INT: It's the hair, it's distracted us, hasn't it.

INT1: Erm, so yeah, is there anything else that you would do differently so maybe.... better school meals...?

RES: I think that we shouldn't expel the children because that, to be honest, expelling the child is worse, is not as bad as making them come to school. Because most of them try and get expelled so they don't have to come to school.

INT: Are these the naughty children that we're talking about.

RES: Because my mate, she got expelled and she was proper happy about it.

INT1: Does she go to another school now?

RES: Yeah. She didn't go to this school either, she went to another one.

INT: Okay, do you ever feel under pressure to do well?

RES: I don't, I try in my subjects but I don't try as hard as I can do?

INT: Okay why is that do you think?

RES: I don't know I just...lessons is usually boring so I'm pretty much talking all the way if not I'll just get bored and then you end up not actually doing any work at all, so you end up just sitting there.

INT: Okay, how about you Abbas, what do you think about being under pressure, do you ever feel under pressure?

RES1: No.

INT: No. What do you think is the reason behind that, is it the teachers do you think or yourselves? Not sure.

RES1: The teachers.

INT: The teachers, yeah? Okay, if you didn't do very well or as well as you normally do one time, what would the teachers say to you?

RES: They've probably say do better next time, but if like, if you're ... you see I don't even think the teachers have actually picked the fact that people are getting less grades.

INT: Okay.

INT1: Less grades than what?

RES: Than what they should do? Because I ain't heard none of them complaining about it.

INT1: Telling you that you need to do better?

RES: No, just like sit there complaining about the system because it's not the teacher that decided it was the government or something and so...

INT1: Okay, so you think the system in the school doesn't help the pupils do as well as they could do?

INT: Okay, that's it for the school questions, next category, Rory its' your turn. Health, that's Laura.

INT1: Health that's my other one. Okay, imagine you are going to make a TV advert to give young people like you ideas about how to be healthy, what sorts of things would you include? What springs to mind when you think of young people's health.

RES: I think its bad at the moment?

INT1: It's bad at the moment?

RES: Yes to me, big children, well some people ain't big but you get like, more so with fat people, they're not as healthy because they eat too much bad, unhealthy food.

INT1: So what would you tell them through your advert?

RES: Stop going to Maryland.

RES1: It's just as simple as that.

INT: What did you say?

RES: He goes there 24/7?

INT: Is that true?

RES1: No, no, it ain't true.

INT: But I'm getting the sneaky suspicion that you quite like it there?

RES: It's nicer than Macdonald's and places like that, I mean, people round here they can't pay for enough like sports, yeah, you just go onto the field, but its dangerous these day so most parents don't want them going out on the streets and then so...the only safe thing to do is to go to an actual place that's indoors or something and then play there, but children pretty much have to pay themselves.

If you get a paper round you can't do it, it's just, you're just not rich enough to be able to do it these days. Everything's going up in price so you can't do it.

INT1: Would you say food is the most important aspect of young people's health or is there anything else really important?

RES: Exercise, I think that's more important than that.

INT1: More important than food?

RES: Because like, if you just ate healthy stuff, it's not just going to make you a healthy person, you got to burn some of it off as well, but then if you eat Maryland like twice a week and then healthy stuff as well and then do exercise, then you'll become more healthier because I think exercise is the best way to be healthier.

INT1: Okay, do you agree with that Abbas?

RES1: Yeah.

INT1: Could you take us through your week, starting with Monday through to the weekend and tell us the sorts of clubs if you do any or activities, who wants to go first?

RES: You go, you can go....

INT1: You go first Abbas?

RES1: Mondays I go to the park with all my mates, on Tuesday I've got youth club and sports and stuff. Wednesday I've got basket ball, Wednesday I've got basketball. Friday I go to the park again. On Saturday I've got basketball and Sunday's I just stay at home.

INT1: And when's your PE lesson?

RES1: Monday and Friday.

INT1: Right okay...

RES: Monday I have Cricket training...

INT: Do you do that in school?

RES: No, outside and in ...on Tuesday I've got cricket training with the school, on Wednesdays erm, I either play tennis or football with my mates, on Thursday I play football or do something with my mates and on Friday I play out again with my mates and on Saturday I've got badminton training and then on Sunday I've got cricket matches.

INT1: Okay, why do you do those activities?

RES: Because they're fun.

RES1: I do it because they're fun as well and just not to [unclear 16.41], and I used to be there...

INT1: Okay do you not go there anymore then?

RES1: Sometimes.

INT1: But not as often. Okay, so do you eat any particular foods to try and stay healthy?

RES: I just eat a load of fruit, I just love fruit, I don't know ... tinned peaches are just [unclear 17.10] just like twice a week, Maryland in school and then on Friday afternoon.

INT1: Okay, have you heard about 5 a day?

RES: That's what I try to do with my peaches.

INT1: Yeah, okay, do you manage it?

RES: Yeah, because a third of the tin equals 1 a day and I have about 3 tins.

INT1: I see, Abbas, how about you, do you manage 5 a day?

RES1: Yeah.

INT1: Yeah. Okay, does anyone tell you that it's really important to be healthy?

RES: Well when we have like, when we do healthy eating in PHSE and food technology.

INT1: Okay so teachers. Yeah? Are teachers the biggest influence over your health do you think or is there anyone else that tells you anything?

RES: Yeah like if we were going, if our parents see that we're eating too healthily like, my Mum, that happened to me, so I used to be fat and now I've started losing weight my Mum don't give me money to go out and get snacks and that, she just gives me the dinner money and I go and play out with my mates.

INT1: Okay so you can be more healthy? Abbas how about you? Does anyone else influence your health?

RES1: Yeah, my dad before because he made me go to Basketball and ....

INT1: Why do you think your dad made you do that?

RES1: I don't know, stay healthy?

INT: Okay. Erm, we've got picture of lots of different sorts of food, lets just have a quick look through them and the first thing we'd like you do is create what you think is a really healthy meal and ideally something that you would eat for your main meal, so whenever that will be, are you able to hold those, because I can't quite fit them on.

RES: What so you like it....

INT: Just shout out different sorts of foods that you think are really healthy that would make a main meal.

RES1: Rice.

RES: Sweetcorn.

INT1: Is that with the rice or on its own?

RES1: You can do it with the rice as well but you can do it on its own as well...

INT1: Anything else?

RES1: Peas and carrots.

INT1: Peas, yeah...

RES: So basically like mixed veg.

INT1: Yeah.

RES1: Broccoli...

RES: Nah, skip on that one.

INT1: Aha .... yeah okay. Anything else, Rory with your veg what would you have with that?

RES: Er, does salad count as veg, because I like salad as well.

INT1: Yeah, would you have anything with the salad?

RES: Probably like spam, or ham.

INT1: Yeah.

RES: And like baby potatoes.

INT1: Okay

RES: And that's about it, for what I would [unclear 20.34]

INT1: What would you have after that if you were having some desert or pudding, if it was a healthy option, what would you have?

RES: I'd have fruit salad or...

RES1: I was going to say that...

INT1: Okay.

RES: Or go down to the shop and get some more peaches.

INT1: I'm getting a sneaky suspicion that you really like your peaches. Abbas what would have with your rice and broccoli – anything else?

RES1: Orange juice.

INT1: Orange Juice?

INT: Would you have any meat with your rice and broccoli?

RES1: Nah, just ketchup man....

RES: What is it with the ketchup... you can't taste it when ... you're supposed to get the flavour out.

INT: Okay what would you have for desert?

RES: Fruit salad...

RES1: I thought that was the desert did you?

INT: Okay... is that lunchtime?

RES: Yeah.

INT: Right we need to wiz through.

INT1: Have another look at the pictures quickly and tell us what you prefer to eat? What's your favourite, it might not be on there?

RES: It's not on there.

INT: Would Maryland be one of your favourites?

RES1: Yeah, chips mate.

RES: If I was saying something unhealthy I'd get Maryland, if I was getting something healthy it be these.

INT: What would it be, what would you have there?

RES: [unclear 21/59]

INT: What do you get in there?

RES: It's like chicken and chips and a drink.

INT: Yeah. And what would the drink be?

RES1: I'd get a chicken wrap.

RES: French fruit juice...

INT: What's in the wrap?

RES1: Like chicken and salad and stuff.

RES: They're rank.

RES1: They're nice.....

INT: Would you have chips with that?

RES: Yeah.

RES1: Yeah, but they come with the meal

INT: Right they come with the meal, and a drink would be...?

RES1: Yeah with a drink as well.

INT: What's the drink?

RES1: I'd get a fanta fruit taste...

INT: Fanta fruit taste, that's the same as you Rory?

RES: Yeah.

INT: and is that a fizzy drink?

RES: Yeah.

INT: Okay why do you prefer to eat that sort of food?

RES: Well even if I said I would eat something unhealthy, I prefer stir fries and stuff like that, spaghetti Bolognese, tuna bake and pasta bake.

INT: Okay so Abbas why would you prefer to eat chicken and chips

RES1: Because it's nice...it's better than healthy food.

INT: It tastes nicer...

INT: Okay, alright....anything you want.... have we got another topic?

INT: Yeah we have.

INT: Okay, so its body isn't' it?

INT1: Yeah.

INT: Okay, what sort of things make young people like yourselves think about their own body size, weight, shape and...

RES: Bullies, like taking the mick....

INT: Mainly bullies... Okay, so have you been bullied in the past about your size, either of you?

RES: I have.

INT: You have Rory...

RES: I used to but I turn it into a joke.

INT: Right so you deal with it with humour, but does it still make you think about...?

RES: No not really.

INT: Erm take a look at these celebrities, I've got some pictures of some celebrities here.

RES: Who the hell's that?

INT: That, apparently he's an actor from Hollyoaks but we didn't know. Okay are there any of these guys that you would like to look like?

RES: [unclear 24.11]...

INT: What you'd like to look like him....yeah? Why would you want to look like him?

RES: He's got a good body.

INT: In what way is it good?

RES: It's muscley.

INT: Is that important to have a muscley body?

RES: Yeah.

INT: Okay what about you Abbas?

RES1: I don't know.

INT: No, don't want to look like any of those. Okay, is there any body on there that you really wouldn't want to look like either of you?

RES: Yeah, him.

INT: So one of the skins guys – the blonde haired one...he's gay?

RES: Yeah.

RES1: And I would like to look like him....

INT: And the guy with glasses from Skins class – why wouldn't you like to look like either of those?

RES1: I don't know he just looks....

INT: Go on say it... its absolutely fine...

RES1: He looks gay.

INT: He looks gay.

RES: That's probably because he is gay.

RES1: Okay.

RES: I wouldn't want to be him because he's a mental head, he hit by a bus....

INT: So you wouldn't like to look like those because they look gay.

RES: Yeah.

INT: Alright then, do you do anything to monitor your own weight or shape, like weight yourselves or...?

RES: Yeah, I used to weigh myself every morning.

INT: And why do you do that?

RES: To see if I've lost weight or not.

INT: And what happens if sometimes it's gone up.

RES: I don't know, I just have a look see whether I've got more muscle.

INT: Right, so if it goes up you look for more muscle?

RES: Yeah.

INT: Okay, what about you?

RES1: Sometimes I check after basketball.

INT: After basketball training? What you check whether you've put on weight...

RES: It don't get on that quickly... [unclear 26.08]

INT: Right but you check after basket ball, but you've told us that you play basketball about 3 times a week, so do you weight yourself 3 times a week.

RES1: Not three times, about 2.

INT: Twice a week, just to see if you've put on weight or muscle?

RES1: Muscle.

INT: How else would you tell whether you were putting on muscle?

RES1: Check, tense.

INT: Tense your muscles...they're giggling a lot about this muscle idea aren't they? And have you ever used a pedometer? You know one of those things that you clip on your waste band and it counts how many steps...no?

RES: No?

INT: Have you ever used one of those clippy things that clip onto your fat and calculate your fat to body ratio. No, nothing like that. Okay, I think we're out of questions. Is there anything else that you guys would like to say?

RES: No.

RES1: No.

INT: Has it been okay talking with us today?

RES: Yeah.

RES1: Yeah.

INT: Great thanks for your time. Take care guys.....

[End of Recording]

Appendix 5

Example Field Notes – Fielding Community College

After sitting in the inner-city morning rush-hour traffic, I was relieved to be approaching Fielding Community College. I was due to spend the day there and having limited experience of a large, inner-city comprehensive school, I felt a little apprehensive and unsure about what to expect. If I'm honest, the experience was a little intimidating. Groups of teenage students poured through the main gates and I felt self-conscious as I walked across the large, concrete playground to access the main school building. It felt extremely oppressive inside the building, the corridors were long and gloomy and various 'school rules' were painted in big, bold letters along the top of the walls e.g., 'we will respect each other', 'we will act sensibly'. The doors to staff offices were re-enforced with steel sheets, which resulted in a dark and dreary environment and gave the impression that the school was not a happy place to either work or learn. I was amazed at how such a busy environment could feel so lonely and isolating, and instantly began to wonder if any of the students could relate to that feeling.

The organisation of the questionnaire dissemination appeared to be good although we soon found that completion rate was affected by the high level of pupil absence and also other events that had been organised for that day. For example, in one class we were expecting 30 pupils and only 5 turned up!

The classes were spread across the school and we found it difficult to attend to each. We hoped that the administration would go smoothly given that we had provided detailed instructions for the teachers but there seemed to be a lot of confusion. One member of staff thought that I would be joining them in September as a teacher!!

The interviews went smoothly although we were concerned about some of the views that the girls had of their bodies – believing that they were fat when they clearly were not. It would seem that they hear the message that they are fat from other pupils in the school and through their interpretation of the media and believe it to be true. Interestingly, this was the view put to us by the Food Technology teacher who believed that the media

interest in obesity was increasing the number of young people who develop eating disorders as they tried to regulate their weight.

It was quite sad to hear the opinions that the young people held of their school. They did not feel that it challenged them or considered their futures. We only spoke with a small number of pupils, however the impression we had of the school suggested that this could in fact be true. It was sad to hear that the Food Technology teacher who seemed to be instrumental in driving initiatives to improve approaches to health related education was leaving the school in the summer.

Appendix 6

Nvivo Coding Example

Nodes

- Nodes
  - Cases
  - Free Nodes
  - Tree Nodes
  - Relationships
  - Node Matrices

Tree Nodes

Look for:

Name	Sources	References	Created On
Balance	1	1	18/12/2008 02:09
Body	6	7	28/05/2009 16:08
bullying	40	89	09/06/2009 11:57
Eating Disorders	46	94	08/06/2009 17:06
Effects	4	4	09/12/2008 04:07
Emotions	3	4	09/12/2008 04:05
Enactment of health imperatives	4	5	18/12/2008 02:18
Food	0	0	09/06/2009 12:30
Givers	14	26	04/06/2009 10:27
Healthy body	0	0	22/12/2008 01:28
Influences on health	4	4	09/12/2008 03:56
Meal practices	9	10	04/06/2009 10:25
Meanings of health	5	6	09/12/2008 03:34
Media headline choice	23	32	04/06/2009 10:33
Nutrition	8	8	18/12/2008 02:06
obesity	33	65	28/05/2009 14:39
Performativity	41	90	08/06/2009 16:39
Physical activity	34	89	18/12/2008 02:06
Public Pedagogy	4	5	10/06/2009 11:16
Rating your health	0	0	18/12/2008 02:10
Resistance	14	29	04/06/2009 10:28
Responsibility	15	23	09/12/2008 04:09
Role Models	4	6	09/06/2009 17:01
School culture	19	29	04/06/2009 10:32
Self perceptions	0	0	22/12/2008 01:12
Sources or resources for health information and knowledge	3	3	09/12/2008 03:57
Teachers talking about young people's health	2	2	18/12/2008 02:14
Weight	0	0	11/06/2009 18:33
Youth at risk	2	7	28/05/2009 15:10

- Sources
- Nodes
- Classifications