Eating Disorders and Comprehensive Ideals

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Introduction

> *A school metaphorically holds up a mirror in which an image is reflected. There may be several images, positive and negative. A school's ideology may be seen as a construction in a mirror through which images are reflected. The question is: who recognises themselves as of value? What other images are excluded by the dominant image of value so that some students are unable to recognise themselves? In the same way, we can ask about the acoustic of the school. Whose voice is heard? Who is speaking? Who is hailed by this voice? For whom is it familiar? In this sense there are visual and temporal features to the images the school reflects and those images are projections of a hierarchy of values, of class values.*
> *(Bernstein, 2000, p. xxi)*

Are new hierarchies being nurtured in comprehensive schools, 'hierarchies of the body', relating to size, shape and weight? Hierarchies that potentially are as virulent, unhelpful and anathema to inclusive, egalitarian comprehensive ideals as those of gender, race and class on which they feed and endorse? Paraphrasing Basil Bernstein, we ask: what body shape or form is being recognised of value in comprehensive schools? Is there a dominant image of value relating to the body, so that some students are unable to recognise themselves as having a 'body' or more broadly 'a self' of any value? What body images are excluded by the dominant images of the school? Whose body is seen and heard? We ask these questions because of our concern over the rising tide of eating disorders, especially anorexia nervosa and bulimia nervosa, afflicting young women (particularly those in the 13–19 age range) in the United Kingdom and elsewhere. And our knowledge that, to date, very little attention has been given to how schools may be implicated in the aetiology and development of these conditions. Information of this kind is needed, we suggest, if schools are to construct curricula that will help students avoid slipping toward disordered eating and instead leave them feeling valued, included, competent, comfortable and in control of their bodies and health. We also suggest that answering these questions requires a much more critical stance towards the core assumptions and beliefs of the health sciences, which feed conceptions of the 'valued body' and its 'correct usage' into the curricula of schools, than is currently the case. We pay particular attention to the way in which 'a discourse of obesity' – the pervasive view that there is a rising tide of 'fatness' afflicting children and adults in the United Kingdom and elsewhere – is influencing the policies and practices of teachers and impacting upon students' sense of identity and health. Our hope is that the analysis which follows will encourage all professionals concerned with the health of students to consider whether they are promoting health or 'healthism' in schools. The latter system of beliefs defines health-promoting activities such as 'correct diet' and involvement in some form of physical activity as a *moral* obligation and an individual responsibility. In so doing, it can be said to divert attention away from the social, cultural conditions which shape and constrain an individual's health while damaging and eroding their confidence, competence and self esteem.

Background

Disordered eating is not simply a 'benign rite of passage' (Steiner-Adair & Vorenburg, 1999, p. 107) or 'an innocent phase of adolescent development caught up in the public gaze' (Evans et al, 2002). Although anorexia nervosa and bulimia nervosa are relatively rare in comparison to other affective disorders, 'the sub threshold components, for example, negative body image, fear of fat, feeling powerless and insecure, are prevalent enough among girls and women in many countries to be considered normative and an epidemic' (Levine & , 1999, p. 321). We share the view that this horrible state of affairs, coupled with the astounding gender differences in eating disorder and the risk periods in early and late adolescence, points to the need to think about what 'eating problems' mean in the

lives of girls, women and increasingly of young men. As others have pointed out, they are the third most common chronic illness among females in the USA. Research suggests that '1–2% of female adolescents develop anorexia nervosa, a slightly higher percentage develop bulimia nervosa, and the prevalence of eating disorder among preteens and younger adolescents is still on the rise' (Goldman, 1996). In the United Kingdom the Eating Disorders Association estimate that about 165,000 people have eating disorders and that this condition is responsible for the highest number of deaths from psychiatric illness (BBC News Online: Health Medical Notes, 2000). Indeed recent research has suggested that children as young as three are developing unhealthy attitudes towards their bodies and eating, potential precursors of disordered eating and ill-health (Bee, 2002). It is hardly surprising, then, that the rise of eating disorders in the US and Western Europe has been described as a modern epidemic, one which now is extending to areas with which they were once thought to be culturally incompatible, for example, China, India, Mexico, and Brazil (Gordon, 2001). They are, it seems, unique amongst psychiatric disorders in the degree to which social and cultural factors, putatively the spread through processes of acculturation, of Western ideas of a 'perfect' body shape, play a part in their development and potentially their aetiology. New patterns of food consumption and production and new styles of eating may also be factors in the spread of the condition. If we accept that the 'thin, taut, slender body' is a powerful and influential imagery exported globally from the socio-cultural and economic conditions of the 'developed' Western world, then we do need to consider whether and how this imagery finds its way in the socio-cultural fabric of schools. Whether it is reflected in specific subject areas and how then interpreted by teachers and young people. This does mean interrogating both the nature of knowledge production in Initial Teacher Education, schools and beyond and the social and discursive practices that socialise the teachers and health professionals into particular pedagogic identities, relations, attitude and practice towards the body and health. However, if we also take it as read that no pedagogue in their right mind would purvey *directly* the notion that a near emaciated body is corporeally how young people ought to be, then we do need to consider whether a discourse of slenderness is transmitted *indirectly* via the cultures of schooling. Paradoxically, is it constructed unintentionally by its inverse, a discourse of 'obesity' driven by the interests of bioscience through the curricula of ITE and schools?

The Fat Epidemic

Hardly a day now goes by, it seems, without the public being told that it is in the midst of an obesity epidemic. Report after official report, invariably mediated by popular media, informs the public mind that the nation is getting fatter, less healthy, that our children are at risk from the creeping spread of fatness afflicting the United Kingdom and the rest of the world. An industry of research is now dedicated to measuring and monitoring the growth and flow of obesity across and beyond the Western World, and a private, multi-million pound, industry of health experts, exercise and diet technologists to match, have emerged to provide the cure to this social and economic ill. We are told that sedentary lifestyles, increasing use of technology, addiction to television and poor diets are to blame. Consider here, for example, the recent House of Commons Public Accounts Select Committee Report entitled *Tackling Obesity in England*. Having received views from a variety of expert sources, the Report states, emphatically and unequivocally, that: 'Most adults in England are overweight, and one in five – around 8 million in total – is obese. The prevalence of obesity is increasing world wide, and in England has nearly trebled in the last twenty years' (House of Commons, 2002, p. 1).

The Report concludes that 'obesity is a major public health concern which is increasing throughout the world and for which there are no easy or short term solutions'. Moreover, we are told that 'unless effective action is taken, over 20% of men and 25% of women could be obese by 2008, with important consequences for the NHS (National Health Service), the economy and the people involved'. Socio-economic changes in life-style, more IT and television, computer games, less active lifestyles, and changes in diet are given as the main reasons. The data is then rationalised to generate recommendations that are intended to influence the practices of health experts in local health authorities, government agencies and teachers concerned with Personal, Social, Health and Physical Education in schools.

One has to note the form, function and content of texts such as this to appreciate their potential significance as a *cultural toxin*: a powerful influence not just upon policy and practice amongst health 'promoting-agencies' and the 'public psyche' but also on the 'mind set' of teachers in schools. First, this is the voice of biomedical expertise, and it therefore has authority, power and authenticity; there are no uncertainties to be seen in its narrative. The reader is asked to accept as a given, for example, that 'overweight' and 'obese' are both fundamentally, inherently, very bad things. Both conditions are conflated (lumped together) in the above text, as in so many others of its kind, to inflate the seriousness of the problem and add impact to the central health theme (fat kills). Nowhere are we invited to consider the veracity of the assertion that 'most adults in England are overweight', despite the imprecision of the techniques used to measure overweight and obesity, the arbitrariness of the thresholds used to draw 'normal weight lines' and the diversity, uncertainty and ambiguity of 'expert opinion' in the field of health science research. Nor are we invited to question at what particular point the condition described as being 'overweight', becomes damaging to ones health or how thresholds are established and measured or what we are to make of the residue of the population: those who fall below the threshold, who, we must assume, are either 'normally healthy' or badly underweight. In the interests of the 'obesity discourse', on these matters the text has nothing at all to say. In effect, this is a narrative of *certainty* and *negativity*, signalling as it does a potential threat to personal, institutional, national and global health and economic well being. It is also a discourse of *immediacy, proximity* and of *risk*; all may fall prey to its advances unless appropriate intervention, investment and action are taken at all appropriate levels. In effect, it is instrumental in helping manufacture a public 'health scare', a problem which only surveillance and treatment of body shape, size, and weight, through intervention, will cure. 'Practice nurses, dieticians and school nurses can play a valuable role in identifying

patients with weight problems and in providing advice and support on weight control, but practices vary. General practices should seek to engage a wider range of health professionals in this work, including those working in the community and school settings' (House of Commons, 2002, p. 2).

The social, cultural, psychological and economic complexities of obesity are thus reduced to the identification of a weight problem and its panacea, weight loss. The moral, evaluative and regulative overtones of this perspective are not difficult to see. Although the aetiology of obesity is described neutrally in biomedicine as a positive imbalance between energy ingested and energy expended, as a social practice it is thus neither innocently neutral nor value free (White et al, 1995). It is a discourse that allows health experts to construct those who are overweight as 'lazy' or 'morally wanting', giving permission on a daily basis for at best intervention in people's lives, at worst ridicule and harassment and the right to publicly monitor the body shape of others. As Ritenbaugh (1982, p. 352) has pointed out, in the USA these terms ('obesity', 'overweight') are 'the biomedical gloss for the moral failings of gluttony and sloth. Important themes in American society are individual control and fear of non-control – obesity is a visual representation of non-control.' In the 'blame the victim' culture which this nurtures, 'fat' is thus interpreted as an outward sign of neglect of one's corporeal self; a condition considered either as shameful as being dirty or irresponsibly ill. The corollary of this, of course, is that control, virtue and goodness are to be found in slenderness and the processes of becoming thin. This is arguably the most powerful and pernicious aspect of fat phobia in the USA. It is equally prevalent, we suggest, in United Kingdom schools and especially, though not just, in those subjects, such as health, sport and PE, concerned directly with how the body is schooled (see Evans et al, 2002). Cautious and dissenting voices, which highlight the ambiguities, uncertainties and contradictions endemic within the field of bio-medical and health-science research, conveniently disappear. In the process the means by which knowledge about obesity is produced becomes hidden, as do its ambiguities and uncertainties.

It has been argued that programmes concentrating on weight and dietary change are not only seriously limited in their foci but are not working. Research on the overweight and obese, for example, suggests that men who are unfit have a higher relative risk for all-cause mortality than do their fit peers in all body fatness and waist circumference categories. In short, size is not the issue. Obese men who are at least moderately fit do not have an elevated mortality rate and, in fact, this group has a much lower death rate than that of unfit men. It can be argued that public health would be better served with more comprehensive attempts to increase population levels of physical activity, rather than emphasising ideal weight and ranges and raising an alarm about increasing prevalence rates of obesity. More sociologically, others have highlighted that any diagnosis requires a belief in the existence of the disease and its aetiology, in this case that obesity and fatness are unhealthy, requiring agreement on criteria and diagnostic equipment, in this case, standards based on weight for height. Ritenbaugh (1982, p. 357), in his quest to demonstrate that obesity, like other eating disorders, is also a 'culture bound syndrome', convincingly demonstrated that the downward drift in such standards over the last forty years in the US has not been based on bio-medical data alone. Confirming his view that cultural forces are at work, he notes, in particular, that the weight standard for females shows the most obvious steady downward trend and mirrors the trend in popular media imagery. Ironically, 'higher mortality rates and health concerns focus on males yet there has been no steady downward trend for them. Thus the changing biomedical standards have paralleled changing cultural values, rather than an accumulation of biomedical knowledge'. Within the 'obesity discourse', then, the focus for change is overwhelmingly on weight and it is this theme that has fed policy and practice in schools and nurtured specific attitudes towards diet, health and intervention. Ritenbaugh wryly points out that two recent articles on the unsuccessful treatment of obese adolescents (see Huse et al, 1982) indicated that initially many of the patients entering the (intervention) programme exhibited denial of their condition. 'Only with the help of the biomedical personnel did they begin to deal with the reality and recognise their disease. At this point, they also became depressed.' The authors had created a problem (depression) in (otherwise) healthy adolescents. The pedagogical implications of this are clear and they prompt us to ask the question: are these powerful discursive practices reflected in the practices of teachers in comprehensive schools?

School, Health Education and the Discursive Production of Ill Health

We now turn our attention to 'health communication' at another level, namely, practice in schools. Drawing on data from an interview with a Health Education co-ordinator (HC) conducted by one of the authors (INT), we interrogate the way in which a 'discourse of obesity', of a kind mentioned above, is reflected in the Personal and Social Education Curriculum (PSE) of a large comprehensive school in England. We then draw out the potential implications of the views expressed for students' identity and health. There are, of course, attendant dangers in centring the analysis on the voice of one teacher. We stress that we are working on the premise that talk is a form of social activity, and that spoken, visual and written discourses not only help constitute the world in which we describe ourselves and others; we also constitute and are constituted by discourse. Our claim is that health and illness are constructed, reproduced and perpetuated through language. In this case, teachers and subsequently students get to know about their illness and health through the language of the health expert, health educators teachers, in schools. We, therefore, look at this teacher's talk as metonymic. This short extract of text is seen to represent the whole, that is to say the wider health discourse, in this case, of obesity. As a specific discourse practice, it cannot help but throw light on the wider cultural practices in which it is embedded. The medical expert, in this case the teacher/health co-ordinator, is the provider of the service, that of health care; the patient, in this case the pupil, is positioned as the one 'at risk', who potentially suffers, is there to be surveyed, monitored and treated. While reading the extract we might also consider the view that 'the real champions of the ideology of

"healthism" in recent years have been the educated middle classes' (White et al, 1995, p. 166). And that in this ideology 'the ethos of individualism has become ascendant and the problems of the lower classes have been identified as personal and not rooted in structure' (p. 166). In effect, the body becomes part of a power relation which contributes to acquiescence to the logic of high capitalism. The social class and gender implications of this are reflected in the extract below. In order not to interrupt the narrative we present the extract in full and at length before adding our commentary at the end.

1. HC Right, um, well, we have a health programme on a spiral curriculum following national curriculum guidelines, so that they do like a food eating section in, um, year 7, then again in year 8, and then in year 9, so that, revisiting and reminding them, um, but in particular, say for year 7, types of diet, um, well, healthy eating, should I say rather than diet and also we look at ethnic diets and cultures because we have the biggest ethnic variety, shall we say, within the city … Um, we try not to push dieting. I am trying to push healthy eating.
2. INT Yeah?
3. HC Um, and also with the dinner ladies, cos the school is a healthy school.
4. INT Right.
5. HC We got the award last year. Um, so I spent quite a lot of time with the dinner ladies, um, the only problem is that the children will like their chips.
6. INT Yeah?
7. HC I tried a couple of days in like a healthy eating week and I banned chips for a week just to see.
8. INT Right?
9. HC Um, but you know they were not happy.
10. INT Yeah.
11. HC I mean, like the other day there was an alternative, you know, there was a pasta on – lasagne – which look quite nice, and, um, a Chinese dish, you know, with rice, but they were still choosing their chips.
12. INT Yeah.
13. HC And their beefburger.
14. INT Yeah.
15. HC And, ur, it's girls and boys. So although they may be conscious of how they feel or weigh or whatever …
16. INT Yeah.
17. HC They still, until they get variety in their diet and stop just going for junk foods or fast foods.
18. INT Yeah.
19. HC And start doing more exercise. So obviously that's the other thing we are obviously trying to encourage more exercise.
20. INT Yeah.
21. HC Um, so we're not particularly trying to say, you know, make sure you're thin or whatever, but …
22. INT Yeah.
23. HC The self-esteem's the most important thing, and looking for a healthy lifestyle.
24. INT Do you think there's a kind of, um, danger in schools, sort of pushing the healthy eating thing, that they might, that there's almost a danger that you might force people towards dieting and things like that?
25. HC Um, well we're not, no, we're really trying to encourage them to have variety.
26. INT Yeah.
27. HC Because I do dinner duty and, most days, or corridor duty, and I'm in the dining hall and I'm watching the same children having the same food every day.
28. INT Yeah.
29. HC You know, it's chips and beefburgers or it's chips and fish fingers or, for some reason, chips they can't leave out. Um, I mean I introduced, say for the last year I was giving them stickers if they were having a healthy variety, um, cos we, you do use stickers as a reward system as part of the system. Um, so I was trying to encourage that and also trying to encourage the dinner ladies to put more fruit on.
30. INT Right.
31. HC You know, put things on like melon, and in fact the melon went down sort of quite well when it was sunny.
32. INT Yeah.
33. HC Um, but as I say, it's getting them to choose a variety of foods, whereas they do tend to just go through and look for chips, chips, chips, all of the time.
34. INT And did the stickers work quite well?
35. HC Yes, I mean the fruit, I mean obviously we used it in the summer term which is easier to get a variety of fruit and there's always apples, but, um, I got some like bananas and melons and, I think, some peaches. Some different fruits and they went down quite well. Ur, but generally, as I say, the most important thing to do is to try and encourage their self-esteem to try and choose and be selective.
36. INT Yeah.
37. HC Rather than go along with the crowd.
38. INT Yeah, and how do you do that?
39. HC Um, right, well, when, in say, in they do, on the spiral curriculum, we do, so we do about peer pressure, um, we do things about, you know, 'how I see myself' and, you know, body image and exercise. Um, we do things about friendship and, um, you know, within the group …
40. HC So I would, I would say that the actual food and diet that we do is only a very small part of the whole. Obviously if they do home economics or food technology they do more child development and more food awareness there.
41. INT And do you do any kind of awareness of how images in the media might affect their own feelings about their own image and things like that?
42. HC Yeah, I mean, in English as well as in health, that's right, we do, um, say look at magazines and adverts and that sort of thing and, um, you do, you know, see which adverts they like or whatever, are they swayed by the adverts in choosing, you know.
43. INT Yeah.
44. HC One, buying products or the actual images that they are being portrayed and pop stars, as well.
45. INT Mmm.
46. HC We haven't actually had, um, we've perhaps had some people who are overweight, but I think we've only

had, say, one out of very few people have actually gone down the route of anorexia.
47. INT Right.
48. HC So I would say our problem might be overweight. The other way …
49. INT Yeah.
50. HC From people who are, you know, unhealthy eating, obviously, and lack of exercise.
51. (INT asks a question about the links between PSHE and PE in terms of healthy exercise.)
52. HC You do find there are some people who will not bring their kit in.
53. INT Yeah?
54. HC And if you look at them, they tend to be often, particularly the girls, the ones who are overweight.
55. INT Right.
56. HC Who are the ones, obviously, who should be doing …
57. INT Yeah.
58. HC more PE. Um, sometimes, there is support at home.
59. INT Mmm.
60. HC Other times, some of the parents sometimes are in a similar sort of situation and you can see, like, like daughter like mum.
61. INT Yeah.
62. HC Out to follow the same pathway. We can't sort of force them to do PE … And I would say they are the ones who are overweight. I can think of a couple of girls who, go down that route …
63. INT Um, do you see differences both in healthy eating and exercise when, between the different ethnic groups that you've got in the school or do you think it's more or less the same?
64. HC Um, right, I would say that the, I mean the eating habits in school aren't different.
65. INT Right.
66. HC And the ethnic groups are just as keen on their chips, but maybe because they don't get them at home.
67. INT Right.
68. HC Um, whereas you might say, I mean this is obviously a stereotyping, very much …
69. INT Yeah.
70. HC But, um, perhaps, I mean I have seen them choosing chips just the same as the others in the dinner time, but generally I would say the overweight people tend to be, um, say, white people.
71. INT Right.
72. HC Um, Asians, I haven't got any overweight of what I can remember. We have a lot of Somali children.
73. INT Mmm.
74. HC From a couple of years back when there was trouble in Somalia and they were all exceptionally tall and thin.
75 HC And you know, obviously their genetic make up is very different.
76. INT Yeah.
77. HC Really tall, well over 6ft by the time they got into the 6th form.
78. INT Wow.
79. HC And really sort of thin with it. Um, and so we've got some Caribbean ones, no I mean I would say that really, you know, for want of another way, it's the white people who tend to be more overweight than the ethnic ones.
80. INT Right.
81. HC And I think perhaps they're getting a better variety from their culture, if they're having chips or whatever in the school then they are getting a variety at home.
82. INT Right.
83. HC Whereas I think a lot of others are still eating fast foods or going down McDonalds or just snacking too often.
84. INT Yeah.
85. HC All the time, rather than eating and stopping.
86. INT Yeah.
87. HC And very much, I mean they all seem to be into, you know, computer games, of course, and the television.
88. INT In terms of eating disorders, are they actually taught what they are and what problems there are and what happens and things like that? Or is it more from the healthy eating side that they're touched on?
89. HC Yes, I mean if they're doing food technology for GCSE they will do in detail about the different disorders and that.
90. INT Right.
91. HC But we, we don't go into any detail, we just mention like overweight, obviously, but then we mention underweight or that sort of route and what effect it would have on your body cos we do body changes and things.
92. INT Right.
93. HC But we don't obviously stress the actual under-eating part.
94. INT Right.
95. HC But try and, you know, go for balance. And the amount of exercise in proportion to what you're eating and …
96. INT Right.
97. HC and variety and that sort of thing.

We stress that we have no wish to contest the commitment of either this teacher or her school to the cause of health education and enhancing the lifestyles of young people in their care. The good intentions are manifest and the school's health education, as mentioned in the extract, had received recognition for its excellence. Our claim, however, is that the actions implied in the above narrative are manifestly practices defined and constituted by the major themes and narratives implicit in wider discourse of obesity and health previously described. The PSE curriculum in this teacher's perspective is a legitimate response to a health epidemic caused by conditions of a postmodern world: too much television and computer games, sedentary lifestyles and bad diets are to blame. With appropriate intervention and given reasons, sound knowledge and a manipulation of diets, individual lifestyles can be re-engineered towards more positive health ideals. This, too, is a discourse of conviction, of

certainty, the HC/teacher and others are positioned as 'expert authority', given the right to intervene in and engineer a new and better lifestyle for the children in their care. The body is 'a site of political and ideological control, surveillance and regulation' (Lupton, 1996, p. 23). In this case, power is exercised through the 'panoptican of the curriculum'. For the pupil there is no escaping the medical/health carer's gaze. The body (its form, value and function) is not just a matter for modification by/from teachers in Personal and Social Education, or Physical Education and sport, those subjects dedicated to body concerns, but also those in Food Technology and English, for dinner ladies in corridors and cooks in canteens. There are few places available for the (abnormal) body to hide, avoid surveillance, and resist the receipt of a health diagnosis, intervention and 'health care'. And in this discourse, everyone *initially* is assumed to be suffering from the overweight disease. Although the PSE curriculum is intentionally 'liberal' and 'non-judgmental', with repeated reference to choice, variety, lifestyle, encouragement, the hierarchies implicit are not difficult to see. Clearly there is a hierarchy of good and bad food, with some ('chips', a metonym for all fat laden food, it seems) so potentially dangerous it has to be banned. And a hierarchy of good and bad lifestyles, that generate allegiances to the right or wrong kind of food. While for some eating chips at school is seen as an expression of rational decision making, of extending lifestyle choices, tasting and testing foodstuffs not experienced at home, for (working class) others, it is mindless conformity to bad eating habits, an extension of the restricted dietary practices of the home into the school canteen. The evaluative class and cultural implications of this stereotyping are not difficult to see. Ironically, although the concept of lifestyle features prominently in this discourse, it is fundamentally disconnected from the socio-cultural conditions that pupils may experience. There is, of course, no more reason to believe that working class/ 'white' children are exercising less of a choice than their 'ethnic' (or middle class) counterparts. Indeed, even if one accepts the veracity of a perspective that assumes working-class children have a restricted diet, we may still need to question the merits of a pedagogy that attempts to erode and dismantle what, for some, is a positive and enjoyable relationship with an essential food, albeit a plate full of chips. Once the child's relationship with enjoyable and healthy eating is broken or damaged and if there is really no alternative at home, then what is left? How is the child now positioned in the social practices of the family and its discursive field to respond? The individual is left with the knowledge that she or he is unavoidably eating bad food (delivered by bad parents or guardians) and a choice, of either imbuing 'bad' foodstuffs with accompanying feelings of guilt and self loathing, or perhaps not eating food at all. Shilling (1993) drawing on the work of Bourdieu (1984) reminds us that bodies are formed through the development of *taste*. 'Taste' refers to the processes whereby individuals appropriate as voluntary choices and preferences, lifestyles that are actually rooted in material constraints. In other words, taste makes a virtue out of necessity (Bourdieu, 1984). The consumption of food is an obvious example of how taste affects the body and develops in class-based material locations. People develop preferences for what is available to them. The development of taste, which can be seen as a conscious manifestation of habits, is embodied and deeply affects people's orientations towards their bodies (Shilling, p. 129). Given the rigid boundaries between expert health knowledge and lay knowledge which the obesity discourse implies, there is little opportunity, or need it seems, for the health expert to explore the life experiences of children, the nature of family life, the structures of schooling, or the sheer visceral pleasure of eating certain foods, that may lead some young people to choose, despite all options available, a plateful of chips rather than lasagne and fruit. Clearly, this process has the potential not only to pathologise pupils but parents and guardians too. Despite the rhetoric of building 'self esteem' this discourse presses towards degradation, the identification and labelling of good and bad eating behaviour, good and bad food, good and bad citizen. We hold the view that the knowledge and practices associated with this obesity discourse matter greatly. They serve not only to classify populations (nations, classes, cultures) but also individuals, as normal or abnormal, good or bad, therefore requiring intervention by the state, in this case, in the form of teachers in schools. It is, therefore, a discourse not only of information and knowledge but also of classification and control that allows us to construct those who are overweight as lazy, or morally wrong. This, then, potentially is a pedagogy of degradation, of classification and separation, no 'smiley sticker' for the fat, or for those unwilling to take concerted actions to lose weight and get thin. This discourse reduces the practice of education to the trivium of food (diet), exercise and weight, social practices in which the student is reduced to a 'body' not a person. It is a discourse which positions the teacher as health expert, he/she is apportioned social arbiter, since it is he or she who will determine the authenticity of the patient's/pupil's condition. If the pupil is seen or shown to be recurrently reprobate in his or her endeavour to seek refuge from potential illness (overweight, obesity) s/he runs the risk of acquiring the reputation of a malingerer, deviant, resistant to positive change.

In passing, we might compare the social practices described above with the repair work that professionals at the Rhodes Farm Clinic in London (a treatment centre for girls suffering from anorexia nervosa) have to engage in to correct the damage done by (mainly middle class) parents and schools dedicated to narrow eating ideals, and to help anorexic girls rebuild a healthy, pleasurable relationship with food, including pizza and a plate full of chips. In short, we are suggesting that a culture of weightism persists, despite the fact that thinking of this sort has, since the early 1980s, been subjected to a great deal of critical scrutiny in the United Kingdom and elsewhere. The actions of teachers and policymakers still seem wrapped in an ideology of 'healthism' designed to make young people 'fit' and thin. Reports such as that of the House of Commons (2002) will continue to ensure that the curriculum is driven not by educational intentions but the functional pursuit of fitness and health, whose goal is the prevention and avoidance of being overweight and fat, indirectly the reproduction of slender ideals.

Conclusion

We have no wish here to draw causal connections between the social practices of schooling and eating disorders involving self-starvation. The 'aetiology' of such conditions is extremely complex and their origins and connections with processes of schooling are yet to be explored. But the obesity discourse we suggest does help feed and define a culture, which builds pressures for perfection and competence that are impossible, even undesirable to achieve. They also may inadvertently help reproduce old social class and gender stereotypes and hierarchies, albeit in new invidious ways. Far from empowering individuals, social practices such as those described may leave young people feeling powerless, labelled, alienated from their bodies and believing that they have less or worse still, no control over base essential elements of their lives. Eating disorders and obsessive exercise may become a response directed at regaining control of one aspect of life that remains in reach – the body – ironically potentially compromising rather than enhancing their health (White et al, 1995). Nor have we a wish to deny that there is a positive relationship between activity and health. But we do need to problematise received wisdom around diet, health and exercise and better reflect the uncertainties, contradictions and ambiguities residing in health science research in the curricula of schools. Only then might we avoid pathologising students and the building of 'body hierarchies' and instead help all students towards taking more informed decisions about their health care.

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