"Food's Yum":
Primary School Children's Constructions of Food and Healthy Food Messages

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Abstract

In the current climate of increasing child obesity levels, and the accompanying media constructions of child obesity, improving children's eating behaviours is the focus of much attention. Traditional methods of promoting healthy eating have had limited success in improving eating behaviours, in part because they do not adequately address the social and environmental complexities associated with food and eating. This study adopts a discursive approach to examine the ways in which children construct food and make meaning of food in their everyday lives. A discursive analysis of conversations from small groups of 9-11 year old children about food, with an emphasis on healthy food, resulted in the identification and reporting of the use of four of the interpretative repertoires drawn on by the children: sensory, nutrition, natural and healthism. I describe the ways in which the children draw upon these repertoires to construct food as an object and to use food as a social marker and personal identifier. By drawing on multiple discourses in their constructions of food, the children demonstrate the socially negotiated nature of food. Unlike previous studies examining children's food preferences and eating habits, these children indicate that they are interested in healthy eating, however this position is negotiated rather than static. The strong presence of the healthism discourse in the conversations indicates that children are receiving healthy food messages, but emphasises that these messages form one part of a complex social negotiation of food practices and are used for the children's own social purposes. The children's focus on the responsibility of individuals to maintain health indicates that some of the concern that health promotion messages create a morality around health behaviours is justified.

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Introduction

Over the past few years, media coverage of child obesity has flourished. I shall examine the popular constructions of child obesity as both an individual problem and as a public health issue, and the consequences of those constructions. I will then look at the area of promoting healthy eating to children in general, as promoting healthy eating is not solely under the rubric of reducing obesity levels, and the limitations of traditional approaches to healthy eating. I argue that research or health promotion and education practices in the area of children's eating habits, need to account for the rich social mediation of health and food.

Facing Child Obesity

As population statistics continue to indicate, children throughout the industrialised world are becoming heavier (see for example: Booth et al., 2001; Lobstein & Frelut, 2003; Ministry of Health, 2003a; Troiano & Flegal, 1998), and child obesity has been recognised as a world-wide epidemic (World Health Organization, 2003). Child obesity has received vast amounts of media attention in the past few years via newspaper and magazine articles, and television documentaries and talk shows. In addition, the role of nutrition in the maintenance of health is increasingly acclaimed.

Child obesity is commonly constructed as a preventable disease, both of individual control and of public concern, and requiring immediate action. Media reports often present child obesity as a disease by emphasising the risk of health problems an overweight child faces. For example, headlines which link obesity to health problems, such as "Fat linked to cancer risk in new study" (MacBrayne, 2003) appear in newspapers regularly. Until recently, health outcomes associated with obesity had mainly been seen in adults and were only relevant to obese children because of the increased likelihood obese children have of becoming obese adults (Dietz, 1998; Freedman, Khan, Dietz, Srinivasan, Berenson, 2001). Obesity has been identified as increasing the risk of all cause morbidity and mortality, as well as being identified as a specific risk factor for a variety disease outcomes including heart disease, sleep apnea, metabolic complications, skeletal problems, and some cancers (Dietz, 1998; Freedman, Dietz, Srinivasan & Berenson, 1999; Freedman, Khan, Dietz, Srinivasan & Berenson, 2001; Guo, Roche, Chumlea, Gardner & Siervogel, 1994; Must, 1996 and Smith, 1999). However, there is growing concern over the increasing number of immediate health

problems diagnosed in obese children. A well publicised example is Type 2 diabetes, which until the 1990s, had been considered an adult onset disease, but is now being diagnosed in obese children (Drake, Smith, Betts, Crowne & Shield, 2002).

Extensive use of the word 'epidemic' to describe the sudden rise in population obesity rates, with its connotations of death and contagion also contributes to the (re)construction of obesity as a disease. The emphasis on obesity as an 'epidemic' and a 'disease' is recognised as part of the 'medicalisation' of obesity (see Chang & Christakis, 2002; Conrad, 1992) and has implications for how obesity is treated in policy and practice.

As well as physical health risks, there is extensive literature indicating that obese children (potentially) face immediate social and psychological consequences of their body size. Young overweight children are often isolated from their peers and labelled as lazy, ugly and stupid (for reviews see Dietz, 1994; Must, 1996; Smith, 1999 or Sobal, 2004). Body weight peer discrimination has been observed in children as young as three (Cramer and Steinwert, 1998) and discrimination can come from diverse groups including dieticians (McArthur & Ross, 1997), nurses (Bagley, Conklin, Isherwood, Pechiulus, & Watson, 1989) and psychologists (Davis-Coelho, Waltz, & Davis-Coelho, 2001). As children move into adolescence, the risk of social and psychological consequences of overweight appears to increase. Self-esteem can be adversely affected by excess weight and overweight adolescents can develop a lasting negative body image (Dietz, 1994; 1998; Gortmaker, Must, Perrin, Sobol & Dietz, 1993; Must, 1996; Smith, 1999; and Sobal, 2004, all provide excellent summaries of the stigma of overweight).

Reducing obesity rates is one of thirteen priority health areas in New Zealand (Ministry of Health, 2003b). Public spending is justified on the grounds of both the personal costs and the public cost in health spending. Presentation of population data on the numbers of overweight and obese children helps create and maintain the 'epidemic' status of child obesity. A major study released last year indicates that almost one third of New Zealand children are classified as overweight or obese (Ministry of Health, 2003a). These data help justify public health policy, activity and even their existence, therefore can not necessarily be taken at face value (Lupton, 1995). While data such as these are usually presented in an unproblematic way, there are often unreported issues. The measure of obesity used in the study (the Body Mass Index or BMI) for example, is not universally accepted as the most appropriate means of gathering weight-related statistics. Hoby (2003a) reports the 'expert' view that the measure of obesity used in the

study (the Body Mass Index or BMI) *under*estimates the health risks associated with obesity, whereas Lockett (2003) reports another expert position, that the BMI *over*estimates obesity risks. Despite these issues, population data are presented as factual representations of the population's obesity levels, unless the aim of the article is to address the measurement issues specifically.

Some reject the construction of obesity as an 'epidemic' and query whether being fat necessarily excludes being healthy or fit (e.g.: Lockett, 2003). According to this view, the population data on weight are flawed (for example, see the discussion of BMI above) and the health consequences of over-weight are exaggerated while the psychological and medical consequences of being thin-at-all-costs to *appear* healthy, are marginalised. This view does not question the need to address obesity, but points to some undesirable consequences of the popular construction of obesity.

Food and Health

There is a long-standing link between food and health (Beardsworth & Keil, 1997; Mennell, Murcott & van Otterloo, 1992), and the wisdom of a 'healthy diet' is seldom challenged. In the industrialised world, the rise of medicine overshadowed the importance of diet to health for many years, but there is increasing interest in a holistic approach to health and diet is an important aspect of that. However, health promotion messages, which encourage healthy lifestyle choices, such as maintaining a healthy diet, are coming under increasingly critical evaluation. Health messages have a strong presence in everyday explanations of health and illness and adults commonly draw upon healthy lifestyle discourses in their daily lives, incorporating themes such as eating a healthy diet, not smoking, exercising regularly and drinking in moderation to explain the presence or absence of illness, as well as feelings of 'positive health' (see for example, work by Blaxter, 1997; Crawford, 1980; Hodgetts, Bolam & Stephens, in press; and Lupton, 1995). However, such messages also create a moral obligation to maintain health because of the emphasis on individual responsibility inherent in many public health messages. Crawford (1980) termed the common desire to achieve positive health and wellbeing through health-related behaviours 'healthism'. Healthism is based on a philosophy of individual responsibility for health, and helps create a morality around health behaviours, whereby behaviours that are 'good for you' possess a 'morally good' status. A healthy person is one who is responsible, and does the 'right thing' by following public health advice to live a healthy lifestyle. This implies the

opposite; that an unhealthy person is someone who has not performed healthy behaviours, has put themself 'at risk' and is therefore to blame for their own illness (Crawford, 1980; Lupton, 1995).

Healthism gives rise to moral judgements of the body, because if lifestyle is under the control of the individual, then individuals are to blame if they do not have a body representative of the healthy ideal. Obesity, for example, is commonly accepted as a preventable disease, and the implication is then, that obese people have chosen to be obese by not 'doing something about it'. Much of the stigma of overweight can be identified in this discourse, in which a person's body fat is attributed to a lack of self-control, over-indulgence and laziness and, where a thin person is celebrated because of their self-discipline and virtuous exercise regime (Lupton, 1995).

In an attempt to engage support for public spending on healthy eating (often justified by the consequential reduction in obesity levels) phrases such as "burdening the health system" construct obesity as an issue of public concern. However, such comments also generate resentment among the healthist public toward obese people because of the "burden" they create unnecessarily and irresponsibly (Chang & Christakis, 2002).

Child nutrition is not all about obesity. Vitamins and minerals for 'proper' growth and development have become big business with cereals, bread and milk now being fortified with vitamin and mineral supplements (see Lawrence & Germov, 2004). The National Children's Nutrition Survey indicated that 18% of New Zealand girls and 12% of New Zealand boys do not get adequate calcium from their diets (Ministry of Health, 2003a). Tooth decay, which occurs in 64% of New Zealand children (Ministry of Health, 2003a), is also constructed as a 'preventable disease' of nutrition. Sugar, in its many forms (e.g.: in fruit juice, soft drinks, snack foods and children's medicines) is vilified in public health messages as the cause of tooth decay (e.g.: Ministry of Health 2003c) and in the media (e.g.: Hoby, 2003b). Life-long food preferences begin to be established in childhood (Backett-Milburn, Cunningham-Burley, & Davis, (2003); Hill, Casswell, Maskill, Jones & Wyllie, 1998) and up to 50% of overweight children become overweight adults (Dietz, 1998). Forming healthy eating habits early in life is therefore understood as important for growth and development and for avoidance of disease, both as children and as adults.

Lifestyle Changes: "More must be done to tackle this growing problem."[1]

Social learning theory and social cognitive models. Health promotion and education are considered logical, cost effective ways of improving child nutrition and reducing rates of child obesity compared to the long-term costs of providing health services (Sobal, 2004; Wang, Yang & Lowry, 2003). Models based on social learning theory and social cognitive theory (see Huon, Wardle & Szarbo, 1996) have dominated research into the food habits of children (see Contento, Randell & Basch, 2002 for a review of measures used in studies) and have been widely applied to interventions aimed at improving children's eating habits (Huon et al., 1996). These models are based on the assumption that social behaviours, which include health behaviours, are primarily determined by individual cognitive variables (see Conner & Norman, 1998). In a review of published literature on interventions aimed at improving children's eating habits, Huon, et al. (1999) indicate that the majority of interventions using social cognitive and social learning theories as their theoretical framework lead to positive improvements, whilst the remaining studies based on 'other' theoretical frameworks (e.g.: those which integrated aspects of various existing models) were inconclusive. While this is promising, in some cases, 'success' of an intervention was measured in terms of children gaining increased knowledge about healthy food or an increased intention to eat healthy food, which does not on its own necessarily change behaviour (Horne, Lowe, Bowdery & Egerton, 1998; Sahota et al., 2001a & b). Indeed, almost thirty years ago, Atkin (1975, cited in Barwise, 1997) found that nutritional knowledge had little effect on food choices.

Socio-ecological models. Research into the causes of child obesity (and obesity in adults) has shown that many social and environmental factors contribute to obesity. Some of the broader determinants of poor childhood nutrition include access to low cost foods that are high in fat, sugar and/or salt and often offer limited nutritional value (for example see commentary by Crtiser, 2003; and policy by Ministry of Health, 2003b). Family structure has changed radically in the past thirty years, with increasing numbers of children coming from single parent families or families in which both parents work full-time. This change in family structure is another social factor blamed for the demand for convenience, takeaway or snack foods, which again, are often low in nutrients, and high in fat, sugar and salt (Beardsworth & Keil, 1997).

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[1] Stewart, 2004

The gain of children as consumers, in their ability to buy their own food or influence the food purchases of their parents, and the ability to advertise food directly to children have also changed the food market place over the past 30 years. There are ever increasing numbers foods marketed directly at children, often based on favoured television or movie characters (e.g.: Simpson's cereal; Finding Nemo muesli bars), and again, these foods are often of dubious nutritional value.

With the 'Healthy Eating - Healthy Action Strategy (Ministry of Health, 2003b), New Zealand's Ministry of Health have provided a framework for public health workers in New Zealand to guide their approach nutrition related health promotion programmes. The strategy identifies three goals; improve nutrition, increase physical activity and reduce obesity. To reach these goals it encourages a combination of environmental, community and personal action.

New Zealand's Ministry of Education (1999) has injected the socio-ecological approach into their primary school health curriculum document. In 1999, an update of the New Zealand primary school health curriculum reflected the public-health-based socio-ecological approach to health education (Tuffin, 2002). Tuffin discusses the language used in the curriculum document. She notes a change in language from supporting an 'individual education' approach to health, to language that supports both individual and community responsibility for health, emulating the language of the 'new public health'. Many schools in New Zealand have also taken up the challenge of providing healthy food environments for their students. The National Heart Foundation has a programme called 'The School Food Programme', which helps schools achieve a healthy food environment (National Heart Foundation, 1996). They do not simply focus on healthy food education; they give practical suggestions such as how to create a healthy food service, including marketing and recipe ideas.

Attempts to broaden the scope of health promotion to encompass social and environmental determinants of health are often met by resistance in a healthist society. Despite their limited success, lifestyle messages, given by way of education continue to be offered as the solution to health problems. Only last month a media release by a New Zealand Minister of Parliament recommended education as *the* way to reduce obesity:

> A national education programme is needed urgently to fight against an epidemic of obesity. It must start with parents. Children eat what their parents eat so it time [*sic*] to educate parents about the importance of a healthy diet and daily exercise. (Stewart, 2004).

With the pervasiveness of healthism and its individualistic core, the acceptance of socio-ecological modes of action may only come after the public perception of the causes of obesity shift. For example, when suggestions are made to tax unhealthy foods and regulate portion sizes as environmental approaches to reducing obesity levels (see for example Diabetes New Zealand Inc. & Fight the Obesity Epidemic, Inc. 2003; Ministry of Health & The University of Auckland, 2003), they are met with resistance from the general public based on the rejection of obesity as a public issue, as the following passionate reaction (published on a public opinion web-site) to the suggestions illustrates:

> "Obesity is the plainest, most obvious and unarguable example of an individual problem that you could imagine. I do all of those bad things listed above (eat fatty foods) and more, and I'll be fucked if I'm going to be lumped in with the lazy fat slobs and made to pay for their lack of self control." (Kearney, 2003).

In supporting the construction of obesity as an epidemic, public health officials can inadvertently provoke this type of reaction because the dominant healthist opinion resents spending money on other people's bad habits. For child obesity however, the situation is perceived slightly differently because children are often seen as 'victims' of obesity, with blame directed at parents rather than the child. Some media examples include the newspaper headline "Parents to blame for fat kids" and from health commentary "But we shouldn't get too far away from the key to all this [child obesity], which is parental responsibility." (Misa, 2003). This difference means that policies aimed at reducing obesity in children may be better received by the healthist public than those with a general scope (Lee & Oliver, 2002).

An Alternative Explanation: Lay Understandings of Health and Illness

Research into lay understandings of health and illness and how people make meaning of their health in their everyday lives is becoming increasingly popular (see for example: Blaxter, 1997; Hodgetts & Chamberlain, 2000). This approach has also grown from theories emphasising the historical context of knowledge, and issues of power inequalities and the privileging of some forms of knowledge over others (see Burr, 2003). With the rapid translation of scientific literature into the mass media, people are assimilating knowledge very quickly into everyday knowledge (Beacco, Claudel, Doury, Petit, & Reboul-Touré, 2002). Research into lay understandings of health and illness emphasises the social context of knowledge and recognises that knowledge is not

simply received "as is" but is reconstructed by each person into their own perspective (Valsiner, 1997). As such, this type of research does not assume to seek general laws but recognises the significance of context.

Coveney (2004) provides an example of lay interaction with health 'knowledge'. He examines the negotiation that goes on between parents, who as moral followers of healthism, encourage their children to eat the 'right' foods, and their children who 'know their right' to have their own preferences valued. Research measuring parental 'intention' or 'motivation' to provide healthy a diet as a predictor of who 'does' provide a healthy diet, misses this type of rich, social negotiation (see also Hill, et al., 1998, for negotiations between parents and adolescents).

Children's Understandings of Health and Illness

Concurrent with the developing interest in lay perspectives of health and illness has been an increasing awareness of the importance of children's perspectives on a variety of issues, including health and illness. Interest in children's perspectives has also grown from criticism of knowledge privileging those in power, as children's interests are often obscured by those of adults, and from ethical issues regarding the treatment of children as research participants (see James & Prout, 1997; Smith, 1988; Woodhead & Faulkner, 2000). Research shows that children's understandings of health and food seem to differ in important ways from adults' perspectives (Backett & Davison, 1995; Watt & Sheiham, 1997) so collaborative research in which children are able to voice their own opinions is important (Mayall, 1996; Smith, 1988; Woodhead & Faulkner, 2000).

Children's place in society is such that their eating habits are based largely on the habits of the food buyer in the house (Mayall, 1996). As children reach adolescence however, their ability to determine their own eating behaviour increases, often with a greater autonomy over meal preparation and increased spending power (Beech, Rice, Myers, Johnson & Nicklas, 1999). Children face contradictions between what is expected of them in terms of health behaviours at school and at home. Mayall (1996) notes the paradox that can exist for children in the school setting: "Indeed, the very notion of independent health-related activity based on knowledge, choice and decision conflicts with the demand schools make for conformity" (p. 76).

Much of the published research on food in schools, and the subsequent development of health promotions, originates from the United States and England, in which schools commonly provide lunch for many students. While New Zealand's

schools typically provide options for buying lunch, most school children in New Zealand bring their lunch to school from home (Ministry of Health, 2003a). One significant difference in these lunch systems is apparent on examining Morrison's (1996) description of the contents of the typical home-brought lunch-box as "a collection of snacks" (p. 654). This is contrasted against the "meal" provided by the school food service. In New Zealand, where packed lunches are the norm, people regard the "collection of snacks" as constituting the lunch meal. As such much of the research in this area has limited or questionable application in New Zealand.

Language and Discourse Analysis

The traditional realist approaches to health psychology research assume that the world consists of 'real' objects and subjects and language is used to convey unbiased facts about the real world (Coyle, 1995; Wetherell & Potter, 1988). However, many researchers are now questioning both the realist status given to psychological variables and the role of language as a neutral tool to reflect the world (Burr, 2003). As I have discussed, many interventions aimed at improving children's eating habits utilise cognitive models of health behaviour, with the assumption that knowledge will lead to attitude change, which will in turn lead to behaviour change. A social constructionist perspective challenges the reality of variables such as 'attitudes' and recognises that people often exhibit different attitudes in different situations. So while "talk is simply packaged as describing the situation" (Wetherell & Potter, 1988, p. 170) language is functional and has an 'action orientation' in that people use language to *do* different things in different situations (Coyle, 1995; Wetherell & Potter, 1988). Language also has consequences, which may be completely unintended or undetected by the speaker. An unintended consequence of health promotion messages, for example, is that health has become bound up in morality, as discussed in *'Healthism'* previously.

Social constructionist perspectives also acknowledge the historical and contextual location of knowledge (Burr, 2003). Coveney, (2004) for example, discusses the changing nature of 'expert advice' to parents on child nutrition. Prior to World War II for example, a "no-nonsense" approach was favoured and children (generally) ate what they were given. In the 1950s and 60s, Dr Spock advised giving choice to children and encouraging their cooperation and self-regulation. Current practices promote freedom of choice, following the logic that children will loose the ability to control their

own satiety if parents dictate too much[2]. What is considered 'expert' opinion changes over time.

Burr (2003) also identifies language as a form of social action. Within schools, children receive nutritional knowledge as part of the health curriculum, however this is not a neutral dissemination of knowledge, the language used in it is a deliberate choice and different language could have been chosen with different effect. Earlier I discussed the change in language in the New Zealand primary school health curriculum to make the dominant discourse in the document the 'health promotion' one (see Tuffin, 2002) This was not a choice without reason or consequence. I also pointed out the difficulty faced in promoting public policy (such as taxes on fatty foods) in a healthist society. Consider how much easier such policies may be to 'sell' to a generation growing up learning about the importance of social and environmental influences on health.

Discourse analysis is an effective method for researchers to examine the actions and consequences of discourse (Wetherell & Potter, 1988). The analytic unit in a discourse analysis following the methodology of Wetherell & Potter (1988, and Potter & Wetherell, 1987), is the interpretative repertoire. Burr (2003) describes the interpretative repertoire as "a kind of culturally shared tool kit of resources for people to use for their own purposes" (p. 60).

Wiggins, Potter & Wildsmith (2001) demonstrate that many aspects of eating that have been treated as matters of individual determination, such as perceptions of taste, or of 'being full' are socially negotiable. People use everyday language to negotiate physiological states rather than describing the absolute reality of them. Wiggins (2001) highlights the limitations of questionnaire type methodologies in understanding the negotiations that occur in everyday language, and suggests discursive methodologies as appropriate to this area of research.

Children receive mixed messages about food and health. The social environment in which many children find themselves is one that encourages healthy eating as a means of maintaining health, yet the majority of food advertised to them does not meet the criteria of 'healthy' (Dibb & Castell, 1995). The school curriculum introduces the idea of healthy environments to children, yet many children are not in a position to do much about the health of their environment (Tuffin, 2002). The

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[2] This freedom of choice is, ironically, also considered one of the social causes of child obesity (Critser- , 2003) as children seem to lose the ability to self regulate their food volume intake at around 3 years of age when portion size consumed increases with portion size offered (Rolls, Engell & Birch, 2000).

individualistic healthism discourses that adults engage in are not compatible with the public health discourse of the curriculum, as they emphasise that individuals, rather than communities, are accountable for health.

The objective of this research is to identify the dominant interpretative repertoires children draw upon when they talk about food, healthy food in particular in an effort to see how children make sense of the messages they receive about healthy food. I will then examine how these interpretative repertoires are used by the children. From a health promotion perspective, having a greater understanding of how children make sense of and use of the available food-related interpretative repertoires, may assist in improving the delivery of healthy food messages and education to children.

Methods

Participants

The participants in this study were volunteers from the year 5 and 6 students at a suburban primary school. I selected the school for its to proximity and availability to me. It is a state school with a roll of around 500 students. Approximately 80% of students at the school are Pākehā (New Zealanders of European origin), 15 % Māori, 2% Pacific Island and 3% 'other'[3].

I chose to interview 8-11 year-old children, because previous research indicates that children of this age have a more coherent understanding of health and illness than children only a few years younger do (Backett & Alexander, 1991; Hart, Bishop & Truby, 2002; Mayall, 1993). I was mindful that as children move toward adolescence, their self-esteem becomes linked to body image and healthy food could become a sensitive topic. In children up to ten years of age there is no established link between body image and self esteem (Strauss, 2000). With these considerations, the research question, and my own lack of interviewing experience, 8-11 year-olds seemed a logical choice.

I invited all 148 year 5 and 6 students at the school participate. Thirty-three children offered to participate and of these, five did not attend interviews (four boys, one girl). I held six focus groups, consisting of 18 girls and 10 boys. While I did not specifically seek demographic data, ages ranged from 9-11 years; most of the children were Pākehā New Zealanders, approximately 25% were of Māori or Pacific Island descent and 2 were Asian students, with English as a second language.

Procedures

The principal, Board of Trustees and the teachers gave their consent for me to work within the school, with acceptance by Massey University's Human Ethics Committee. No major ethical concerns were raised although the potential for teasing was noted (see Information Sheet, Appendix A). Teachers assured me that the risk of teasing was low; as one teacher observed "we do this stuff every year (talk about food as part of the curriculum) and there's never been a problem".

I introduced the study to the children in an assembly of all the eligible classes. Following this, the class teachers distributed information sheets, consent forms, and a

[3] Categories as defined by the Ministry of Education, see http:www.minedu.govt.nz

return envelope (Appendices A, B, & C). Children were asked to return their forms in the envelope provided, whether participating or not, in an effort to help protect the identity of those participating; only six non-participating students returned their blank forms.

I chose to use focus groups to gather data as they provide an effective and appropriate means of collecting discursive data from this age group (Deatrick & Faux, 1991). Group discussions are appropriate to the topic, as it is not sensitive or controversial (Lupton, 1995) and are an effective way to generate a variety of shared discourses. In a group setting, the adult interviewer is less likely to control the conversations and it was important that the children were able to introduce topics freely (Mayall, 1993, 1996).

Groups were intentionally single sex (with one exception where time constraints created a group of two girls and two boys), as some authors suggest children in this age group tend to respond best to homogenous groups (Deatrick & Faux, 1991; Krueger & Casey, 2000; Scott, 2000). Suggestions for group sizes in the literature ranged from three to twelve (Deatrick and Faux, 1991; Greig & Taylor, 1999; Krueger & Casey, 2000; Scott, 2000). As an inexperienced facilitator, I chose to restrict group sizes to the lower end of the scale. The group numbers (attendees only) ranged between three and six students.

All interviews were held immediately after school in the school library. The timing and location of the interviews ensured no disruption of class time, and made it easy for children to remember to attend (Borg, 1998). The school library is considered to be as 'neutral' a location as any within a school setting, as it has comfortable, equitable seating and lacks the association a classroom has with everyday work and activities, or the power imbalance implicit in a Principal's office or staff-room (Borg, 1998).

I notified each child of their interview time, in writing, three or four days before the interview and where possible rang the children the night before their interview to remind them to attend. All of the children that I was able to contact by telephone attended the interviews, so it seemed an effective tool to maximise participation.

Each group met for an hour, with an additional 15 minutes at the start to allow people to arrive and have some afternoon tea, and we took a break when the children became restless. I provided a 'healthy' (although this was eagerly challenged) afternoon tea for children, as they attended the group immediately after school and were likely to

be hungry. The afternoon tea had the additional benefits of creating an opportunity to build rapport, and providing an opening for conversation. Two boys said that the afternoon tea was a primary motivator for attending the interview.

While we were eating afternoon tea, I introduced the study, telling the children that we were having an informal conversation about food and that they could talk about anything they could think of that they felt was important or interesting about food. The children and I said our names into the tape recorder and played this back. The exercise serves as an icebreaker and relieves curiosity about the recorder (Deatrick & Faux, 1991). I encouraged the children to lead the conversation themselves, explaining that while they needed to respect each other's opinions and turns, they did not need to put their hands up or look to me to keep the conversation going. I began each conversation by asking the children what they thought of the food we were eating.

When the conversation got off topic, or stopped, I prompted conversations using earlier comments from the children to generate questions. In this way, I ensured that I prioritised the children's topics over mine. Referring back to children's own comments is an effective way of showing them that you are listening to what they say, and helps build and maintain rapport throughout the interview (Ledger, 1998).

Transcription and Analysis

I used discourse analysis to analyse the data and the stages I followed (including those for the transcription of audiotapes) are described by Potter and Wetherell (1987). As no written transcript can ever be a complete representation of speech, I carefully contemplated how to construct the transcriptions for this study (Taylor, 2001). I judged the inclusion of timing and intonation to be unnecessary, as the meanings of passages of speech were apparent without going into such detail (cf. Potter and Wetherell, 1987). However, to emphasise that the words represent a conversation rather than a standard piece of written text, I used punctuation to reflect how sentences were spoken rather than how they would be structured in written language and spelt some words phonetically (see Appendix D: Notes on Transcription).

I initially coded the transcripts for content and dominant topics. Then, through numerous readings of the transcripts I became familiar with the data and began looking for patterns of speech, and disclaimers as signs of function (Wetherell & Potter, 1988). I looked also for variability or inconsistencies in individual accounts. If a child made comments that appeared contradictory, this was a cue to ask, "how is this child making

sense of this contradiction?". During this process, I began to identify possible (and probable) interpretative repertoires in the speech. Once I had done this, I looked at the functions of each and how they worked together (or separately) to do important discursive work. I then chose four interpretative repertoires that collectively account for much of the function of the children's speech to report here.

Results and Discussion

"A Little Bit of Everything": Introducing the Interpretative Repertoires

In the course of the interviews, the children drew upon a variety of interpretative repertoires while talking about food and healthy and unhealthy food. I have selected four interpretative repertoires that the children drew upon when constructing food, normal food practices and their self-image in relation to food. The first is a *sensory repertoire*, which draws upon sensory perceptions of food to make and justify food choices and preferences. The second is a *nutritional repertoire* that the children used to classify food as *good* or *bad*, *healthy* or *unhealthy*. Closely related to the nutritional repertoire is the *natural repertoire*, which the children used to make similar good/bad, healthy/unhealthy distinctions. The final repertoire that I will discuss is the *healthism repertoire*, which in respect to food, refers to the morality of eating a healthy diet. I will give an overview of the 'ingredients' of each interpretative repertoire, then I will discuss how they are used by the children to construct food as an 'object', normal eating practices, and to construct, maintain and reconstruct of their own self-images.

Food's yum": The sensory repertoire. Taste is of prime importance to children (Hart, et al. 2002; Guinard & Marty, 1997) and as such, they draw on an interpretative repertoire of food as a sensory object, to construct food and define their food preferences. Most frequently, the children referred to taste (commonly "yum" and "yuck"), but also texture ("the budget ones and stuff like that, they're soggy") and less often, smell ("Bananas are disGUSting (...) they smell too much).

Taste, texture and smell are commonly treated as 'properties' of the food, and while people prefer different tastes, the taste is considered to be in the food. Yet, observations of cultural food differences and application of social constructionist theory to mealtimes (Wiggins, et al. 2001) indicate that these properties are negotiable. The application of taste across categories gives an example of the negotiability of taste. Several children applied sensory qualities to individual foods, for example, silverbeet: "usually we just have silverbeet and stuff like that which is yuck" and to categories of food such as vegetables: "I don't like vegetables". Almost half of the children claimed explicitly not to like vegetables, yet all of them gave examples, at some stage in the interview, of vegetables they did like.

The primacy of the senses in food preferences was evident in the number of

references to taste and in the order of the children's comments. When someone mentioned a food that someone else in the group had not tasted for example, the first thing the children asked about was taste. Questions such as "was it nice?" and "did you like it?" featured regularly in the conversations.

That's prob'ly healthy": The nutrition repertoire. The nutrition interpretative repertoire draws upon "knowledge" of the nutritional composition of the food to identify food as either healthy (good for you) or unhealthy (bad for you). The children readily identified foods as unhealthy if they had high levels of fat, sugar or salt:

> Sam: this is not healthy [looking at the nutrition information on the muesli bar box]
> Mark: cos its got too much sugars

Similarly, negative health outcomes were blamed on excess fat, sugar and salt. While the children did not always make accurate links between food intake and health outcomes (for example, sugar was said to "clog up your blood veins") the message was clear, that fat, sugar and salt are the 'big three' when it came to unhealthy food. Previous studies have also found that children readily link excess fat, sugar, and salt with definitions of healthy food and health outcomes (Backett & Alexander, 1991; Hill et al., 1998; Noble, Corney, Eves, Kipps & Lumbers, 2001; Roos, 2002). Other negative health outcomes mentioned were allergies and 'being sick' from eating too much.

Positive health outcomes were less regularly identified and were done so at a general level; for example, one group spoke about how healthy food "gets your brain going".

> Caleb: and food gets your brain going
> Ben: yeah
> [....]
> Julie: okay so those foods at the top [of the food pyramid] don't get you going don't get your brain going
> Tom & Adam: nup
> Josh: but the stuff at the bottom does

When foods were identified as healthy, the justification was usually based on an absence, or low levels, of fat, salt or sugar, rather than any positive nutritional value the food had, for example:

> Julie: So what makes it so good?
> Mark: um hardly any sugar, hardly any fat

Hill et al. (1998) found a similar lack of specificity on the health benefits of food in their research with 13-16 year-old children. While children know something is 'good for

you', they do not know, or do not articulate, why.

The absence of high levels of salt, sugar and fat is an indicator to the children that a food is 'healthy', but they had recently been taught foods may have acceptable levels of one 'bad' ingredient, but high levels of another. In the following example we were talking about the Heart Foundation's 'Tick', which is given to food that meets the Foundation's heart-health criteria and Olivia shows that she is aware that some things are not as good as they seem:

> Olivia: I know, I know why that um they've got um that [the tick] is because they're, sometimes it says um the um ice-cream if you buy it, it says its got 78 or 79% fat free (Julie: imhm) and that means its taken ahhh not so much um chicken it's taken a little bit of chicken fat[4] out of the um ice-cream (Julie: right?) and they've added more sugar to it though, to make it taste nice.

The children viewed situations like this as 'tricks' played by food manufacturers and advertisers (cf. Gunter & Furnham's, 1998, discussion of the 'credibility gap' in which, by the age of eight, few children still believe that all advertisements are telling the truth). This situation of 'being tricked' and trying to determine whether food is healthy or not, seems only to be a dilemma for the children at an academic level (i.e., deciding which category food belongs in), because from their comments and actions elsewhere, nutrition is not a major consideration when actually deciding what to eat; that choice is usually a sensory one or they simply eat what is provided.

However, the nutritional content of food was sometimes used by the children to support food choices, as in the following extract, where Leah justifies her choice of bacon brand on it's fat content:

> Leah: I um I normally have Kiwi bacon, I don't like any other bacon.
> [....]
> Julie: why is that?
> Leah: all the other ones are like fat bacon

The status of fat, sugar and salt as unhealthy and therefore bad was assumed to be common knowledge by the children, however, as with the sensory qualities of food, nutritional value (which is generally considered an inherent property of food) was negotiated by the children, as the next section will show.

"From the natural goodness": The natural repertoire. In their construction of

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[4] There is a belief among these children that ice cream, (especially from McDonald's) contains chicken fat, so I asked McDonald's if this was the case and they assured me that ii is a myth. I note that McDonald's now explicitly advertise the 'natural' qualities of their ice cream ingredients.

food as healthy or unhealthy, the children also drew upon a natural repertoire, in which natural foods are deemed healthy (or good), and artificial foods and ingredients are unhealthy (or bad). This repertoire was often used negotiate the health status of food that the children perceived as healthy, but had high levels of fat, sugar or salt and would therefore be considered unhealthy using the nutrition repertoire. In the following example, Mark deals with the apparent contradiction between his image of Light and Tasty as a healthy cereal, with its high sugar levels by drawing on the natural repertoire.

> Mark: um well also, on like Light and Tasty, they say its got heaps of sugar but its actually natural sugar from the fruits 'n stuff
> Sam: yeah
> Julie: oh, ok, so is natural sugar from the fruit good or bad?
> All agree that it's good: it's good; yeah it's good

The high sugar levels that would be considered bad under the nutrition repertoire are re-constructed as good with the natural repertoire. These types of reconstruction are particularly apparent when being used by the children to maintain their image of themselves as a certain type of eater. I will expand on this in the section *'Construction of the self'.*

About healthy food and what you should be eating": The healthism repertoire.

The term healthism (Crawford, 1980) encapsulates the common desire to achieve positive health and wellbeing through lifestyle choices and forms a dominant interpretative repertoire among adults (Blaxter, 1997; Crawford, 1994). During these interviews, the children also drew heavily on healthism discourses. When the children spoke about ways in which food could make you healthy or unhealthy, they did so in a way that made it clear that they considered negative health outcomes to be the fault of the individual. They also disapproved of others' eating habits and many of them indicated their intention to modify their own behaviour so to better conform to healthist ideals.

Fillings (tooth decay) were mentioned by all groups as a health outcome, probably because fillings occur in over 50% of children this age (Ministry of Health, 2003a) and are a reality to the children in the present, whereas many other health outcomes associated with food often happen in the future and are invisible, biological processes with little relevance to the children's immediate lives (e.g. heart disease). Because tooth decay is constructed as a preventable disease, when children have fillings, there is a proportioning of blame on those who did not prevent it. Blame for tooth decay is directed at the individual for eating too many lollies (sweets) or for

drinking too much juice or soft drink. Parents are also blamed for supplying the food in the first place. Blaming parents is congruous with children's status in society as not being completely responsible for themselves (see Mayall, 1996; Prout & James, 1990; Qvortrup, 1997), and reflects a growing call for parental responsibility for all aspects of children's heath-related lifestyle choices ("Parents to blame," 2003; Stewart, 2004). The following example shows quite plainly not only what, but who Georgia and her mother consider to be at fault for Georgia's fillings:

> Georgia: my um I've got lots of fillings
> Alicia: have you? oh poor you
> Meggie: I've got two
> Georgia: because I eat sweets and my Mum tells my Dad that he can't do it and next time he can go to the dentist and get the blame

Mum is clearly unhappy about her daughter's fillings, and makes it known that it is not *her* departure from healthy eating that has caused them. Mum also indicates that she has felt ashamed or blamed when going to the dentist for her daughter's fillings.

Another common health outcome mentioned by the children was 'fat', again probably because this is something the children see around them, and is not some vague distant or internal outcome. Being fat is understood to be bad, because the fat person has caused their own problem by eating too much and not exercising enough. In the next extract, Olivia regards 'fat' as the consequence of the bad personal choices, eating too much chocolate and not exercising:

> Olivia: Ok, UM, aand its [chocolate] got lots of sugar in it, fat, and people, who don't exercise while they're eating the chocolate (Leah chuckles) mind you you'll choke on it while you're running, um (laughter from others), so that goes for one thing, um then there is people who grow very fat cos they eat too much chocolate and other bad things

The children often criticised the eating habits of others, which served to show their disapproval of unhealthy lifestyle choices, thus establishing themselves as healthy:

> Mark: um my friend Richie, he gets Weetbix and he puts like three tablespoons of sugar on it (Julie: yeah?) ah, it's just covered in sugar and he gets about three bowls every day

While Mark does not actually say that his friend eats too much sugar, we the listeners, 'know' this and in voicing it, Mark implies that his own sugar consumption is more appropriate.

Another aspect of healthism is the resisting of cultural or societal pressure to take up or continue with, unhealthy behaviours. Several of the children spoke of a

preference to play outside rather than watch TV after school. Excessive television watching is commonly blamed for increased obesity levels among children because it contributes to both decreased activity levels and increased snacking (see for example Gortmaker, et al., 1996; Kennedy 2000). Proponents of healthism therefore frown upon television watching and here, the girls show their adherence to the healthism ideal, by resisting the television, and playing outside:

> Leah: I'd rather go and play sport than watch television
> Olivia, Eve & Lisa: yeah same
> Kayla: I'd rather do both
> Eve: I only watch television (Julie: do both) I only watch televis-
> Olivia: An then you just get addicted[5] to the televisions (giggles from others)
> Eve: I only watch television when its like when the weather's bad or something, otherwise I'd be outside or doing my homework or something.

A further indicator of healthism is expressing a desire to modify behaviour to bring it more in line with the healthist ideal. Several children indicate that they must, or should, eat differently, for example:

> Leah: yeah I like eat it up, I eat so much sugar though - (quieter) gotta cut down on it – um I um I get chop it in half in put it in little pieces

Although her admission "I eat so much sugar though" constructs Leah as unhealthy she quickly (and seriously, by dropping her voice) indicates that she is aware of this inconsistency and (re)constructs herself as 'healthy' through her imperative "gotta cut down". She acknowledges where she departs from the principles and indicates her desire to bring her behaviour more in line with the healthist ideals.

"I'm a meat": Constructing the Self

While introducing the main interpretative repertoires drawn on by the children, I focussed on the ways in which the children draw upon these repertoires to construct food. I have also touched on the ways in which the children use the repertoires to construct themselves and it is this of constructing and re-constructing the self that is done while talking about food work that I will expand on in this section.

As I have mentioned, many of the children described vegetables as "yuck", yet gave examples of vegetables they liked. Despite these examples, the children often defended their construction of vegetables as "yuck", thus maintaining their construction

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[5] The children's use of the word 'addiction' functioned within the four repertoires I am discussing here, so I felt it was unnecessary to discuss an *addiction interpretative repertoire*, although I acknowledge it as a choice I could have made.

of themselves as 'someone who doesn't like vegetables' using the sensory repertoire. Josh provides an excellent example; when his friend mentions carrots earlier in the interview, Josh calls out "Carrots are delicious!" yet as he says, he does not like vegetables:

> Josh: and some food you don't like like vegetables
> [...]
> Julie: so do you not like vegetables at all
> Josh: nah
> Caleb: I do
> Josh: I'm a meat
> Ben: I like vegie-tables not vegetables
> Josh: um n m hum {I like um
> Tom: {I'm a meat-a-tarian
> [...]
> Josh: oh yeah I like I like I've got two things. I like vegetables um ah what have that er yummy stuff on them er that sauce stuff.

The incongruence between the image of their eating habits and their actual eating habits does not appear to be a problem to the children. While the claim "I don't like vegetables" may be true in that the child really does not like the taste of some vegetables, the claim functions in constructing the child as someone who wont eat, or will fight efforts to make them eat vegetables. The maintenance of the self as a non-vegetable eater may provide an immediate excuse for Josh not to eat or try new vegetables, it may also reduce the likelihood of being presented with vegetables at mealtimes (Campbell & Crawford, 2001), or reinforce his masculinity by being a 'meat eater' (see the section 'The gendered nature of food'). The reasons for the maintenance of self-image should be of interest to parents and health promoters, because at some point the children may need, or choose, to change their image or they will continue to resist changes to their diet. Understanding the function of the language should help in the change process.

The children have no problem constructing food as simultaneously good and bad. They do this by drawing upon different interpretative repertoires, each lending to different definitions of good and bad: the sensory 'tastes good'; nutritional and natural 'good for you'; and the healthist 'a good thing to do'. Hart et al. (2002) found similar categorisations. A common contradiction for the children in this study is food that *tastes good* but is *bad for you* (and is therefore bad to eat). When dealing with these apparent incongruities, what appears to be important to the children is the maintenance of their self-constructions rather than their food-constructions. In the following extract, the boys

construct themselves as people who 'don't like healthy food'. When I challenge them, by giving an example of healthy food that they thought tasted good, the boys work together to resolve the contradiction by re-constructing the healthy food as unhealthy ("it has butter on it"):

> Adam: junk food tastes good but its bad but um um um good food um tastes bad but its good
> Josh: like vegetables
> Tom: yeah like vegetables you don't like it
> Adam: yeah but they're really actually good for you
> Josh: yeah and like lollies they're yum but they're bad for you
> Julie: but that food that we remember we were talking before about that food that we've just eaten [distraction] that that was healthy
> Josh: like this
> Julie: so was that that tasted all right though?
> All at once: Yeah, yes etc
> Caleb: it tasted nice but the butters bad on the popcorn
> Josh: so it must be bad
> Tom: yeah bro!
> Adam: yeah every food that tastes good is probly bad

The boys draw on the nutrition repertoire to reject my claim that the food that they liked was healthy, and retain their original claim. For anyone encouraging healthy eating, this is potentially useful, as it seems the boys are likely to respond to messages of taste not nutrition.

Some children utilised the nutrition and healthism repertoires to construct themselves as healthy or sporty, as Mark and James do (respectively) here:

> Mark: so you don't want too much food from McDonald's like if I go there I get a diet {lemonade cos I don't want too much fat in it.
> James: {I can't eat too much food [cos then I wont be] fast
> Julie: are you fast are you James?
> James: yeah, I'm one of the fastest people in our school

Mark expresses his healthiness by reporting that he makes the 'low fat' choice of diet lemonade and James speaks of limiting his intake of junk food so he remains "fast". Several other authors have also noted that children readily link food intake with activity and energy levels (Ross, 1995; Watt & Sheiham, 1997). Among this group of children, the construction of the self as sporty was far less common than constructing the self as healthy.

Many of the children constructed themselves as healthy, virtuous people through their talk about the types of food they eat, would like to eat and be seen eating. The following extract is from a conversation about the advertising of burgers:

Mark: oh sometimes you look at the um the um bacon and stuff and its got all the fat euw you go "euw its fat"
Julie: yeah, so does it put you off eating it
Mark: um not {really, I just peel the fat off it, I just peel the fat off it
Julie: {or d'ya jus' go down to McDonald's an

It is not important here whether or not what Mark is saying is 'true'; that is, it doesn't matter whether he actually peels the fat off. What is interesting is his effort to create an image of himself as someone who does this. He also stated "too much salt is bad" but later proceeded to wipe his finger around the popcorn bowl and lick all the salt off. His actions may not directly reflect his knowledge (and this is all too common) but he is constructing himself as a person who is knowledgeable about food and makes healthy choices, at least in the context of this interview. In another context, he may not be so concerned about his healthy image and his food choices may reflect that.

In the following extract, Amy also does discursive work to maintain a virtuous self. Amy admits to having fillings, and because we (the listeners) 'know' that fillings are bad, Amy's status as a healthy, morally good person is in dispute.

Eve: the only time I have sugar
Olivia: not allowed to have lollies either
Leah: {I am
Eve: {the only time I have sugar is when I have it on Weetbix and when mum cooks. I don't have it on lollies.
Amy: I have about four fillings, one; one; one; one [as she points to positions in her jaw] but one filling came out and I had to have it re-done.
Julie: oh, ow
Olivia: you have very bad teeth
Amy: no, not really [brief external interruption] but they're natural fillings

Amy counteracts the potential construction of herself as unhealthy or bad, by drawing upon the natural repertoire to do the work of maintaining her healthy image, by reconstructing the bad fillings as natural, and therefore good.

All of the children drew on the healthism repertoire to construct 'other people' as unhealthy, or bad, even those that did not make a concerted effort to construct themselves as healthy. In doing so, the children repeatedly implied their own adherence to the healthist ideals, thus constructing themselves, at least in their ability to identify the unhealthy habits of others, as healthy. In the next extract, Sam draws on both the nutrition repertoire ("heaps of sugar") and the healthism repertoire ("should only have") to justify his assertion about the appropriate consumption of chips:

Sam: y' y'you know those little packets of chips, you know those
Julie: yip

Sam: you should only um have like one or two a week
Julie: why is that?
Sam: cos they've got heaps'n heaps of sugar on them

With his use of the word "should", Sam indicates that to eat more than one or two packets of chips a week is a 'bad thing to do' because of the high sugar content. In doing so, he also implies his adherence to healthism.

Similarly, in the following extract, the Meggie, Alicia and Georgia disapprove of other people's over-consumption of the bad foods, salt and butter.

Meggie: I've been to people's houses and its like can you pass the sugar pl I mean the salt please and you just go like I mean like the Dad or the Mum opens it on the widest one it can go and like little mountains of salt over their stuff
Julie: so they use heaps {more salt than you're used to
Meggie: {salt like they just eat it all nice I'm like euw (quietly) its disgusting
Alicia: euw
Georgia: [my sister] went to her friend's and her friend's like obese and um and they had a bun like a sticky bun and cos sticky buns are already like sw- quite sweet and then um they um she hers cut it open and she had like that much butter [indicates about 1 cm]
Alicia: euwwww
Georgia: and she was like put one layer on and then put another layer on she just started to eat it and [my sister] was like [makes gagging sounds]
Alicia: euww I hate like big mountains of butter

By voicing their disapproval, the girls establish that their own consumption of butter and sugar is far more acceptable. The construction of the friend as obese enables the other girls to readily accept the story, as eating too much butter is something they 'know' will cause obesity and is therefore likely behaviour from a person who is obese. This perpetuates the moralistic, healthist notion of behavioural failings as the cause of ill health.

Fat as 'personal responsibility' was not challenged or re-constructed by the children. Previously, I showed the re-construction of bad fillings as good, but this type of reconstruction did not happen with fat. None of the children constructed themselves as fat, although some of them were. Perhaps there is no repertoire readily available to the children which makes 'being fat' a good thing, in the way that Amy was able to draw on the natural repertoire to construct her fillings as good. Stigmatisation of overweight people is perhaps particularly strong, compared with other health outcomes (like fillings) so it is not something children are prepared to admit to or publicly discuss.

"Bread and Milk and the Normal Stuff": Rules, Routine & the Construction of 'Normal'

Much of the children's understanding of food was constructed and constrained by rules and routines. I group 'rules' and 'routines' together because, while the two are differentiated in common understanding, rhetorically, they worked together to perform similar actions. Both rules and routines delineated the boundaries of 'normality' in terms of foods the children considered were appropriate for particular meal times; who, or which occasion, allowed for departures from rules and routines; and who was positioned to make food choices for various meals and occasions. The children used these boundaries to construct themselves and their families as 'normal' in their eating practices. Wiggins et al. (2001) also found that individuals compare their eating habits with other's to establish their own consumption as normal, relative to the 'other'.

The children had no trouble identifying or describing what they felt were normal or usual eating habits. For example, when questioned about their usual breakfasts or afternoon teas, they have no trouble describing them. They are also clear about what is not normal.

> Julie: so who makes most of the decisions about what you eat
> Three voices: Mum
> Caleb: myself
> Julie: yourself Caleb
> Caleb: yeah but sometimes my Mum
> Adam: what? you don't choose lollies for dinner and milk and chocolate

Adam's comment indicates that he 'knows' that Caleb's food choices will be constrained by what his family considers appropriate for the meal in question, despite Caleb's claim that he makes his own food decisions. For the children, making their own choices about food is highly constrained by familial norms. A common example of constraining choice by range occurred at breakfast, where most of the children said that they chose their own breakfasts but that they did so within a very small range of items, provided to them. Perhaps then, the scope of the child's opportunities to make choices depends on their conformity to those norms. A parent or caregiver giving a child 'free choice' for meals may then indicate that the child is both capable of, and willing to, make conforming choices.

The children made comparisons of normality on wider, societal levels. In the following extract, we were talking about the ingredients in McDonald's ice cream, when Sam announces that he has never had one:

> Sam: I ah I've never tasted them never ever ever

James: tasted a ice cream?
Sam: I have never had a McDonald's
Julie: never had a McDonald's ice cream
Sam: [not] once { oah ah ah
James: {oh my GOD!
Julie: don't you go to McDonald's very much
Sam: I've only had a cheeseburger
Julie: re{ally?
James: {IN YOUR LIFE!!

In his exaggeration of the announcement with "never ever ever" Sam indicates that he aware that it is uncommon for someone his age, in his society to have not had one. This exaggeration encourages an emphatic reply, which James provides, supporting the construction that it is indeed an unusual situation in their social world.

Inextricably linked to the bounds of normal food practices, are deviations from the norm, which includes notions of what are acceptable justifications for deviation, and who is privileged to make them. The children regularly mention birthdays as important occasions and identify them as times when special or treat foods are permissible. In the next extract, a common food item at an unusual time of day becomes a real treat:

Amy: When it's our birthday we always have ice-cream for breakfast (giggles) when its our
Leah: WHAT THE!

The giggle from Amy and the emphatic reply from Leah, (re)constructs 'ice cream for breakfast' as unusual.

This type of social interaction constructs and reconstructs ideas of social acceptability and norms of eating behaviours and it enables individuals to place their own eating practices in relation to others. The family's eating, not just individual eating was important to the children, as can be seen in the above examples. The children negotiate images of themselves through such comparisons.

"She Still Watches What She Eats": The Gendered Nature of Food

In accordance with sociological and social psychological literature I found that the children's experiences of food are highly gendered (see for example: Beardsworth & Keil, 1997; Mayall, 1996; Sobal, 2000) both in terms of differences between the girls and boys, and in their shared perceptions of the gender differences between their parents.

Both mothers and fathers enforced family food rules, but when the children talked about 'the rules' being broken (usually the commonly held rules of healthism), it

was almost exclusively fathers breaking them. This was the case whether the parents lived together or apart. Consider the rule makers and breakers in the following extract:

> Sally: whenever, every Sunday we go and buy lollies at the supermarket
> Julie: do you
> Emma: DO you?
> Sally: yeah Dad always buys them
> Emma: we don't
> Sally: because
> Julie: is that like a treat because Dad{gets you
> Sally: {Dad usually eats them all though
> Julie: oh
> Sally: and we only get like four or five though cos Dad eats{the rest
> Julie: {and Dad gets the rest?!
> Aiden: Yeah, Dad's usually a hogger!
> Julie: Your Dad's a hogger{as well!
> Aiden: {yeah, he eats, he eats all the chocolate
> [...]
> Sally: and Mum packs him [Dad] a lunch, otherwise he'll buy chocolate

Sally and Aiden's Dads break the rules by eating lots of lollies and overindulging (being "hoggers"). Sally's Mum takes the role of maintaining food rules, and takes responsibility for Dad as well (by packing him a lunch so he'll eat healthily).

Discussions around vegetarianism were gendered, with the vegetarians mentioned all being female. Boys were almost unanimous in their distaste for vegetarian food; the sole exception being the son of a vegetarian mother. Several boys described themselves as 'meat-atarian' but no girls described themselves this way. The National Children's Nutrition Survey figures show that more urban girls than boys avoid red meat and that girls aged 11 – 14 years are most likely to have an iron deficiency (Ministry of Health, 2003a). The girls in this study are moving into those age groups and it may be important for them to consider the impact of a vegetarian or red-meat free diet on their iron intake.

The discourses around meat eating communicated by the children in this study are reflected in the current advertising campaigns 'Red Meat, Feel Good' by the New Zealand Beef and Lamb Marketing Bureau and the 'Salad's Plus Menu' at McDonald's. The 'Red Meat, Feel Good' advertisement aimed at children of this age group shows a young, sporty boy being encouraged to eat red meat by his male coach. The campaign does not target girls of the same age. In the 'Salads Plus' advertisements a boy and a man (in similar but separate ads) each say how much they enjoy the new salad menu, because they can eat at McDonald's more often. The 'joke' is that they are enjoying a

meaty burger, while their women (a mother and a partner) enjoy the salads. These campaigns perpetuate and appeal to the notions of red meat as masculine, and the McDonald's ads construct women as conforming to healthism more than men do.

Hegemonic forms of masculinity do not position men well to perform health behaviours or to take responsibility for their own health (Courtenay, 2000; Hodgetts & Chamberlain, 2002; Seymour-Smith, Wetherell & Phoenix, 2002) and women (particularly mothers) are positioned to take responsibility for their family's health (Roos, Prättälä, & Koski, 2001; Young, 1999). Hegemonic constructions of masculinity potentially pose a paradox for boys (and men) as they attempt to define themselves as masculine and face the moral impetus to maintain their health. For James, the 'sporty self' is an effective way to negotiate his healthy choices and maintain his masculinity, but for a boy like Mark, who is not particularly interested in sports, his attempts to construct himself as healthy and to follow a healthy diet are not supported by current conceptions of masculinity. In the absence of a readily available identity that accepts both 'masculinity' and 'healthy', Mark (and boys like him) may have trouble negotiating both positions, with the conceivable outcome of giving up the 'healthy' identity. An identity in which non-sports oriented boys (and men) can position themselves as both masculine and healthy, seems to be lacking.

Since hunter/gatherer times, there has been a connection between masculinity and meat, particularly red meat and between femininity and vegetables (see for example: Beardsworth & Keil, 1997; Counihan, 1999; Roos, et al., 2001) which seems to be apparent not only in the boys' talk about their own preferences but also in the actions of their fathers. In the following extract, James shows his preference for eating meat, which his father supports, while his mother is the voice of rules and vegetables:

> James: I jus I just eat all my tea and then I jus say an when I'm at my Dad's I just eat like up the meat, cos I'm a meat eater
> Me: yeah
> James: an all I eat is meat and when I'm at my Dad's he just puts like mixed vegetables on it. My Dad he only puts a little bit on it cos I never eat the whole lot of greens
> Me: so is Dad a bit easier to get away with not eating stuff than mum?
> [...]
> James: yeah Mum makes me eat heaps of vegebulls
> Me: does she?
> James: I just like my Dad cos he always lets me eat meat.

When I reported this part of the results to the teachers at the school, several of the (female) teachers commented exasperatedly that there was most definitely a dominant

'anti-vegetarian' sentiment expressed by the male teachers and fathers who attended the school camp. Roos et al. (2001) indicate, that at least in some social groups, vegetable eating is becoming 'less feminine' than it once was. Their results also suggest that men of higher social status are able to negotiate a masculinity in which health behaviours are acceptable and this positioning may offer an alternative for boys as they consider their health behaviours in future.

Girls tended to construct themselves as selective based on their image of being more adult-like in their eating behaviour. In the following extracts, "decaf" and "McCafé" are undoubtedly superior to, or more 'adult' in status than, hot chocolate or 'plain' McDonald's respectively.

> Lisa: I have hot choco{lates I get like two huge ones like then I put
> Amy: {I like decaf
> Lisa: marsh{mallows in
> Leah: {we have decaf, that's nice
> Amy: um cos we have this machine thing that can froth up milk. So I just make a decaf coffee, and um without putting the milk in, I just heat the milk up for a minute in the microwave and then um make froth and stir it in

> The following conversation about McDonald's burgers, Olivia is describing them as 'gross'.
> Me: so a:n, you don't go to McDonald's then?
> Olivia: I do go to McDonald's except I go to um the McCafé.
> Amy: yeah we only go to McDonald's for the um café or um hm, yeah yeah. I go to McCafé

This 'adult-like' image was also reflected in girls who chose to be vegetarians. Unlike the majority of food choices, which were based on sensory repertoire, when girls chose to cut red meat from their diets, they did so for ethical reasons or because they were modelling the behaviour of a significant adult. With their desire to be adult-like in their food choices, the girls highlight the importance of adults as role models, not just in what they eat but what they *don't* eat and how they negotiate rules and routines to food.

Conclusion

This study aimed to identify the major interpretative repertoires children use when talking about food, in particular healthy food, and examine the functions of the repertoires. In identifying the sensory, nutritional, natural and healthism interpretative repertoires, I was able to demonstrate the ways in which the children constructed food as an object and how they drew on the repertoires to construct and maintain their own self-images and to make sense of their everyday food habits. The results of this study support many previously reported results about children's food and the meaning of food to children and because of the discursive approach, adds new information to the area.

While the school health curriculum that these children learn, supports the public health discourse (Ministry of Education, 1999; Tuffin, 2002), the messages the children get from this source become part of the negotiated meaning of food. These messages form a part of their understanding of food and healthy eating and individuals incorporate the messages into their own social world.

Previous studies have concluded that while children are aware of the links between food and health, they are not particularly concerned with eating healthy food (Noble et al. 2001; Ross, 1995; Watt & Sheiham, 1998). In this study however, all of the children made some effort to position themselves as healthy eaters. All, at some point, criticised the unhealthy eating habits of others and in doing so, implied their superior healthism (see Yardley, 1997, for comment on the implications of 'linguistic opposites' in health psychology). I suggest that this could be a function of the type of analysis used in this study, and the context of the study, both in the study's appeal, and where and when the study is situated in a broader social context.

A discourse analysis allows the analyst to examine "what's going on" with passages of speech, rather than "reading for meaning". Variation (or contradiction) in talk is viewed as a clue to the repertoires being drawn upon rather than an anomaly in someone's internally held attitude (or opinion). This allowed me to notice that children who "just eat what tastes good" and claim not to care about the health value of food, still drew upon the healthism discourse, which appears to be a contradictory position. From a discursive perspective, the individual is considered to be drawing upon available repertoires to *negotiate* a position, rather than needing to be categorised as *having* a position. In this way, discourse analysis is an appropriate methodology for researching everyday conversations as it accounts for social negotiation.

Both self identity and group membership can be based around food choices (Beardsworth & Keil, 1997; Germov & Williams, 2004). These assertions are supported in this data; the constructions that the children form regarding their status as 'sporty' or 'healthy', etc, create not only individual identity (e.g.: "I am sporty") but also group identity (e.g.: I identify with other sporty people). Future research could investigate the importance of food to group membership in children's environments (notably of course, school) and the way this functions to encourage or discourage eating habits.

The study findings showed that the children were able to construct themselves as healthy eaters if they chose to. The construction of 'weight' as a personal responsibility was also apparent in the children's talk and the moral impetus to maintain health was strong. The implications are that overweight children will continue to face stigmatisation and that the body will continue to be a physical representation of moral fortitude.

Ramifications extend beyond the stigmatisation of individuals and into the political and policy arena. It has been observed, that while the public consider obesity to be caused by individual rather than environmental factors and do not perceive obesity to be a strong health risk, there will be little support for environmentally focussed measures to help reduce obesity (see Lee & Oliver, 2002; Schwartz & Puhl, 2003). Therefore, health messages, as part of attempts to improve the health at a population level, may inadvertently encourage public understandings of obesity that do not support the theoretical position that public health is constructed on (socio-ecological in New Zealand), thus reducing public support population level policy action.

As knowledge is historically and contextually situated, it is important to consider the context within which these interviews were held. Two major school events seemed to have a significant impact on the context of the conversations. The school was visited by the "Life Ed(ucation) Van" during the interview period. It had just arrived when I interviewed group one and had left before the final interview. The Life Ed Van provides specialised coverage of the school health curriculum, which I believe, will have influenced the content of the interviews. One boy for example, said he "didn't used to worry about" the nutritional tables on food packaging, but did since the van's visit. I queried whether he had learnt about the tables before and he admitted that he had but that he forgets again in "just a couple of months".

The second event was the school camp. The camp food was entirely vegetarian, so the frequency of references to vegetarian food was probably higher than if the camp

had not been so close to the time of interviews, nor if it had been an omnivorous camp. While these events probably increased the *frequency* of references to nutritional tables or vegetarianism, the *function* of the talk around these would not necessarily have changed, so the effect of these events on the results is minimised by the form of discourse analysis I have used. The children can only draw on repertoires that are available to them, however, the frequency of references may have prioritised my selecting one interpretative repertoire over another.

One of the reasons I selected the school library as the location for the focus groups was because it is considered more 'neutral' than a classroom, where children are used to having little power over presiding adults (Bloor, Frankland, Thomas & Robson (2000). When introducing the study, I made a point of telling the children that they were able to speak when they wanted (as long as it wasn't "all at once") and specifically said that they did not have to put up their hands to take a turn. However, despite these efforts at 'neutrality' I discovered that many children still behaved as they would in the classroom, putting up their hands and looking to me to guide the conversation (at least initially). This observation reflects the statement by Bloor et al. that "There is no such thing as a neutral venue for a focus group." (p.39).

It is likely that some participants were motivated to volunteer for the study because they are interested in healthy food and the context in which we met may have inspired some children to 'appear' healthy in their attitudes toward food (despite my assurance that this wasn't necessary). However, the repertoires that the children draw upon are readily available in their social worlds and are available for children to use regardless of who they are talking to. The discourse analytic method helps the analyst to identify and understand the use of the available interpretative repertoires so the 'bias' of the sample is not an issue in the way it is when using empiricist methods. Discourse analysis does not seeking to 'find' truth or generalisable laws, but to acknowledges that all knowledge is historically and contextually cited. In saying that, it is also important to consider the 'middle-class-ness' of both my participants and of healthism (Crawford, 1980; 1994; Lupton, 1995) and acknowledge that the healthism repertoire may not have featured as strongly in a group of lower socioeconomic status children or in a group from a different cultural background.

As such, future research into the area of children and food might benefit from interviewing children of different socio-economic or cultural backgrounds. An area of interest in New Zealand for example, is that there were no Pacific children in this study,

yet as Pacific children have higher rates of obesity than other ethnic groups in New Zealand (Ministry of Health, 2003a) their views would be valuable. Deliberately seeking and creating focus groups of Pacific children may be a useful focus for future studies as important cultural differences in the use of interpretative repertoires may be apparent.

Another area that presents itself for future research is lay understandings of 'natural', as there is surprisingly little research into the way natural foods are understood. The children in this study held the belief that 'natural is good' and while there is research in the areas of menopause (e.g.: Lyons & Griffin, 2003; Stephens, Budge & Carryer, 2002) and death (e.g.: Bennett & Bennett, 2000) demonstrating that people draw upon 'natural' discourses to construct versions of these physical events, I found no similar research in the area of food. With increasing public concern over scientific interventions in food sources, such as the use of pesticides or genetic modification of crops (see Lawrence & Grice, 2004; Leahy, 2004) the meanings of the words 'natural' and 'organic' may be highly negotiable. The words 'natural' and 'organic' are often used in product promotion (not just food, but cleaning products, cosmetics etc) yet little is known about how the public makes sense of these concepts.

It has long been recognised, particularly in sociological literature, that food represents more than just a means of providing nutrition. It is a marker of special occasions, status, gender and more (see for example: Beardsworth & Keil, 1997; Counihan, 1999; Mennell et al., 1992). It is therefore no surprise that the children construct food using several different interpretative repertoires. It is clear that children are receiving healthy food messages and are drawing on the discursive resources in those messages to make sense of their everyday understandings and experiences of food, health and society. However, it is also clear that children (as do adults), draw upon the interpretative repertoires for their own social purposes and some of those purposes are potentially damaging. This study reinforces the importance of appreciating the social action of language and the importance of considering consequences of language choices.

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Appendix A

Information Sheet
Children and food study

June/July 2003

Dear Students, Parents and Caregivers

My name is Julie Sargisson and I am a student researcher from Massey University. I am doing a study on the way children talk about food and what food means to them. The purpose of the study is to learn about the way children talk about food and to see if that matches the way adults try to teach children about food. We learn about food from many different places, like home, school, TV or magazines. Sometimes messages can be confusing or they might contradict each other. It would be helpful for people trying to give these messages to understand how children make sense of them.

I am offering all year 5 and 6 students the chance to participate in this study. I will be talking with several small groups of students. I will do my best to put friends in the same group, so that you will be talking with people you know quite well, people that you eat your lunch with every day. I will tape the group's conversation and use the information to come up with a really good understanding of how the groups make sense of food and food messages. The information will be used in my Masters thesis and may be published in psychological journals.

Being a participant should be interesting and fun and to make sure that it is, there are several rights that participants have:

- **You have the right to withdraw** from the study at any time– even if you sign up to be a participant now, it is OK to change your mind later.
- **You have the right to ask questions;** feel free to contact me, or my supervisor, at any time.
- **Confidentiality is assured** – no one will be able to identify you when I write up the results.
- **You have a right to the results of the study** – fill in the appropriate part of the consent form.
- When you agree to be a participant, you also **agree to me taping your conversation** and using it for the study. The only people to listen to the tapes will be my supervisor and me.
- **There should be no risk to participants,** but if you feel uncomfortable about anything in the study, including things that people have said to you or about you, or your comments, you can approach your classroom teacher or me about your concerns in confidence.

The conversations should take about an hour and will take place on one day straight after school. I will provide a healthy afternoon tea to all participants. Please indicate any food allergies and preferred interview day on the consent form. I will let you know about the time for your group.

I would greatly appreciate your participation, so please discuss this with your parents or caregivers and sign the consent forms (one for students & one for your parent/caregiver) and bring them back to the school office in the envelope provided. If you are unable to participate please return the blank consent forms in the envelope to the school office. *Participation is voluntary and independent of schoolwork. Children will not be penalised if they do not take part.*

Thankyou for considering this offer,

Julie Sargisson
Researcher
[redacted]

Dr. Chris Stephens
Supervisor
[redacted]

This project has been reviewed and approved by the Massey University Human Ethics Committee, ALB (MUAHEC 03/037). If you have any concerns about the conduct of this research, please contact Associate Professor Kerry P Chamberlain, Chair, Massey University Campus Human Ethics Committee: Albany, telephone 09 443 9700 x9078, email K.Chamberlain@massey.ac.nz.

Appendix B

Participant (Student) Consent Form

Children and Food Study

July/August 2003

This consent form will be held for a period of five (5) years

I have read and understood the Children and Food Study information sheet. I have asked any questions I have had and had them answered fully and I understand that I may ask further questions at any time.

I understand that my conversation will be audio taped and used by the researcher, but that my identity will remain secret. By signing this form I am agreeing to be audio taped.

I wish to receive a copy of the results of the study (if yes, please give your postal address).

Yes ☐

No ☐

I, ...(print your full name) of room ..... (print your room number) hereby consent to participate in this study, under the conditions set out in the Information Sheet.

Signature..... Date...../...../.....

Appendix C

Parent/Caregiver Consent Form

Children and Food Study

July/August 2003
This consent form will be held for a period of five (5) years

I have read and understood the Children and Food Study information sheet. I have had any questions about the study answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand that the discussion with my child will be audio-taped and that by signing this consent form, I also agree to the audio-taping of my child's conversation.

I wish to receive a copy of the results of the study (if yes please give your postal address).

Yes ☐
No ☐

I, ...(your full name, printed) as the parent or legal guardian of .....

(your child's full name, printed) hereby consent to my child's participation in this study under the conditions set out in the Information Sheet.

If your child has food allergies or restrictions, please list them on the back of this sheet.

Signature..... Date...../...../.....

Phone number (optional) .....

Please circle the days of the week that would most suit for your child to participate (please circle all days that your child is usually available).

Monday Tuesday Wednesday Thursday Friday

Appendix D

Notes on Transcription

1. All names have been changed to protect participants' identities.
2. Words written in capitals indicate an increase in volume relative to surrounding speech.
3. Some words are spelt phonetically to resemble spoken rather than written words.
4. (…) indicates omission of words within a sentence or turn of talk.
5. [….] indicates an omission of entire sentences or turns of talk.
6. Words enclosed in [brackets] are added for clearer understanding of the quote, or inserted when the spoken words were impossible to hear.
7. Words enclosed in (parentheses) are acknowledgement tokens (e.g.: "im" or "yeah") or quietly spoken.
8. A large gap between words indicates a pause.
9. Passages of overlapping talk are designated with [on two separate lines: the talk on [the lower line interjects the top.