



Embodying health identities: A study of young people with asthma



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ABSTRACT

The embodiment of health identities is a growing area of interest. Questions posed in this literature include: how important is the body in our understandings/experiences of health, how are everyday definitions of health and self embodied despite chronic illness, and how do social relations influence these interpretations? Mindful of such questions, this paper draws on a qualitative study of mild to moderate asthma among young people in Ireland. In-depth interviews were undertaken with 31 respondents aged between 5 and 17, including boys ($n = 15$) and girls ($n = 16$) from different class and ethnic backgrounds. Core themes included: the importance of play, physical activity and sport; diet/nutrition; and physical appearance. Asthma sometimes presented challenges in relation to specific domains, notably strenuous physical activity, though in many other respects its potential impact was discursively minimised. Attentive to various modalities of the lived body, we illustrate how health identities are negotiated among young people diagnosed with a chronic illness. Connections are also made with the sociology of childhood and (ill) health, which views young people as active agents.

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1. Introduction

The embodiment of health identities, and in particular how 'the lived body' is dialectically related to selfhood in everyday contexts of wellness and illness, is a relatively new field of study. James and Hockey (2007), for instance, employ an eclectic range of theory to 'being and bodies' in order to explore the social as well as physical aspects of everyday life. This eclecticism, they maintain, is necessary because authors writing on health and illness have tended to approach embodiment in 'a rather limited fashion' (p. 12); for instance, the body as a text inscribed by culture rather than as a multi-dimensional process. To be sure, research on the various embodied meanings of health is identifiable (e.g. Monaghan, 2001) as part of a corporeal sociology that 'treats the bodily basis of social order and action as central' (Williams and Bendelow, 1998, p. 3). However, such research has largely focused on adults' rather than young people's understandings. Accordingly, gaps persist in our knowledge, including about those diagnosed with a chronic illness at a relatively early stage in the lifecourse. In this paper we help to redress this lacuna by drawing from a qualitative study of asthma

among young people in Ireland. The aim of the study was to explore the meanings and experiences of mild to moderate asthma, though, as will be seen, data also emerged on what it means to be healthy and identify as healthy despite chronic illness. First, though, we will review some relevant literature.

2. Chronic illness, young people, asthma and embodiment

Qualitative research has largely focused on chronic illness as 'biographical disruption' or a crisis situation that challenges adults' everyday lives and identities (Bury, 1982; Lawton, 2003). Such a focus is understandable given the demographic transition in Western societies and the burden of ill-health associated with the greying of populations. Yet, studies also challenge the biographical disruption concept. Illness may simply be anticipated or part of a biography in flow, for instance (e.g. Sinding and Wiernikowski, 2008). In going beyond adults' experiences of chronic illness, qualitative research has also increasingly included young people's voices (e.g. Brady et al., 2015; Bray et al., 2014). Indeed, as seen in studies of illness and the new sociology of childhood, much emphasis is given to the ways in which young people exhibit agency and, as social actors, are capable of negotiating, constructing and reframing experiences such as pain and discomfort (Jenkins, 2015).

Moving to asthma, clinical researchers bemoan the lack of

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research on the patient perspective (Jonsson et al., 2014). This perceived lack is surprising given the high prevalence of asthma, especially amongst children (Lai et al., 2009), defined by some as a 'new epidemic' (Rudestam et al., 2004, p. 424). In Ireland, Manning et al. (2007) report a prevalence rate of 21.6 per cent for those aged 13 to 14, while in the UK this figure is 24.7 per cent (Asher et al., 2006). However, despite concern about the lack of research, the deficit is not absolute. Besides research on adults (e.g. Keddem et al., 2015), Newbould et al. (2007), Meah et al. (2009) and Venning et al. (2008) explore issues such as medication use and interactions between parents and their children in order to mitigate the risk of potentially fatal asthma attacks. At the same time, such work, for a healthcare audience, shares the tendency within medicine to pathologise children's bodies (James and Hockey, 2007).

Within medical sociology, qualitative studies of asthma have provided insights about, for instance, the 'ordinariness' of inhaler use (Prout et al., 1999). Findings have also been reported on the ways in which gender and age mediate chronic illness, as seen in Williams (2000) research on identity construction among teenage boys and girls with asthma and diabetes. Such studies usefully illustrate the agency of young people when seeking to manage their condition and limit its impact, though, as with Gabe et al. (2002), there is an immediate concern with everyday restrictions and associated adaptations. In short, attention has largely centred on the negotiation of *illness* rather than *health identities*, with young asthmatics seen to be disadvantaged in certain respects (Rudestam et al., 2004). What is lost in this otherwise useful literature is the degree to which asthma may itself be eclipsed by young people in myriad ways as they actively negotiate and embody health identities, do 'being healthy' and even project a sense of 'vibrant physicality' (Monaghan, 2001).

Conceptually our study draws on embodied sociology (e.g. Waskul and Vannini, 2006; Watson, 2000; Williams, 2003; Williams and Bendelow, 1998). Such an approach views the 'lived body' as socially embedded, relational and a vehicle for challenging seemingly 'natural' dualisms such as biology/society and, as we will see, healthy/ill. As explained by Williams (2003), for example, it is necessary to engage 'a variety of "bodies", or, perhaps more correctly, *perspectives on and dimensions of embodiment*' when addressing neglected questions such as 'what is health?' (pp. 29–30, emphasis added). James and Hockey (2007) appear to have similar concerns in mind when taking steps 'towards a theory of embodiment' wherein the lived body is conceptualised as an existential 'reality' that 'comes into being through the process of objectifying our embodied experiences as participants in the social world' (pp. 54–5). This, in turn, leads to an appreciation of how the body 'can take many forms' as part of a dynamic, socially embedded and contingent process. Similar to the aforementioned authors, we draw on an eclectic range of theory and incorporate multiple perspectives on 'bodies' when exploring health. In particular, we are indebted to Watson's (2000) approach to modalities of the (adult male) body, which, we would suggest, has a more general applicability.

Watson's body schema is developed in a qualitative study of men's health in Scotland. His schema differentiates between four interdependent modes of embodiment: (1) *the normative* (i.e. the size, shape and weight of bodies), (2) *the experiential* (incorporating a positive sense of well-being, for instance), (3) *the pragmatic* (the body which acts in the world, typically according to various gendered role requirements) and (4) *the visceral* (a material body, with hidden biological depths, which can be medically visualised). Located in everyday life, Watson presents a grounded theorisation of how modes of gendered embodiment relate to concepts such as 'being in shape' and 'social fit-ness'. Pertinent questions include how do people make sense of health and negotiate normative

expectations? Associated themes range from the relevance of having a 'normal everyday body', which is functional, to the symbolic significance of physical appearance and behaviour when defining (poor) health. Formally, Watson's schema provides a useful heuristic for exploring the indeterminacy of lived bodies' relationships to health, culture, society and identity.

Theorising on the 'looking-glass body' is also relevant (Waskul and Vannini, 2006), meshing well with issues raised by writers such as Petersen (2007) on the re-shaping and perfecting of bodies in high modernity. Furthering Cooley's concept of the looking-glass self, such work also tallies with James and Hockey's (2007) interest in how the social self is reflective of societal frames, definitions and interpretations – a dialectical process inseparable from real and imagined bodies as constructed and experienced in the world of interaction. Finally, given the emphasis upon normative embodiment in our sample, especially weight-related talk, we will refer to studies of obesity discourse (e.g. Evans et al., 2008). Repeated reference to weight/fatness as a manifest index and determinant of health and well-being was not anticipated in our study, but, as will be seen, such talk was commonplace. As per Evans et al.'s research in schools, our study heeds earlier suggestions in body studies that there is a need 'to appreciate the importance of embodiment to the process through which children participate in social life' (Williams and Bendelow, 1998, p. 4; see also Monaghan, 2014).

3. Methods

Funding was obtained for a two year study of childhood asthma from the Irish Government's Programme for Research in Third Level Institutions (PRTL-IV). Medical sociologists employing qualitative methods have largely explored moderate to severe asthma (Gabe et al., 2002; Williams, 2000); hence, we purposively selected young people with mild to moderate manifestations of the disease. Asthma severity was determined by asking parents to complete a questionnaire, based on the global initiative of asthma classification (Liard et al., 2000). This was subsequent to obtaining their written informed consent, in line with university Research Ethics Committee (REC) protocol and approval, with the researcher providing parents with an information sheet describing, for example, the title and purpose of the study, the methodology, measures to ensure confidentiality and anonymity, the benefits of the study and options should their child become embarrassed or uncomfortable.

In line with our methodological and ethical concerns, in-depth one-on-one interviews were chosen given (a) our interest in intersubjective meanings and situated definitions, (b) the sensitivity of the subject matter, which could potentially spoil identities if explored in group contexts (e.g. focus groups), and (c) the demonstrated value of interviewing when exploring embodied themes, as noted in some of the above sociological literature (e.g. Evans et al., 2008; Monaghan, 2001; Watson, 2000). Questions included: 'how do young people define their asthma' and 'how do they manage their identities when talking with others, such as a researcher with no apparent health problems?'

In-depth interviews ($n = 31$) were undertaken in South-west Ireland in 2010 by a female researcher. Interviewees were aged between 5 and 17 years. While this range offered some opportunity to explore divergent views among respondents according to their relative stage in the lifecourse, the contingencies of the recruitment process meant that only one interviewee was under 8 years of age (aged 5): the mean age was 12.7 years, the mode was 16 years (seven respondents) and the median was 12 (six respondents). The sample comprised 15 boys and 16 girls. None were newly diagnosed. Unlike Keddem et al.'s (2015) research on adults with asthma, respondents' Body Mass Index (BMI) was not recorded. However, there is no indication from transcribed data that any of

our interviewees identified as overweight. This is relevant when interpreting their definitions of healthy bodies.

Interviewees were recruited via a GP, the health authority's Traveller Health Unit, and snowballing. These channels enabled us to obtain the views of young people from a middle-class suburban setting ($n = 17$) and the Irish Traveller community ($n = 14$), reflecting our interest in how class and ethnicity might shape health identities. Travellers are differentiated from the larger 'settled' population by their distinctive 'value system, language, customs and traditions' with a 'culture based on a nomadic tradition' (All Ireland Traveller Health Study, 2010, p. 9). The impact of social inequality on Travellers' health is well documented in the aforementioned study. For example, doctor-diagnosed asthma in the previous 12 months is the most commonly reported condition and is two to four times higher than in the general population (pp. 64–5). This observation tallies with what is generally known about deprivation, childhood asthma and morbidity (Milton et al., 2004).

The researcher informed young people that she wanted to talk to them about health, including but not limited to their experiences of asthma. She told them that she hoped to get a sense of what they knew about health and to understand their health practices. A context-specific approach was employed, with young people encouraged to reflect on everyday activities, relationships and experiences in particular situations (e.g. when playing sports at school or when socialising with friends and family). Interviewees were generally receptive to this framing of the research. All were informed that they could end the interview whenever they wished, and they were not obliged to answer any questions. Similar to Morgan et al. (2002), who sought to reduce the power hierarchy between adults and children, interviewees were also encouraged to refer informally to the researcher using her first name.

Interviews were conducted at respondents' homes. The university's REC stipulated that a parent should be present. In practice, many of the parents remained in the vicinity rather than the room where the interviews were conducted. The researcher did not feel that participants withheld information because of parental presence. Interviewees were invited to choose a pseudonym in order to preserve their anonymity. They were also subsequently given an identifying code to signify their gender, age and whether they were from the Traveller or settled community (e.g. F8T, M12S).

Interview data were transcribed verbatim. The lead author took a central role in indexing and analysing these data. While there are debates in the methodological literature concerning the degree to which qualitative researchers can or should remain uninfluenced by other studies (Charmaz and Mitchell, 2001), the lead author's previous immersion in and contributions to embodied sociology proved useful when analysing the data. For example, his writings on the obesity debate, particularly in relation to young people (Monaghan, 2014), and the embodiment of health among adults (Monaghan, 2001), provided an awareness of and sensitivity to emergent corporeal issues and themes that were unanticipated in the present study and which might have otherwise remained taken-for-granted. In order to analyse these data systematically, the transcripts were indexed using coding software, Atlas.ti. This indexing facilitated a thematic approach, with emergent codes (e.g. health talk, food and sport) allocated to segments of text to be retrieved later and further analysed. A comparable approach is used by Williams (2000) in her research on asthma and diabetes.

Two final points are worth making briefly. First, while some readers may question whether interviews allow researchers to grapple with the experiences of the body, we would return to writers such as James and Hockey (2007) who view persons as

actively *in* and *as* their bodies. They explain that bodily being is always a socially mediated process and that embodied realities are continually co-constructed, objectified and re-presented through participation in the social world. Second, and critically, we remain cognisant that the moralisation of health in everyday life served as a backdrop to the generation of these data. We briefly return to this point at the end of our paper.

4. Negotiating health identities: an embodied, contingent process

Health was interpreted by young people as a positive or super-value that was not only symbolised in particular ways (e.g. with reference to foodstuffs) but also as something that had to be maintained or achieved in order to live a happy, full and successful life. Their own asthma diagnoses notwithstanding, interviewees often championed the merits of being healthy, following a healthy lifestyle and being knowledgeable about what that might entail. Consider how Luke (M9S) understood health as an embodied concept and practice. After describing how the lungs risk being starved of oxygen during accidental suffocation, he was invited to share his knowledge about the body and how it works. This quickly resulted in a testimonial about his good health, despite being diagnosed as asthmatic when aged 5:

I'm very healthy ... I'm strong and I play loads of sport and I can run really fast. If I was sick I wouldn't be able to do that. And I eat healthy food, cheese sandwiches and apples and loads of pasta dinners and fish. I drink loads of milk too, so I have very strong teeth and bones and they're really white. I know that the bones in my leg are white because when I broke this one [points to leg] when I was 7 the man showed me the X-ray and it was full of very white bones.

When discussion turned to health across our sample, three main themes emerged: (1) play, physical activity and sports; (2) diet/nutrition; and (3) physical appearance. Two of these – physical activity and diet – have also been mentioned recently by urban African American adults with asthma when discussing how to keep healthy (Keddem et al., 2015). The three themes in our study, in addition to capturing various dimensions of positive health as socially constructed/accomplished, were also tied to different modes of embodiment, i.e. how relational bodies look, feel, move and their visceral depth (Watson, 2000). We will explore these themes in turn after offering three caveats.

First, as seen in the quote above, themes were interwoven as part of a general discussion and presentation of a healthy self. Nonetheless, we have organised our analysis under three separate sub-headings for heuristic purposes. Second, other themes emerged when exploring the meanings of health and its accomplishment, such as ensuring adequate sleep, avoiding smoking and visiting healthcare professionals (or, conversely, not having to frequent hospitals). However, we have limited ourselves to the three themes above due to space constraints and because these dominated our interviewees' talk. Third, there are non-conforming cases in our sample, where young people embodied an *unhealthy* identity, or identified as 'not fully healthy'. Given the contingency of mild asthma as a 'sometimes problem' (Monaghan and Gabe, 2015), it is perhaps unsurprising that health identities were similarly framed. Even so, young people overwhelmingly self-presented as healthy, all things considered. In asserting their agency, they also defined themselves as knowledgeable of what was required for health and well-being. It is to the three core themes, listed above, that we now turn.

4.1. Play, physical activity and sports

You know [if somebody is healthy] because they would be fit and strong and they will always look really happy too. They will be smiling and always doing things in the garden and on the beach. They will be getting lots of clean air [and] cycling their bikes everywhere. (Nadine, F9S)

As seen above, Nadine linked health (fitness, strength and happiness) to an active outdoor life. Elsewhere in the interview, she described her own playful participation in such activities and, by extension, asserted her own health status despite having to use her 'puffer' (inhaler) two to three times per week. Similarly, most respondents emphasised play, physical activity and sports as aspects of a healthy life which they often embraced and even excelled at. Travellers could be fairly vocal in this regard. Cass the Bad Ass (M12T) seemed enthusiastic when constructing a healthy identity. In the following extract, Cass was asked why he chose that pseudonym. This exchange emerged early in the interview, before he described various health problems which included, but went beyond, asthma:

Interviewer: What made you choose that name?

Cass: It's a name of a horse that my daddy had one time that won [lots of] races.

Interviewer: And what kind of a horse was Cass the Bad Ass?

Cass: A very fast runner. Big, black, fierce. Strong and fierce fast.

Interviewer: Are you a fast runner too?

Cass: The fastest boy on this [halting] site, I can tell you that here and now.

Interviewer: Do you guys have a lot of races?

Cass: We do be always race'n one another. We go up there to them fields and we run like our lives are depending on it. Most of the boys are fast enough too, mind.

Interviewer: Do you like other sports?

Cass: Yeah. Swimm'n on Saturday mornings and me and the boys play football nearly every day.

Fitness/health, for our interviewees, was a precondition for and product of play, comprising regular physical activity and/or sports. Ideal typically, a fit and healthy person was seen to be actively engaged in the world, often with other people. This construction was typically gendered. For Stringer (M13S), 'guys' enjoy sports and he found it difficult relating to those who did not. Accordingly, Stringer (a pseudonym in honour of a local rugby hero) was a 'normal' boy who preferred sports to a more sedentary existence. In his words: 'I love it [sports]. Can't believe it when you meet guys and they say they don't like sports'. When explaining his preference, he added: 'You get to move around with your friends. It keeps you fit because you're just not sitting around playing [video] games and being bored. Otherwise you could get really lazy and never want to do anything'. As an aside, Stringer confided that he used his inhaler after playing rugby at school but was fairly private about this because he feared others would view him as 'sick' and unfit. In that respect, he was similar to teenage boys with asthma in Williams' (2000) study. Additionally, when referring to asthma attacks his biggest complaint was that these episodes stopped him playing sports for a while.

Meaningful physical activity took various forms depending upon the age and gender of respondents. Boys, especially teenagers, usually talked about football and rugby whereas younger girls typically referred to playing with friends on bikes, rollerblades and other sociable outdoor pastimes (e.g. walking in the woods with family). After Nadine (F9S) mentioned playing outside on her

bicycle, she talked about age-appropriate physical activity and its bodily effects. Such talk also implicates class-based constructions of health as an individualised accomplishment, with the gym and aerobics being preferred by Nadine's and other middle-class respondents' mothers:

Nadine: You just have to do good things that are healthy. I'm not allowed to go to the gym with my mom because I won't be 16 for a very long time but when I am 16 she is going to bring me and we're going to do aerobics together. Now we do that with the Wii [electronic games console], me and my mom, but she goes to the gym a lot.

Interviewer: Is doing aerobics good for you?

Nadine: Yeah. You do loads of moving and jumping so then all your muscles are moving and you are healthy and your heart beats fast but that is a GOOD thing because you are being fit.

Some teenage girls said they disliked exercise. While this is associated with guilt and identifying as unhealthy in Williams' (2000) study, teenage girls in our research quickly stressed that they were not completely sedentary and consequently in poor health. For example, Katie Perry (F16S) disliked sports participation but emphasised that she would walk up to an hour into and from town on Saturdays with her friends, in contrast to unhealthy people who she defined as lazy.

Research by Rudestam et al. (2004) found that children with severe asthma limited their time outside and that the condition affected their social lives. While the cold weather could trigger asthma symptoms for some of our respondents, they nonetheless endorsed the virtues of being outdoors. Indeed, being physically active outdoors and enjoying being in the open air, especially during summertime, was a recurrent theme. What had particular resonance for our interviewees was the idea of breathing in 'fresh' or 'clean' air, serving as a counterbalance to the cultural typification and/or reports that asthmatics struggle to breathe and are constantly wheezing (see Gabe et al., 2002). Numerous (health) benefits were ascribed to outdoor activity, as seen with Josh (M16S) who rejected his mother's definition that he had 'really bad asthma'. After commenting that he loved 'fresh air, sunshine' and was 'really healthy' by virtue of skateboarding most days, he said: 'when I'm out in the fresh air I get hungry for healthy food, and I stay fit and healthy and I can sleep really well'.

Other benefits ascribed to being outside included sociality, albeit in ways that implicated children's understandings of material corporeality. Consider Princess Tiana (F5S), who identified as an 'asthma girl' and was thus comparable to teenage girls in Williams' (2000) study who incorporated asthma into their social identities. She talked about outdoor activity as a social activity wherein pragmatic embodiment benefitted the experiential and visceral body (the happy, sociable child who has a healthy, functioning heart). Resonating with Nadine's (F9S) comment about being active on the beach or in the garden, normative embodiment also features in such reasoning, with positive reference to a suntan that symbolises a healthy, happy existence:

Interviewer: Why do you prefer being outside?

Princess Tiana: It's so much fun and you can see all your friends and get loads of fresh air and make a suntan.

Interviewer: So, you like the fresh air [interrupted]?

Princess Tiana: I do like it, yes. Yes, I do. It makes you all really healthy and happy.

Interviewer: Oh, really? How does it do that?

Princess Tiana: When you breathe in like this [draws a long breath and keeps her mouth closed for a few seconds] then the air goes in and makes you healthy in your heart and in your legs.

If you don't breathe in fresh air then you have a black heart and it could be broken, but if you suck in clean air like this [draws a deep breath and exhales] then your heart will turn red again and it's perfect. Now do you see how it works, silly billy? If you stay outside and play then you will have lots and lots and lots of fresh air and you will be super-duper healthy.

Being active outside was also linked to mental health, as captured by Kelly (F17T) who reported taking medication for depression and expressed boredom with her life on the halting site. For her, walking in the fresh air: 'gives you a bit of time to yourself and when you're out you just feel cleaner and your head don't be fuzzy'. Young Traveller men also endorsed the health benefits of outdoor activity. Jesse James (M16T), for instance, described himself as 'healthy as a horse' and 'I always feel healthy inside and outside 'cos I'm forever out and about'. Big Dipper (M17T) agreed, stating that Travellers were healthier than settled people as a result.

In summary, even when relying on inhalers, most respondents endorsed physical activity as an aspect of healthy living. They emphasised physical fitness as a precondition and product of active play and valued being outdoors. Physical activity was gendered with boys talking about football and rugby while girls mentioned playing on bikes and walking with friends. Some Travellers claimed they were healthier than settled people by virtue of their preference for outdoor activities, despite evidence of health inequalities and high rates of asthma (All Ireland Traveller Health Study Team, 2010).

4.2. Diet/nutrition

A healthy person eats nourishing food and all that and goes to the gym and looks healthy and they're happy. The unhealthy ones eat crap food. (Anna, F16S)

As Anna notes above, 'a healthy person' is not only physically active; they are also mindful of their diet, ensuring good nutrition rather than consuming 'crap food'. This construction of a healthy person is an ideal type, and one that was sometimes openly contradicted by interviewees. Yet, it remained the case that when embodying health identities, interviewees often drew from commonly circulating typifications regarding good/bad, or healthy/unhealthy, foodstuffs in order to present themselves in a positive light. This was so for Ali (F14S) who said: 'I'm kind of healthy like, I, you know with the asthma it's kind of hard to keep up with sports and stuff but, like I eat well'.

'Eating well' encompassed various practices and reasoning, ranging from the desire to promote healthy visceral embodiment (e.g. strong bones and good blood) to the ability to concentrate in school and function to the best of their abilities. And, various sources were identified by young people when describing how they acquired such knowledge. First, though, we will flag interviewees' orientations to types of foodstuff. The distinction between junk food (notably, calorific takeaway food, sweets and carbonated drinks) and healthy food (fruit and vegetables) was common. Junk food was seldom condemned outright, or if it was then the interviewee would subsequently talk about occasions when it was acceptable or when parents 'allowed' them to consume such foods (e.g. when going to the cinema or into town at the weekend). Junk food, for these young people, tasted nice and was something to be enjoyed *in moderation* so as to avoid sickness:

Princess Tiana: I LOVE pizza [rubs her stomach]. That's my favourite junk food in the world.

Interviewer: Why do you think we call some food 'junk food'?

Princess Tiana: 'Cos it's just junk. It is made of all sugar and dirty stuff that makes you feel really bad when you are eating way too much of it [pause] so you could be sick, very sick.

Interviewer: Oh, I see. What type of food isn't junk food?

Princess Tiana: Oh, I know that question. Good food, healthy food that is yummy in my tummy.

Interviewer: What kind of food would that be?

Princess Tiana: Apples and celery and yoghurts and eggy bread and beef stew and rice and [pause] no Taytos [crisps] or fizzy drinks. (F5S)

Fruit was often lauded by young people when doing health. Beoir (F16T), for instance, remarked: 'I eat a press [cupboard] full of fruit. I love bananas and apples'. Other girls from the halting site, like Manie (F12T), also stressed their virtuousness in relation to diet and food outlets: 'I don't eat takeaway foods a lot of time. That grub is all greasy and gives you pimples and fat arms and bellies'.

While diet had particular meanings for girls who were focused on normative embodiment, equating beauty with health (discussed further below), boys tended to emphasise pragmatic, visceral and experiential embodiment. Nutritious food provided energy for physical activity and also contributed to bodily structure, notably strong bones. Immediately after claiming he always felt healthy 'inside and outside', Jesse James (M16T) said: 'I eat stuff for energy. I eat sandwiches, stews, apples, all that type of stuff and I drink a pint of cold milk with my dinner for my bones'.

Respondents sometimes contrasted themselves with the interviewer, after she mentioned she was a vegetarian. Stringer (M13S) believed vegetarianism was unhealthy. For him, consuming meat was vital, with reference to internal functioning (one's heart), though physical appearance (skin condition) was also cited. Other interviewees talked about food that was said by parents to be bad for their asthma and flagged dietary measures intended to help with their condition. Thus, Woody's (M8T) mother disallowed him from having custard and, invoking what appeared to be a folk remedy for respiratory problems, was constantly giving him thyme to 'dry up the chest'. Other interviewees claimed they still consumed foodstuffs banned by their mothers but did not tell them.

Parents, even if ignored at times, were not the only source of information about healthful food. After stating she preferred 'healthy foods', Mary Jane (F12T) explained how her teacher gave a class on nutrition. All the children in her class were then provided with a nutrition chart to take home. Mary Jane added: 'I showed it to my mommy, and we looked at it and I told her what we should buy in the supermarket that was healthy'. There were other sources too. Paul (M12S) mentioned a rugby summer camp, which added to the stock of nutritional knowledge provided by his mother and sister:

Interviewer: So can I ask you what kind of things you do to help your health?

Paul: OK, so I know the things that you are supposed to do and I just do them. I eat food that is good for me. We did this summer camp last year down in the university and this guy that trains with the [rugby] squad showed us the food that is good for energy so it's like rice and vegetables and brown bread, fruit, smoothies and drinking loads of water. Yeah the water bit is really good for you too and he was on about why you should never skip eating breakfast [...] Yeah, I learnt lots at the summer camp but my mom and sister are always making healthy stuff anyway so I kind of knew a lot before I went there. My [16 year old] sister thinks she's going to be a model so she goes nuts about her food [laugh].

In sum, young people equated healthy embodiment not just with physical activity but also good nutrition. At the same time, most were partial to 'junk food' and saw it as a source of pleasure when consumed occasionally. Healthful food or diets were considered important for their own bodies; 'real food' was seen as a source of energy, aiding the development of healthy bones, skin, blood, teeth and a proper functioning heart. Bad food was defined by some as that which their parents said worsened their asthma, but this view was sometimes challenged. Besides parents, sources of dietary information included school and summer camp. Nutrition was also strongly associated with physical appearance, especially by girls who equated slimness with health and beauty.

4.3. Physical appearance

Health was also tied to normative embodiment. How bodies are presented (the degree of self-care inferred from one's look, the body's fit with hegemonic definitions of physical attractiveness and virtuousness) emerged as a relevant topic of conversation. Through such talk, young people presented themselves and others as 'looking-glass bodies' (Waskul and Vannini, 2006), with the exteriority of the physique serving as a symbol of a healthy or compromised self that had succeeded or failed to exercise self-care. As we will see, obesity or fatness also emerged in such talk.

Before exploring these themes, it is worth noting that 'doing health' through an emphasis on normative embodiment was an exemplary way of 'doing gender' (Williams, 2000), with looking-glass bodies often constructed as female bodies. In line with the objectification of female bodies in patriarchy, girls emphasised their own appearance when describing positive health and well-being: long hair, bright eyes, tanned skin and feminine curves as distinctly gendered components of a 'healthy look'. Interestingly, when discussing their own healthy physicality, boys more often emphasised pragmatic embodiment – their actual involvement in sport, or being a fast runner, took priority over how their body looked. Boys referenced bodies that 'worked properly', though this did not stop them from passing comment on how *other people looked* (almost exclusively girls and women defined as fat) when constructing a 'type' against which they could be more favourably compared. When boys did discuss their own bodily appearance and its relation to their sense of health and self, they typically emphasised looking strong rather than 'skinny'. Consider Rainbow Rider's (M12T) response to the question 'are you healthy?':

Rainbow Rider: I am, look at this [shows his muscles].

Interviewer: Wow, check that out for strong. You must spend hours in the gym, do you?

Rainbow Rider: [laughs] Not allowed into there 'til you're 18.

In contrast, 'doing health' among girls is clearly demonstrated by Hannah Montana (F12S), who emphasised physical aspects of idealised femininity. For her, breasts were important for young women seeking a 'healthy look'. Good skin, hair and weight were also accorded symbolic value. In her words: 'You just look a lot healthier if you have them [breasts] because that's the way that girls are supposed to be' and 'you can make yourself look healthy if you mind your hair and skin and you don't get fat'. Other girls offered similar words. Lady Gaga (F15S), after enthusiastically endorsing the merits of suntanned skin (looking and feeling healthy) and fashionable clothing, said:

There's hair as well, so if it's shiny and just in really good condition, you know that person is healthy enough. And then you know by how big or small they are too. It's like if someone is really big and kind of fat you know that they eat too much food,

way too much junk food like sweets and Tayto's [crisps] and that they don't like doing much exercise. If someone is small enough, like thin and in good shape and just [pause] like not too skinny, then you know that they eat proper food and might go to the gym to stay in shape and healthy.

Adults' (especially women's) looking-glass bodies were also invoked, especially by boys. Ronaldo (M12T) referred to the researcher's looks (teeth, hair and 'shiny eyes') when defining health and his 'mammy' when defining poor health: 'She's fat and tired and she always has them cold sore things ... She doesn't have shiny eyes'. Stringer (M13S) also contrasted the researcher's healthy looking-glass body with his teacher's poor physical condition. What is also interesting about Stringer's talk is that he sought to avoid 'courtesy stigma' (Goffman, 1968), or stigma by association, by insisting that his 'fat' and breathless teacher was *not* asthmatic:

Stringer: You look healthy and stuff.

Interviewer: You think I look healthy? What makes you think that?

Stringer: You don't look tired like lots of adults look tired. You're tall and you're not fat. I don't know, you just look like a healthy enough lady.

Interviewer: And what would an unhealthy lady or any unhealthy person look like?

Stringer: Big and fat and kind of puffy. You know, like when people can't run for the bus. Or when they just have no energy and they have greasy hair and just look very lazy. One of my teachers is really fat and when she talks, she can't breathe like normal. She sounds like Darth Vader. We all say that. All you can hear is weird breathing [he mimics her]. It's very funny but you feel bad for her. It's not very nice to say she's fat, but she is so we all say it.

Interviewer: Do you think that maybe she might have asthma, if her breathing sounds like that?

Stringer: No! [Annoyed] You don't get asthma because you're fat! Anyway, every fat person in the world doesn't have asthma. And, I don't know, but she doesn't have asthma.

In line with the perfection codes noted among schoolchildren by Evans et al. (2008) and Monaghan (2014), our respondents were well versed in obesity discourse and related body-centric concerns. For them, people deemed 'fat' represented the unhealthy 'other' against which they implicitly or explicitly defined themselves. The 'fat' rather than the 'very thin' person overindulged in 'junk food', resulting in an inability to participate in Physical Education that compounded their assumed poor health. Reproducing dominant 'fat fabrications' (Evans et al., 2008), which pathologise larger bodies in accord with an energy model of body weight (notions of gluttony and sloth), Luke (M9S) said:

Luke: There is a girl in my class and she is super big, like the girl from Glee [TV show] and she eats loads of junk food, even at school and then she tells me 'oh I was in McDonald's last night and they have a new McFlurry' [ice cream]. And then when she can't do PE she doesn't even know that she could do it if she stopped going to McDonald's every single day.

Interviewer: Can big people be healthy?

Luke: No [shakes head].

Interviewer: Can very thin people be healthy?

Luke: Yeah. They only eat SOME junk food, just for treats so their bodies work properly and then that keeps them very healthy. Then if they are healthy they can play soccer and stuff and that keeps them even more healthy.

Such an emphasis on the putative deficiencies of fat bodies has to be understood in a cultural context where there is a preoccupation with objectified physicality (lean, attractive bodies) in addition to the relative invisibility of asthma. If poor health 'looks' a certain way, then asthma may, in a social sense, be eclipsed by other 'conditions' which constitute, in [Goffman \(1968\)](#) sense, discredited stigma. Asthma is not immediately seen, it is discreditable, in contrast to obtrusive physical stigmata:

That's what I'm saying to you. Nobody sees asthma, they just know you have it but it's not like you have a cleft palate. God forgive me for saying that, but do you see what I mean? They can't tell it by looking at you so they don't know if there's anything at all wrong with you. (Kelly F17T)

In sum, health was tied to normative embodiment in terms of weight, size, shape and general appearance. Gender was exemplified through such talk. When doing health in such terms, girls tended to talk about hair, skin, slenderness and fashion while boys referred to their strong-looking bodies, which were suggestive of their involvement in physical activity and sports. Respondents across the sample also invoked the (typically female) fat body, which was emblematic of the unhealthy 'other'. Fatness served as the antithesis of the valued, healthy looking-glass body, which was explicitly or implicitly displayed by the interviewee. Such talk enabled respondents to present themselves as being in 'good (enough) shape' and fit for a body oriented healthist culture. However, some acknowledged that 'looks' could disguise internal ill-health in the form of asthma.

5. Discussion

The limited studies of childhood asthma, outlined above, typically depict young people as either impaired or endeavouring to negotiate illness rather than embodying health identities. This focus is understandable, especially given alliances with biomedicine and/or concerns about the restrictions faced by young people with more severe manifestations of the disease. We would not reject such research and attendant insights. Indeed, even when researching mild to moderate asthma it is evident from our study that the condition may pose various challenges for young people, such as ensuring easy access to inhalers in order to prevent or mitigate breathing difficulties ([Monaghan and Gabe, 2015](#)). What is also important to recognise, though, is that this difference from 'normal' (healthy) childhood could potentially discredit the identities of those diagnosed as asthmatic – the 'sick child' who 'arouses great concern' ([James and Hockey, 2007](#), p. 153). What interested us in this paper was how health could be defined as resilience to such depictions in a world shared with others.

As observed in our study, health identities were socially embedded and negotiated, with young people referring not only to themselves but also other people such as the interviewer, parents, friends and teachers. The general lesson to be taken from these data is that 'being healthy' or 'doing health' are relational processes that were not precluded by a medical diagnosis and treatment for a chronic illness. In that respect, our interviewees' talk not only countered the 'sickly child' label, alluded to by [James and Hockey \(2007\)](#), but also the worrying 'epidemic' narrative surrounding asthma ([Rudestam et al., 2004](#)). Formally comparable processes have been discussed by [Lowton and Gabe \(2003\)](#) in relation to cystic fibrosis. Our work also supports recent sociologies of childhood health wherein young people are viewed as active agents, albeit within various constraints (such as inter-generational power relations) ([Brady et al., 2015](#)).

Attentive to the 'lived body' as the experiential site of self,

culture and society, our study also contributes substantively (empirically) and formally (conceptually) to an embodied sociology that foregrounds corporeality and collapses dualities such as healthy/ill. As observed, embodiment was integral to young people's definitions/experiences of (ill) health, shaping contingent identities in a social world where health is typically framed as an obligation, virtue and index of moral worth ([Lupton, 1995](#)). Forms of embodiment served as the source, location and medium of health (identities). Perspectives on and dimensions of embodiment, to return to [Williams \(2003\)](#), were therefore made explicit in our analysis. Using [Watson's \(2000\)](#) (male) body schema as a heuristic, we explored empirically some of the ways in which the body is the site of emotional well-being or otherwise, moulded through action in the world (the *pragmatic* body which, for instance, engages in play with friends) and is seen by oneself and others as more or less aligned with *normative* definitions of good health (a body that looks fit, that is of the 'correct' shape and weight).

While Watson's schema was developed in relation to adults, our study shows that it can be extended to young people and their health identities. Following Watson, concepts such as 'being in shape' or having a 'normal everyday body' also applied to our interviewees who demonstrated 'social fit-ness'. This, of course, was mediated by the lifecourse and other divisions. While men in Watson's research talked about being fit enough to provide for their family in ways that often marginalised the physical body, young males in our study, in the absence of such obligations, talked about being physically able to play football regularly with 'the boys' or join their school's rugby team. Teenage girls sometimes eschewed physical activity and instead emphasised appearance, but they remained 'fit enough' to walk to town with friends, for instance. As noted, asthma also presented certain challenges, with some interviewees (especially sporty teenage boys) remaining fairly private about their inhaler use through fear of being seen as sick and unfit. Foodstuffs, as per the instructions of mothers, were also prohibited at times because they exacerbated asthma symptoms – visceral processes that could affect the experiential body and constrain the social self that was otherwise defined as healthy/fit enough. Such insights help to redress the tendency for the sociology of the body, similar to the sociology of chronic illness, to prioritise adults' experiences ([Brady et al., 2015](#)). We would also underscore, along with medical sociologists such as [Williams \(2003\)](#), that social studies of medicine, chronic illness and the body may be furthered by foregrounding the embodied meanings of *health* across social divisions.

In elaborating upon the latter point, there is evidence from our study that deep structural divisions influenced the co-construction of health identities in interaction. While contributors to sociological studies of the body, drawing on feminist scholars, have detailed the degree to which health and beauty (industries) are intimately enmeshed (e.g. [Petersen, 2007](#)), our study provides grounded knowledge of how such practices and representations are also implicated in the social construction of health identities among young people diagnosed with a chronic illness. And such processes evidently intersect with axes of power that implicate lived bodies that are differentially located in social hierarchies that are more or less likely to foster positive health outcomes. For example, young Travellers were often keen when talking to a healthy-looking middle-class female researcher to assert that they were fit and healthy, despite high recorded rates of chronic illness and morbidity in their minority ethnic group. Indeed, somewhat paradoxically, there seemed to be a positive relationship between the degree of health problems in their marginalised community and the tendency for narrators *enthusiastically* to self-present as healthy and engaged in health-enhancing behaviours, as far as was practical. Yet, we would also stress the *general importance* attached to

embodying health *across our sample*. Indeed, our study empirically supports claims within the sociology of the body that a healthy existence and moral worth in high modernity are often indexed by the flesh.

Our exploration of such issues also demonstrated the usefulness of interactionist accounts of the 'looking-glass body' (Waskul and Vannini, 2006), and studies of obesity discourse (Evans et al., 2008). Whilst a critical interrogation of the war on fat was beyond the scope of our paper, we observed that obesity discourse framed looking-glass bodies, creating discredited 'others' (typically female bodies) against which those with normative looking bodies were able to embody health identities. In so doing, interviewees, who did not personally identify as overweight, constructed a positive sense of well-being and even virtuousness. Their own 'goodness' – and, for girls, approximations to idealised constructions of beauty that are especially associated with middle-class prescriptions and body work – was defined in contradistinction to the 'badness' of obese, big or fat bodies (lazy, gluttonous, ignorant and ugly: implicitly working-class bodies). Accordingly, a contingent and, to an extent, concealable, chronic illness such as mild to moderate asthma was not necessarily an impediment to being (seen as) healthy.

In a context of healthism, it is perhaps unsurprising that young people often emphasised 'lifestyle' and assumed bodily effects even if they recognised there is more to health than 'looks' and, indeed, diet and physical activity. Lifestyle approaches reproduce a behavioural model of health that holds ideological sway in everyday life, health policy and practice. Critically, though, it is a limited model given the measurable impact of structural inequality on health outcomes. In that regard, and in line with James and Hockey's (2007) concern to move beyond analyses of the body as wholly socially constructed, we would emphasise the materiality of lived bodies in an inequitable world. Such a world exerts its potentially fatal effects, even on those who proclaim they are 'fit enough' or embody an image of vibrant physicality. Rather than individualise and de-politicise health determinants, we stress the need to connect with recent studies within the sociology of childhood that seek to inform policies intended to tackle growing inequalities (Brady et al., 2015). This approach is vital if social studies of young people's health are to make a discernible difference at critical stages in the lifecourse.

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