Curricular Disorder: Disability Studies, Eating Disorders, and Health and Physical Education in Ontario, Canada

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Abstract

Ontario's health and physical education curriculum is a major site of sport-health ideology in Canada, shaping young people's ideas of exercise and bodies at a particularly vulnerable time in their lives. Using a disability lens, this paper explores how this health and physical education regime encourages an ethos of bodily control that not only disables certain bodies and obscures the interdependency of human bodies, but also encourages the kind of preoccupation with bodily control typical in those with eating disorders. We suggest that disability studies is a particularly useful lens for considering eating disorders because of its focus on the ways in which society creates disabled bodies by demanding idealization, objectification, and control of the body—a three-pronged attitude that is also very much prevalent amongst eating-disordered individuals. Techniques present in the curriculum include (a) subjecting students' physical abilities to rigorous scrutiny and evaluation; (b) treating physical activity levels and diet as a matter of choice while minimizing various social factors that affect health; (c) engaging in a healthist discourse that conflates obese bodies with inactive bodies and unhealthy bodies; and (d) making youth engage in quantified self-evaluation of their own bodies and activity practices. In using these tactics, this physical and health education regime exploits societal preoccupations to fuel a disordered fear and contempt of the disabled, "unfit" body in the minds of the young Ontarians.

Keywords*: Curriculum, eating disorder, health education, physical education, disability, anorexia, Ontario*

In this paper we investigate the 2018 health and physical education curriculum in Ontario for Grades 1‑8, examining how its emphasis on health contradictorily perpetuates a potentially unhealthy neoliberal bodily discipline. We argue that by subjecting students' bodies to rigorous evaluation, encouraging a regime of self-surveillance, splitting the body apart from the mind, promoting disgust of the obese body, and suggesting that the individual can overcome any mental or bodily inadequacies, Ontario's curriculum attempts to normalize understandings of the "healthy body" as able-bodied and fit, while promoting students' anxieties and preoccupations about non-normative bodies. Many scholars have discussed how school practice and policy is healthist, emphasizing bodily control, individualizing responsibility for personal health, and promoting ideologies that equate weight and health (Evans, Rich, Davies, & Allwood, 2008; Paechter, 2011; Rice, 2010). Our work adds to this literature by using a disability lens to show how the curriculum's emphasis on bodily objectification, normalization, and control not only disables certain student bodies, but also aligns with eating-disordered pathologies.

Within Ontario's education system, certain ubiquitous discourses, linked to health and fitness, are symptomatic of a culture of revulsion towards body size and eating that is a fertile environment for the development of eating disorders. We suggest that disability studies is particularly useful for considering eating disorders because it focuses on the ways in which society creates disabled bodies by demanding we idealize, objectify, and control our bodies—imperatives that those with eating disorders often report feeling obligated to fulfill. While we cannot (and will not) argue a causal relationship between health/physical education and eating disorders, we will look at the Ontario Ministry of Education's 2018 policies and curriculum for evidence that the ideologies they promote are both disabling and eating-disordered. A discussion of the various ways educators interpret or even challenge the curriculum is also beyond the scope of this paper, but is a fruitful subject for further study.

We begin by discussing some of the major insights that disability theory can offer to the study of both eating disorders and fatness. We next outline the ways formal education disciplines the body, and how this has become magnified in an era of obesity panic. Finally, we use these insights to critically examine the Ontario Ministry of Education's health and physical education curriculum. Using disability theory, we demonstrate how the explicit focus on bodily discipline potentially aligns with eating disordered thinking and counterintuitively perpetuates a potentially disabling understanding of the body.[1]

Our discussion of eating disordered individuals includes those individuals fitting the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V)[2] for anorexia nervosa, bulimia nervosa, binge eating disorder, and other specified feeding or eating disorder (OS-FED).[3] Though we speak primarily of food-restricting behaviour, much of what we say is applicable to bingeing and binge-purging behaviour, which are often fuelled by restricting behaviour.

Curricular Analysis: Methods

Using a conventional content analysis, we examined the Ontario Ministry of Education's health and physical education curriculum for Grades 1 to 8 (Hsieh & Shannon, 2005). Our analysis involved reading through the curriculum and grouping different passages into "meaningful clusters" (p. 1279) that appeared germane to the topics of obesity, healthism, disability, and bodily control. We did not predetermine the categories before reading, but rather engaged in a hermeneutic process whereby what we read informed the themes we considered. In the end, we wound up

1. The government of Ontario's introduction of progressive sexual education lessons (including discussion of consent, same-sex relationships, and gender identity) in the 2015 Health and Physical Education Curriculum faced backlash from a conservative minority, and when Doug Ford's Progressive Conservatives replaced Kathleen Wynne's Liberal government following the 2018 provincial election, they replaced the 2015 Grade 1–8 Health and Physical Education Curriculum with an interim version comprised mostly of the 2010 curriculum, with the exception of the sections on sexuality, which are from the 1998 curriculum (Hauen, 2018; Ministry of Education, 2018). Ostensibly an interim measure until a new curriculum can be introduced in the fall of 2019 ("Modern Sex-Ed Curriculum," 2018), it is this version we discuss in this paper, because it is the one being taught in schools at the time of writing.

2. This is the manual the American Psychiatric Association uses to diagnose mental illnesses.

3. Bulimia nervosa involves binging episodes followed by attempts to prevent weight gain, including fasting, over-exercising, and/or purging (APA, 2013). Binge eating disorder involves binging episodes, which may be triggered by attempts at restriction and self-deprivation (Burton & Abbott, 2019). OS-FED may involve wide variety of eating disorder symptoms, and the diagnosis covers those who are restricting or purging but do not meet the exact weight guidelines for anorexia nervosa, or the frequency guidelines for bulimia nervosa (APA, 2013).

with over a dozen clusters, including healthy fitness and food choices; self-surveillance and monitoring (and the use of technology to achieve this surveillance); self-improvement; self-responsibility; student responsibility for the health of those around them (e.g., peers, family); the merits of pushing oneself to the limit; consequences of "bad" health (including consequences of mental illness); benefits of "good" health; and nutritional information (including calories and macronutrients). In the following sections, we discuss several of the most pertinent or prevalent clusters, showing how the curriculum (a) constructs health as a question of binary choice, as opposed to something largely determined by social environment; (b) encourages students to objectify, quantify, and push their bodies with a disregard for their body's visceral needs and desires; (c) conflates good health with productivity, morality, and happiness, and (d) encourages a paradoxically disembodied self-surveillance of the body. We will then explain how these goals work together to both disable othered bodies, particularly fat bodies, and encourage eating-disordered ideologies and behaviours. First, however, we will discuss the intersections between eating disorders, fatness, and disability, establishing that eating disorders and fatness are disabilities.[4]

Constructing the Disabled Body

Early disability scholarship did not address fatness, nor did early disability activists necessarily consider fatness or eating disorders as disabilities. This attitude has shifted over time. There now exists a large body of literature from scholars in both fat studies and disability studies arguing that for many, fatness is a disability (Aphramor, 2009; Brandon & Pritchard, 2009; Chan & Gillick, 2009; Cooper, 1997; Hladki, 2015; Mollow, 2015). These scholars draw from the social model of disability, which puts less emphasis on physical impairment and more on the interaction between physical impairment and the social environment (Shakespeare, 2013). In this formulation, disabled people are not solely disabled by their bodies, but rather by societal attitudes towards them; social environments that pose barriers to their access; and medical interventions (Shakespeare, 2013). Medical interventions may go so far as eugenics, where the goal becomes to eliminate disabled populations altogether (LeBesco, 2011; Mollow, 2015). Thus, when we speak about fatness as a disability, we are not referring to the health conditions or mobility issues sometimes associated with large bodies. Rather, we are talking about the difficulty and shame of being fat in our society. Scholars who link fatness and disability point out that like disabled people, fat people experience public stigmatization (Aphramor, 2009; Cooper, 1997); "functional restriction because of bodily difference" (Aphramor, 2009, p. 899), and harmful medical interventions (Aphramor, 2009; Brandon & Pritchard, 2009; Cooper 1997). Both disabled people and fat people find that their bodies come to symbolize a lack of control in the public sphere, a state of being at once abject, reviled, and feared (Chan & Gillick, 2009; Mollow, 2015; Wendell, 1996), particularly in a neoliberal society that suggests that bodily control and health (or the appearance of it in the form of slimness and able-bodiedness) are matters of individual responsibility and markers of good citizenship (Elliott, 2007; LeBesco, 2011).

4. In line with fat studies scholars, we have chosen the term "fatness" over the medical term "obesity," as a way of privileging individual's subjective experiences of fatness over medicalized definitions. Furthermore, the Body Mass Index, a measure of height compared to weight that the medical establishment uses to define obesity, was originally developed as a tool for evaluating the weight of populations and not individuals, does not take factors like body fat percentage and muscle mass into account, and is considered to be particularly ineffective in gauging the weight of children, who grow at variable rates (Evans & Colls, 2009; Evans et al., 2008).

Although there is little literature on the connection between eating disorders and disability, there is some scholarship on the links between mental illness (which includes eating disorders) and disability. Donaldson (2002) points out that "repositioning mental illness as a physical impairment" makes sense, given that the mind and body are always connected (p. 112). Western society constructs itself around able-bodiedness *and* able-mindedness, which disables the mentally ill by assuming that they "can simply 'snap out' of their conditions" (Nicki, 2001, p. 81). Lewis (2013) discusses the development of "Mad Pride" activism, a movement devoted to exposing and ending abuses psychiatric "consumers" or "survivors" have experienced in interactions with psychiatric systems and in psychiatric institutions. He finds that this movement has, like disability activism, problematized the medicalization of difference, questioned the authority of medical experts in this domain, and challenged the "binary between normal and abnormal" (pp. 116‑117). Aphramor (2009) similarly draws a parallel between the two community's experiences of institutionalization, stating, "I personally find no barriers in claiming disablement for psychological impairment—more particularly when identity is constructed in relation to the psychiatric system as 'users,' 'refusers,' or 'survivors'" (p. 898). Lewis (2013) suggests that experiences of institutionalization may be even more disabling and oppressive for those who are labelled mentally ill, as they "must deal with an additional layer of state-sponsored coercion in the forms of involuntary commitment and forced medication laws" (p. 117).

When looking specifically at eating disorders, it becomes clear that theorizations of eating disorders and disability support, parallel, and clarify each other. Studies of both disability and eating disorders merge around the notion that it is impossible to consider the body without considering its social context. As various disability theorists point out, disabled bodies exist within environments that are inhospitable or hostile to their differences (Garland-Thomson, 1997; Titchkosky, 2003). Similarly, eating disorders rely on certain social and cultural understandings of food, appetite, desire, and bodies for their existence (Brumberg, 2000).

The connection between othering and a fear of a lack of bodily control is key to our understanding of eating disorders. Here, the eating-disordered individual treats their body "as a natural force that can be overcome" by their mind (Lintott, 2003, p. 75). An eating disorder becomes the "domination of self over nature" where both self and nature occur within the same body (Lintott, 2003, p. 75). An eating-disordered individual experiences their body as other, attempting to control its uncontrollability to a degree that paradoxically becomes disabling. An eating disorder may involve various disabling experiences, including gaining or losing so much weight as to become socially marked as physically different or deviant, finding it difficult or impossible to navigate social situations involving food, losing control over one's ability to eat (either finding oneself unable to eat, or unable to stop eating), and becoming institutionalized within either the medical or the psychiatric system. Finally, the effects of eating disorders can result in the development of more conventional physiological disabilities, including severe osteoporosis leading to mobility impairment, and the loss of bowel and bladder control (NEDIC, n.d.). If eating disorders, as disabilities, are "suffered in and through the polis" (Michalko, 2002, p. 6), then action to address this suffering must go beyond the individual and biomedical to involve the social and the political.

Schooling the Student Body

As children's bodies signify "the future health and prosperity of nation" (Rice, 2010, p. 143), schools are a quintessential site of body discourse and discipline. Rice (2010) asserts that "furniture and dress codes, playground interactions, seating arrangements, student placement in

class pictures" all convey messages about which bodies are "expected" and acceptable (p. 138). Likewise, Paechter (2011) details the disciplining of the body inherent in a day of schooling:

> [Children] are expected to spend a considerable part of the day sitting still and quiet…to move around only when deemed necessary or with permission, and only use the lavatories at specified break times…They are expected to comport their bodies in a disciplined manner, to hold them in a way that denotes respect for the teachers, to walk, not run, in the corridors. (pp. 310‑311)

Not only does the school subject the child's body to relentless discipline, it also consistently evaluates and judges both the mind and body, encouraging, through "performance and perfection codes" (Evans et al., 2008, p. 126), a domination of self. Relations with peers, including peer competition, sporting achievement, and the establishment and policing of social groups, lead to an "othering" of bodies and minds, and by extension, a policing of the self (Evans et al., 2008, p. 132)—an attitude conducive to disordered eating.

As White, Young and Gillet (1995) document, by the 1970s, ideas about the body, and its link to health and fitness, began to change in North America. The body was reconceptualized in popular culture as a project that could be managed and controlled through personal discipline and control. This body discipline, still predominant throughout schools today, is most intense when it engages in the moral panic present around obesity. Particularly evident in physical education and health classes, this panic mirrors a larger "crisis" of childhood inactivity and obesity playing out in society at large, privileging weight as the foremost indicator of well-being and health (Evans et al., 2008, p. 13). Using moralizing, neo-liberal language, educational systems perpetuate ideas of obesity as a "personal moral failing of bad parents, lazy children, and malevolent corporations" (Gard, 2009, p. 39). While ignoring the material conditions and class structures that over-determine obesity in certain populations, the language of the obesity panic is nevertheless classist:

> The "fat," and, by innuendo, poor people or the inadequate, middle- or working-class single-parent families that produce them, are represented as irresponsible monsters, threats to the social order because of their misuse or overuse of resources. (Evans et al., 2008, p. 12)

The specter of obesity stirs up great fears and strong language, but this panic lacks empirical support. Many academics argue that institutions "manufacture" the obesity epidemic, pointing out that there is little proof that weight loss can be steadily maintained through individual choice (defined as consumption of diet food and fitness products) (Gard, 2009, p. 36; also see Cooper, 2010). Indeed, "overweight" is often a discursively produced state. For example, 50 million Americans became "fat" instantaneously in 1998 when the National Institutes of Health changed the Body Mass Index's (BMI) obese threshold from 27 to 25 (Evans et al., 2008, p. 11). Weight, furthermore, is not a reliable indicator of health, and a focus on weight directs attention away from other indicators that might better predict ill health. However, weight's hyper-visibility, as marked on the body, makes it a significant source of anxiety to be exploited. Scientists "explicitly and strategically use doomsday language" (Gard, 2009, p. 36) in order to get the attention of policy-makers and funding for their projects, and there exists a wide variety of interests who stand to gain monetarily from the obesity crisis. They include the government, the fitness industry, drug companies, and the medical profession (Kirk & Colquhoun, 1989, p. 431). When these institutions

shape messages about obesity that dovetail with our cultural preoccupations around controlling the body, a panic is born.

The obesity panic further gains momentum by invoking the future health of the nation, producing children as a population "at risk" (Evans et al., 2008, p. 15). The obesity panic, therefore, is particularly acute in school in general, and in health and physical education classes in particular. The disciplinary nature of physical education classes pre-dates the obesity panic; PE in "the late nineteenth century was framed within a similarly repressive, quasi-militaristic form, creating a legacy that remained" (Kirk & Colquhoun, 1989, p. 418). As Catherine Gidney's (2015) work on physical training in Canadian universities points out, the use of PE in the first half of the twentieth century began as a character development project for both women and men, developed in pursuit of God and nation. But by the 1970s, these school health projects had begun to shift focus from the development of character to the development of the self, with a focus on personality (Smith Maguire, 2008). The external form of the body became the visible marker (however flawed) of good health and good moral discipline (White, Young & Gillet, 1995). The impact of these shifting fitness and health ideals worked to support the rise of "healthism" in the classroom and beyond. Social scientists have defined healthism as "a belief that health can be achieved unproblematically through individual effort and discipline, directed mainly at regulating the size and shape of the body" (Kirk & Colquhoun, 1989, p. 419).

Others have noted that healthism helps to buttress other societal inequalities, as it has "underpinned racism and eugenic campaigns that separate the 'healthy' (which equates to moral and pure) from the 'unhealthy' (the foreign or impure)" (Skrabanek qtd. in LeBesco, 2011, p. 160). The influence of healthism in the classroom, coincident with the rise of the obesity panic, has turned PE into a site of "intervention, prevention, and health promotion" (Evans et al., 2008, p. 130). Healthism reduces PE and health classes to lessons that pose a causal relationship between health, diet, and exercise (Evans et al., 2008). As will be seen in the first section of our curricular analysis, this sort of healthism is dominant in the Ontario curriculum, not only reducing health to a matter of diet and exercise but reducing diet and exercise to a question of choice.

Curricular Analysis: Health as Binary Choice

Health education in Ontario involves the application of reductionist thinking to many complex issues and activities, food not least among them. While the ministry does not regulate the food in lunches students bring from home, they do have restrictions on food sold or given away in cafeterias, vending machines, and at any school special events. Eighty percent of the school food and beverages must meet standards for low fat, sugar, and sodium content, and high essential nutrient content (Ontario Ministry of Education, 2010). Food with "few or no essential nutrients and/or contain high amounts of fat, sugar, and/or sodium" is banned altogether (Ontario Ministry of Education, 2010, p. 4). While providing nutritious food is important, policies such as this suggest that food choices can be quantifiably identified as good or bad, and that, by extension, there is a right way and a wrong way to eat. Students are taught to read food labels beginning in Grade 5, and to consider the amount of calories, fat, sugar, and salt in different products, learning that "foods with less saturated fat, trans fats, salt, and sugar are better than those with more" and that "foods with more nutrients like fibre and vitamins A and C are healthier than those with smaller amounts of these nutrients" (Ontario Ministry of Education, 2018, p. 144). Again, the curriculum sets up a clear dichotomy between "better" and "worse." Moreover, the vagueness and corresponding unattainability of the guidelines (one can always eat less of the "bad" and more of the "good")

may foster a situation whereby youth develop orthorexic eating patterns, trying to achieve increasingly impossible and extreme levels of "healthy" eating by maximizing and minimizing their consumption of certain foods. Setting eating norms in this binary and scientific fashion, particularly when combined with the curriculum's emphasis on fitness standards and personal responsibility, may encourage an eating-disordered attitude towards food and diet in vulnerable children and youth.

The curriculum gives various examples of "better" or "healthy" choices students can make, often contrasting them with choices that are implicitly bad. These include playing outside after school instead of watching television or playing video games (p. 82), eating a salad instead of fries (p. 96), eating fresh food instead of processed food (p. 109), choosing milk over pop (p. 129), and playing a game like tag at recess instead of standing around (p. 163). The word "choice" occurs 176 times in the Grade 1-8 curriculum, the vast majority of those referring to student choice, with over 50 uses of the word appearing in conjunction with the word "health" or "healthy," and over 70 referencing food (as in "healthy food choices" or "eating choices"). While there are certainly benefits to making the choices the curriculum promotes, this consistent binary framing may encourage black-and-white thinking, "other" youth who are perceived to be making "bad" choices, and rob children of their ability to eat intuitively, without moralizing, scrutiny, or judgement. Fat students who do not have the opportunity to make "correct" eating or exercise choices (due, for example, to poverty, different familial or cultural eating patterns, a lack of recreational space, or family responsibilities that keep them from extracurricular sports activities) may wind up marginalized and expected to either accept their bodies as unhealthy or take measures to "improve" themselves. Students who are fat due to various conditions that have nothing to do with healthy eating or exercise may also be marginalized by these curricular guidelines. Further, when students, teachers, administrators and others construct "unhealthy" (e.g., fat) bodies as the outcome of poor decisions, it is possible that these bodies can become targets for ostracization, ridicule, and even problematic intervention. A more liberatory education might involve challenging notion of choice in capitalist consumer society, teaching students about the institutional, sociological, and historical roots of food inequality and poverty, and learning about how activist groups and communities have taken action to address these conditions.

Curricular Analysis: Unattainable Health for Neoliberal Citizenship

The Ontario curriculum promotes the achievement of certain norms, especially those associated with eating and athletic performance, throughout the grades. Attempting to live up to these norms can be a trying process. Achievement level marks, which measure "movement skills," such as "stability, locomotion, and manipulation" (Ontario Ministry of Education, 2018, p. 214), and the "transfer of planning skills to contexts such as fitness, [and] healthy eating" (p. 39), apply quantitative measures to students' physical activities. The curriculum consistently expects students to improve their fitness levels. There is no such standard as "good enough," and the maintenance of existing fitness levels and skills is never suggested as a goal. In Grade 6, students must develop a plan for improving a specific aspect of their fitness and provide examples of "signs of fitness development over time" (p. 154). Furthermore, there is an emphasis on students pushing themselves to their utmost, without consideration of the fact that consistently expending maximum effort is not necessarily healthy. The curriculum states that Grade 7 students should learn, "If I am taking frequent breaks, not breathing very hard, or not feeling my muscles work, I am not working my hardest" (p. 173). Far from evaluating students on effort, fair play, good conduct, or other

factors, physical education evaluates the properties of their bodies and their ability/willingness to exert themselves to maximum levels. This sort of evaluation might make children and youth experience their bodies as hyper-visible, particularly when those bodies do not perform to the often-unreachable standards set out by the curriculum.

The curriculum offers a neoliberal justification for its focus on healthy active living, stating that promotion of this lifestyle will benefit society by "increasing productivity and readiness for learning, improving morale, decreasing absenteeism, reducing health-care costs, decreasing anti-social behaviour such as bullying and violence" (p. 7). The Ministry's focus is on shaping a healthy workforce of productive, wage-earning citizens, rather than on creating an environment where youth of all different sizes and abilities can feel included and valued.

A neoliberal attitude that seeks to make individual children responsible for their own health, and not the adults and institutions surrounding them, is also evident in this sample dialogue from the curriculum, wherein a teacher asks a student to consider how they feel when they do not eat breakfast. The curriculum details the desired response: "I feel sluggish in the morning, and I'm starving by ten o'clock. When I'm so hungry, I'm more likely to eat less nutritious food at break" (p. 198). Presented as a way encourage youth to eat a good breakfast, this proposed line of questioning is a cruel joke for children and youth who do not have any breakfast to eat. As of 2014, 11.9% of households in Ontario were food insecure (PROOF, 2017). In Indigenous communities in Northern Ontario, food insecurity rates are above 50% (Dillabough, 2018). Far from empowering youth to make healthy choices, this dialogue inadvertently highlights the powerlessness of many Ontario students. Yet the curriculum also encourages students to assume responsibility for the health of others. In Grade 8, students must "identify strategies for promoting healthy eating within the school, home, and community" (p. 199). Many of these strategies involve activism—"e.g., implementing school healthy food policies, launching healthy-eating campaigns, choosing healthy food items to sell in fundraising campaigns…urging local restaurants to highlight healthy food choices," (p. 199)—but none of these suggested activities actually involve addressing the root causes of health inequality. The curriculum also asks Grade 8 students to consider how the fitness activities of one person might influence others. Yet all the examples focus on the individual student positively influencing those around them. The following is provided as a desired response:

> "At school I am a fitness buddy for a Grade 2 student. Our classes get together and we help the younger students participate in physical activities."
>
> "Sometimes just by participating, you can motivate others to join you. Because I play water polo, my younger sister wants to try it."
>
> "On the weekends when I go for a bike ride, my father often comes with me. He might not go out on his own if I were not going." (p. 189)

Although the curriculum gestures here to both activism and the inter-connected nature of health and well-being, it falls back on the usual lessons of individual responsibility and individual choice. A better, less oppressive health curriculum might use these examples of students affecting the health of those around them not as an end goal but as a starting point to a discussion about the interconnections between health and social environment. Such a curriculum could discuss the influence of social structures that shape people's health, not as immutable realities but as historically and socially contingent, subject to collective action and intervention.

Curricular Analysis: (Un)healthy Bodies, (Un)happy Lives

One of the ways in which Ontario's curriculum promotes an eating-disordered mindset is by suggesting that suffering can be avoided through healthy diet and exercise choices. In North America, disabled and unfit bodies have come to symbolize suffering; the disabled body is typed as "one who suffers an affliction, one who is forced to bear the weight of divine intervention, who is barred from the center of society and relegated to its margins" (Michalko, 2002, p. 1). Similarly, representations of fat women tend to emphasize the negative aspects of their fatness, to the exclusion of other discussions (Herndon, 2002, p. 133). Eating disorders often develop as an attempt to avoid such embodied suffering, as people with the disorder try to manage internal pain by pursuing an ideal external form. For example, the goal of many people with eating disorders involving restriction "is the construction of the body as desireless and inviolate" (MacSween, 1993, p. 194). Indeed, even though the anorexic body, in particular, is a vulnerable body, "the dominant experience through the illness is of *invulnerability*" (Bordo, 1988, p. 100). This invulnerability and inviolability derives from a lack of need, a lack of appetite, an ability to control the body's hunger until it no longer exists (Allen, 2008; Burns, 2004; Lintott, 2003)—and this body is not dissimilar to the invulnerable-to-bad-health body promoted at school.

As discussed above, the health curriculum at many levels promotes the notion that a "healthy" body leads to a happy life, and that a simple prescription of exercise and healthy eating will enable students to attain happy bodies and happy lives. Although there is a connection between exercise and mental health, some researchers argue that the role of exercise in promoting physical and mental health is widely over-stated (e.g., see Tulle, 2008). Moreover, physiological and mental health are overdetermined by social factors, including race and poverty (White, Young & Gillet, 1995). Yet as early as Grade 3, students are told to "engage in a physical activity when they feel anxious or unhappy, to help make them feel better" and "make sure that they are getting enough sleep and eating healthy food to help them learn and grow" (Ontario Ministry of Education, 2018, p. 100). In the same grade, students learn that exercise will lead to "better sleep, more energy, reduced risk of getting sick...improved interaction with peers, greater empathy, stronger interpersonal skills, improved independence...stress release, greater self-confidence, improved concentration" (p. 103). Similarly, by Grade 6, students are meant to understand that the development of fitness will help them "have more energy...get sick less often, and...generally feel more positive and happier" (p. 153). Not only do such imperatives place responsibility for maintaining health on the individual child, as opposed to the people and institutions surrounding the child, but they also suggest a simple causal relationship between exercise and happiness. When young people—particularly those who face various social marginalizations, or those who are disabled or chronically ill—receive the (implicit or explicit) message that their health and happiness are achievable through diet and exercise, they may feel encouraged to go to extremes in their diet and exercise. Alternately, they may blame themselves, or their eating and exercise patterns, for health problems and social difficulties that are out of their control. Such language in the curriculum may also encourage students to evaluate the bodies of their peers, and deem fat, visibly disabled, or sedentary peer bodies as inherently and voluntarily unhealthy. The curriculum might have a more positive effect on student self-esteem and happiness by spending more time celebrating a diversity of people in different bodies (of different races, abilities, sizes, genders), framing bodily difference not as a problem to overcome but as a fact of life that informs a rich diversity of perspectives, achievements, stories, and creative and intellectual outputs.

Curricular Analysis: Self-Surveillance

Davis (2006) posits that the West emphasizes care *of* the body, defined as beauty and fitness regimens, and care *for* the body, defined as medicalization. Both of these kinds of care construct the body as an object to be worked upon (p. 239). Davis (2006) argues instead for an ethic of care *about* the body, which takes the body as subject and "subsumes and analyzes care *of* and care *for* the body" (p. 240), in addition to recognizing the fundamental dependence of all bodies (p. 241). Unfortunately, Ontario's curriculum perpetuates the myth of the independent body that needs care *of* and *for* only. Care *about* the body is emphasized in the Ontario curriculum in Grade 1, where students learn to "know and recognize cues to hunger, thirst, and the feeling of fullness" (Ontario Ministry of Education, 2018, p. 81). Learning to recognize hunger and thirst cues is part of experiencing one's body as an active, feeling subject, and exemplifies a more intuitive, less objectified approach to bodies and health. Yet in the same year, students learn about the Canada Food Guide, and learn to follow its recommendations regarding "what kinds of foods to eat and how much" (p. 81). Throughout the years, the focus on Canada's Food Guide and nutritional information becomes greater and greater. In Grade 5, care of the body becomes a matter of mathematics, as students learn to analyze "the number of calories per serving, the serving size, and other information, such as the amount of trans fats" (p. 144). These are all lessons in body regimentation, imparting to students the idea that one government document with one set of guidelines (though varied slightly for different ages and genders, Indigenous peoples, and pregnant women), could possibly sufficiently address a populace with widely varying cultures, bodies, desires, appetites, and needs (see Amend, 2018). It encourages students to trust documents, guidelines, and experts over the physical cues of their own bodies.

The sort of objectification necessary for this care *of* (and control of) the body is not possible without a splitting of the consciousness, where one sees the body as separate from the mind, ignoring one's very experience of their body (Wendell, 1996). This splitting is especially present in eating disorders, where the subjects move from experiencing the body as a centre "*from* which we act to the body as locus *in which* we act" (MacSween, 1993, p. 155). In the Ontario curriculum, a regime of self-evaluation encourages this consciousness-splitting. The word "monitor" appears 26 times in the Grade 1–8 curriculum, and the vast majority of the times the word appears, it is referring to self-monitoring around fitness and exercise. Throughout the elementary and secondary grades, students must record, plan, and judge their eating and fitness habits. This begins in Grade 3, where the curriculum suggests that students "monitor their own progress...placing a sticker on the Active Living calendar on the fridge in their home each time they participate in a physical activity with a family member" (Ontario Ministry of Education, 2018, p. 100). The monitoring extends to food in Grade 4, when students must "analyse personal food selections through self-monitoring over time, using the criteria in Canada's Food Guide *(e.g., food groups, portion size, serving size),* and develop a simple healthy-eating goal" (p. 129). The evaluative technologies to which students are expected to subject themselves become more complex as the grades go on; in Grade 4, they learn how to measure their pulse, and by Grade 5 they are encouraged to wear pedometers. The curriculum encourages the use of health surveillance technologies as a "natural extension of the learning expectations," stating that students might use software "to record food choices over a period of time, calculate nutrient intake, maintain a fitness profile, monitor fitness targets, and assist with other tasks that help students achieve healthy living goals" (p. 64). These programs of self-evaluation suggest that the body is an object—even more, a machine—whose intake (in the form of food) and output (in the form of physical activity) can be carefully calibrated

for optimum performance. These sorts of activities seem to be a short step away from the scrutiny to which individuals with eating disorders subject their bodies, counting every calorie consumed and burned in an attempt to control inner chaos. A better educational program might focus less on reducing bodily activities to quantitative data, and instead focus on supporting students to attend to their lived, momentary, visceral experiences, in order to understand how their bodies communicate their emotional and physiological needs, and how they can respond from a place of caring and self-compassion.

From Curriculum Control to Eating Disorder

The dissemination of a discourse that encourages and provides formulas for the control of the body, like the one perpetuated in the Ontario curriculum, is a practice that fuels eating-disordered thinking. Allen (2008) points out that when obesity symbolizes a lack of control and morality, "controlled, responsible, rational and entrepreneurial behavior" becomes valued as containing the risk of obesity—and "the anorexic subject position is constructed as the most comprehensive subjectivity for containing these interior risks" (p. 596). Thus, the narrative of control and order paradoxically "produces the defensive behaviour that generates *dis*order" (p. 598). Paechter (2011) describes this situation in the context of schooling, arguing that anorexia nervosa is "the most obvious pathology" of the "bounded, contained, and under mental control" body "required by formal education systems" (p. 315). The anorexic body is thus one that has gone past hyperdiscipline to a state of undiscipline (p. 315). Thus, while we normally think of eating disorders and obesity as independent problems under the purview of different institutions—biomedical institutions for obesity, psychological and psychiatric institutions for eating disorders (Evans et al., 2008, p. 216), in fact it is hard to speak about one without, at the very least, gesturing towards the other. For this reason, the body pedagogies that educators "mobilise in the name of obesity have potentially dangerous repercussions for many young people" (Cliff and Wright, 2010, p. 230). Namely, by creating a hierarchy of good and bad food, good and bad lifestyles, good and bad citizens, students become classified "as normal or abnormal, good or bad" (Evans et al., 2008, 234). This contrasting of good and bad is pervasive in the curriculum, as discussed above.

Ethical physical and health education may not be possible in societies where inequality and food insecurity exist. The money and resources devoted to developing nutrition and fitness education programs are no substitute for actual redistributive efforts aimed at ending poverty and marginalization. Still, even in our deeply unequal society, better forms of health education are possible. Education that does not merely acknowledge the social structures that work to produce healthy and unhealthy bodies, but instead teaches and encourages a radical, critical, interventionist politics around issues of health inequality would be one step towards a more ethical and less disabling health education. Another step would involve leaving behind the sort of education that nods towards body acceptance but immediately undermines this acceptance by introducing self-evaluative measures of fitness and health as a way of warding off the spectre of the unhealthy self. A more ethical education policy would instead deconstruct the binary between orderly and disorderly bodies by celebrating a diversity of bodies, both in motion and in stillness. It is very possible that there are already some educators enacting versions of these lessons, working against the current curriculum. However, as such education challenges the status quo, societal power structures, and neoliberal health ideology, it seems unlikely that state actors will codify it in a curriculum anytime soon. Ontario's students will thus continue to negotiate a binary between orderly and disorderly bodies, where attempts to stay on the side of order paradoxically give rise to disorder(s).

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