# Health Discourses in Formal Education: Why a Counter-Paradigm is Essential in the Quest for Social Justice

Krishna Bhagat & Michelle Teegarden

***Abstract***

*Fueled by the dominant obesity discourse, public health officials worldwide have been giving increasing attention, making behavioral recommendations, and initiating interventions for reducing obesity. However, there is mounting evidence that brings into question the safety and efficacy of these efforts. Critical obesity scholars bring to light the uncertainties, complexities, and contradictions in the scientific literature about obesity. Acknowledging that the outcomes of propagating the dominant obesity discourse are connected to weight-stigma and poor health, we use critical obesity scholarship as a catalyst for calling attention to the responsibility that formal education has in offering a counter-paradigm to the dominant obesity discourse. We begin by describing how educational institutions often act to reinforce specific, narrow knowledge regarding health and bodies. Second, we argue why delivering a counter-paradigm regarding health and bodies within institutional settings is a necessary component of social justice. Third, we offer suggestions for how to begin conducting a counter-paradigm at different levels of the educational setting. Finally, we provide personal examples of how various institutional forces have shaped our own (Krishna and Michelle's) perceptions of health and bodies.*

***Keywords:*** *dominant obesity discourse; critical obesity scholarship; weight-stigma; formal education; social justice*

## Introduction

**S**ince the 2003 World Health Organization declaration that almost all countries are experiencing an obesity epidemic, public health officials worldwide are seeking ways to reduce obesity rates, with behavioral recommendations and interventions constituting the bulk of the reduction strategies (Shelley, O'Hara & Gregg, 2010). Despite the widespread efforts to fight the "obesity epidemic," there is growing evidence which brings into question the accuracy, ethics, effectiveness, and safety of these initiatives. Though obesity *is* associated with increased risk for diseases, causation is less well established; studies that argue a direct effect of overweight and obesity on health do not always control for personal, behavioral, and social factors that help explain the links between Body Mass Index (BMI) and health outcomes (e.g., Bacon & Aphramor, 2011; Rail, 2012; Tylka et al., 2014). Moreover, though short-term weight loss interventions do result in improved health measures, it cannot be concluded that these improvements are due to the weight loss itself or rather the behavioral modification that comes with it

(e.g., Heran et al., 2011). In fact, there is evidence that weight loss efforts can be damaging to health (e.g., Hunger & Tomiyama, 2014; Vartanian & Smyth, 2013). In reality, many health indicators thought to be weight-related can be improved through participating in healthier behaviors, such as increasing physical activity or improving diet, regardless of whether weight is lost (e.g., Bacon & Aphramor, 2011; Gaesser, 2007).

The panic about an epidemic of obesity as well as the behavioral interventions being implemented are being questioned by "critical obesity scholars." Critical obesity scholars perform a careful analysis of historical, scientific, and social factors which have fueled this fight against obesity over the last few decades. They do not question that the scientists and medical professionals who warn against or try to prevent obesity are doing so with ill intentions, but rather aim to bring to light the uncertainties, complexities, and contradictions in the scientific literature about obesity (Lupton, 2012). Specifically, critical obesity scholars question the validity, relevance, and safety of the "dominant obesity discourse" (Evans & Rich, 2011; Rail, 2012; Saguy & Gruys, 2010) which rests on the assumption that weight and disease are related in a linear fashion and emphasizes personal responsibility for "healthy lifestyle choices" and the maintenance of "healthy weights" (Tylka et al., 2014). Accordingly, these scholars critique the disciplinary practices for protecting individuals from the "risks" of obesity that have been encouraged through the web, television, radio, film, billboards, clinical settings, and even schools (Wright, 2009). Tylka et al. (2014) argue that knowing the associated outcomes of propagating the dominant obesity discourse are connected to further stigmatization and poor health, this discourse can no longer be used as a pathway to wellness.

In the following commentary, we use critical obesity scholarship as a springboard for emphasizing the responsibility that formal education—regardless of discipline—specifically has in creating a counter-paradigm to the dominant obesity discourse. First, we illustrate the ways in which various educational settings have functioned and continue to act as powerful and effective platforms for producing and propagating limited knowledges regarding health and bodies. Next, we present the case for how and why delivering a counter-paradigm regarding health and bodies within institutional settings is a necessary component of social justice. Acknowledging the challenges that could arise when delivering ideas regarding health and bodies which do not conform to the traditional, linear model between weight and health, we provide several examples and suggestions for conducting a counter-paradigm in our primary, secondary, and tertiary school settings. Finally, we (Krishna and Michelle) offer some personal examples of how institutional structures, practices, and knowledges have shaped our attitudes regarding, and experiences with, our own health and bodies.

## Formal Education as Powerful Site for the Reproduction of the Dominant Obesity Discourse

Formal education is assigned an active and vital role in shaping young minds, particularly with regards to how students interpret, internalize, and spread ideas related to health and bodies (Harwood, 2009; Shilling, 2010). Students are often educated with the perspective that obesity is a disease (Ward, Beausoleil, & Heath, 2016) and moreover, that it is a problem of individual behavior that can be fixed through a focus on healthy lifestyles that achieve a balance between calories in and calories out (Shea & Beausoleil, 2012).

Health and physical education curricula in the primary and secondary (K-12) education settings have long been responsible for addressing the "obesity" epidemic among children in

many western countries (Petherick & Beausoleil, 2015). For instance, weight control specifically underlines the framework for the Health and Physical Education (HPE) curriculum in New Zealand, which aims to regulate students' exercise and eating habits as a means for public health intervention (Pringle & Pringle, 2012). The government in the province of Alberta, Canada also represents its daily physical activity initiative as a strategy *specifically* designed to combat the rising rates of childhood obesity, as opposed to emphasizing the other potential benefits of activity, such as bodily competence, confidence, and pleasure (McDermott, 2012). Likewise, the United States Department of Health and Human Services describes statistics related to overweight as "alarming" and positions the issue as a national priority. In response, there have been a multitude of educational policies to reduce national overweight and obesity in the U.S., such as measuring students' BMI and sending this information home to parents (Vander Schee, 2009). For years, former First Lady, Michelle Obama's Let's Move! Initiative—arguably the most public face of the anti-obesity agenda in the United States—focused on schools as the primary site for the obesity reduction (Jette, Bhagat, & Andrews, 2016).

In higher education—especially within professional health programs, but also in other coursework—students are expected to possess knowledge of the health risks, potential outcomes, and strategies to prevent and treat "obesity" (Rothblum, 2016). It is therefore assumed that obesity is something to be fixed and fought, as opposed to a label—and a judgment—that itself could lead to discrimination and poor health outcomes. This critical oversight, intentional or not, is reinforced through formal instruction. For example, Royce (2016) remarks on how university professors often acknowledge the role of race, class, gender, age, and sexuality in impacting the quality of medical services, but that body size is not readily mentioned as a determinant during classroom discussions. Often, college students take up the dominant obesity discourse on their *own* terms even when this has not been formally directed of them. For instance, Guthman (2009), a college professor and critical obesity scholar, noticed that many of the students who come to study food and agriculture at her university wanted to do internships with low-income people *because* of what they perceived as an obesity epidemic in this population, rather than with the aim to address health equities or other social determinants of health.

Thus, schools, purposed as a safe environment for the growth of new ideas, also act to reproduce the dominant obesity discourse by analyzing, surveying, and scrutinizing health behavior and weight (Petherick & Beausoleil, 2015). Through these discourses, students develop specific understandings about their own and others' bodies, and these understandings are neither politically or morally neutral. They are explicitly linked to and serve to reinforce ideas about what a healthy and "correct" body is and the "right" behaviors and attitudes necessary to achieve such a body. When the dominant obesity discourse is the *only* health and weight-related discourse that students interact with and are exposed to, it can restrict their ability to understand the complexities of obesity and hinder them from exploring, engaging with, or promoting health related practices that contradict this approach (Ward, Beausoleil, & Heath, 2016).

## Confronting the Dominant Discourse as an Issue of Social Justice

In the decades since the rise of the obesity epidemic, "weight stigma," which is the social rejection and devaluation of those who do not comply with prevailing social norms of adequate body weight and shape, has spread and deepened globally (Tomiyama et al., 2018). This trend results in false and negative stereotypes of larger bodies. For example, individuals considered

fat are less likely to be hired and receive promotions, are being paid less, receive biased medical treatment, and are at risk of being socially excluded and bullied (Bacon & Severson, 2019). Weight stigma negatively impacts fat people's educational opportunities, employment options, health care, health insurance coverage, income, physical and mental health, and social relations (Brownell, Puhl, Schwartz, & Rudd, 2005). Moreover, weight stigma intersects with other better-known forms of oppression such as racism, classism, and sexism (Cameron, 2015). Educating students through the lens of the dominant obesity discourse can not only result in pervasive weight stigma within the general population, but also among individuals training to become health care professionals; that is, the very people who are responsible for and trusted with promoting health in a safe, efficacious, and holistic manner (Puhl & Heuer, 2009).

It becomes increasingly clear that addressing weight stigma in educational settings—and promoting a counter-paradigm that is more holistic, efficacious, nuanced, and inclusive in discussing weight and health—is crucial in the quest for social justice. Interaction with this counter-paradigm is imperative for *all* students, regardless of whether they are studying the health professions or not. Education and society are intrinsically connected; the purpose of education is the improvement of social justice for all (McArthur, 2010). According to hooks (1996), the point of critical pedagogy is to make sense of the experiences of the oppressed. Challenging dominant discourses in health can be seen as being a part of a bigger effort to lead the way to a more socially just world. Therefore, in a society that stigmatizes difference and fatness, we need educational theory, research, and practice to address weight-based oppression in our educational institutions (Cameron & Russell, 2016).

## Deconstructing the Dominant Obesity Discourse in Formal Education: Challenges and Possibilities

Introducing a counter-paradigm regarding weight and health in educational settings can be challenging when the dominant obesity discourse is so ingrained in numerous cultural sites, including the classroom. Students could have a hard time when someone challenges the familiar "facts" regarding the relationship between health and weight, especially if it seems that instructors are dismissive of medical evidence regarding fatness (Guthman, 2009). Acknowledging these challenges, scholars and educators who are critical of the dominant obesity discourse have presented recommendations for how to start deconstructing it in the educational framework (Cameron, 2015; Jones & Hughes-Decatur, 2012; Quennerstedt et al., 2010).

One suggested strategy to encourage a more nuanced approach to health, especially as related to body weight, is to problematize the individualistic approach to health (i.e., health is a result of individually controlled behavior change and lifestyle choices) and instead embrace a socio-cultural approach which acknowledges the complex interplay of economic, socio-political, cultural, and environmental factors that impact health status (Quennerstedt et al., 2010). For instance, when applying this socio-cultural approach to health or physical education settings, instead of teaching students to *be* healthy, instructors can ask them to reflect on how they "do" health, how they learn to make sense of themselves as healthy (or not), and to position this in the local and global contexts in which they live. Learning health would be something students do *constantly.* Specifically, educators should embrace multiple perspectives on what compromises healthy living rather than requiring students to subscribe to a universalized, often ethnocentric view of what health entails. Instead of asking students to replicate "correct" answers

about fitness and health, instructors can challenge students to explore and critique different perspectives (Jones & Hughes-Decatur, 2012). Educators do not need to tell students what to think, but rather offer guidance so that they can learn *how* to think and develop their own understandings regarding weight and health in order to organically begin to deconstruct the dominant obesity discourse.

Jones and Hughes-Decatur (2012) propose another strategy for beginning to unpack the dominant obesity discourse in educational settings that may not be inherently related to health or physical education. First, they encourage instructors to reflect on their own body as a pedagogy; educators can think critically about how their own bodies are socially and politically molded, explore assumptions they have about their bodies, and how their bodies are read by others, including their students. This can then set the stage for an on-going discussion regarding how and why ideas regarding health and bodies are "constructed." For instance, students can be assigned or choose novels and memoirs to read with the aim of paying particular attention to how different characters and their bodies are positioned in different spaces. While engaging in these texts, students can think critically about how society got to the place of arbitrarily deciding that a certain skin color is more superior than another, that being slim is better than being curvy, or that certain facial features should be celebrated while others can be criticized. Unpacking the social and political forces that shape our ideas of what is "healthy" and "normal" can set the framework for having healthier perceptions of our own bodies as well as the bodies of others.

The findings from Cameron's (2015) study of the pedagogical practices of twenty-six educators who challenge dominant notions of "obesity" in a variety of health and non-health related college courses offer insights for university instructors to start promoting a counter-paradigm in their classrooms. First, the importance of framing the topic emerged as an important issue in setting the stage for classroom discussions which disrupted the dominant obesity discourse. Through their course objectives, instructors communicated to students that they wanted them to become better critical thinkers, question their assumptions, be engaged citizens, and be more aware of the complexity in life. In presenting the course goals this way, any forthcoming discussions which unpacked the dominant obesity discourse would not be exclusive to critical obesity scholarship, but rather related to the broader aim of social justice. While many students had previously been exposed to critical ideas about racism, classism, and sexism in other courses, most had never heard of "sizeism" and so raising awareness about the power, privilege, and prejudice around health and bodies offered students a relevant issue to think differently about in a different light. Cameron's research also affirmed that prior to the beginning conversations regarding health and bodies, it was vital to create a safe and comfortable atmosphere based on trust and respect. To do so, the instructors included in this study often employed a specific set of guidelines or list of statements to help facilitate a discussion in which students felt empowered to speak but did not contribute potentially harmful or oppressive comments. Cameron also found that instructors felt it was effective to use a "layering" approach; educators needed to cautiously, carefully move forward when it came to problematizing the dominant obesity discourse. Instructors determined what students already knew or perceived about health and bodies and then built slowly on that in order to minimize resistance. For instance, students were encouraged to first look within themselves (e.g., examine their own beliefs, attitudes, and biases) and then build outward from there. To facilitate and empathize with this process, it was helpful for instructors—especially those who identified as critical obesity scholars—to recognize that they too at some point may have conformed to the dominant obesity discourse and that

their journey in problematizing it did not happen overnight. Another theme that Cameron found in her research was that connecting students to authentic human experiences helped the content come to life. In many cases, instructors or students themselves explicitly discussed their own body and bodily experiences as they related to fat stigma, oppression, and discrimination. Finally, the instructors who participated in Cameron's study noted how it was vital to talk about the politics of language, the importance of history, and the role of social justice when it came to disrupting the dominant obesity discourse. For example, instructors discussed how we often talk about medical science as "neutral" knowledge when in actuality the language used in medicine has a powerful role in persuading us to think and act differently about our health. In addition, providing a historical context to help students understand where ideas regarding health and bodies come from and how they are still emerging was another key focus of classroom discussion. Moreover, most of the instructors in the study discussed how they used a social-justice perspective to help students understand structures of power and the idea that *everyone* is affected by body privilege.

While efforts on behalf of educators are crucial in confronting the dominant obesity discourse in educational settings, social, cultural, and institutional support is necessary in order to sustain a counter-paradigm. In some instances, instructors may be aware of the consequences of endorsing a weight-focused approach, but there are institutional obstacles which make it difficult to promote health in a more holistic way. Curricula that is critical of the dominant obesity discourse is often dismissed as not being "valid" scholarship (Pausé, 2016). Specifically, universities, seen as producers and distributors of knowledge, can sometimes function to exclude alternative ways of engaging with taken-for-granted phenomena (Angell & Price, 2012). Furthermore, a non-weight-focused health approach does not always garner as much social and policy level support as other health-promoting behaviors such as smoking cessation where the limits of individual level interventions have been recognized (Newmark-Sztainer et al., 2006). As Neumark-Sztainer et al. (2006) observe, for instance, state and federal laws discourage people from smoking, and cigarette advertisements have also been banned from television, leading to shift in social norms and increased cultural pressure not to smoke. On the other hand, while some health promotion campaigns do promote the idea that health comes in different sizes and researchers are drawing more attention to the structural and economic barriers to eating nutritious foods and performing physical activity (e.g., Schwartz, 2012; Sumithran et al., 2011), overly simplistic and individualistic explanations regarding health and bodies are still more prevalent and widely disseminated not only in schools, but also through a variety of cultural settings (Bhagat & Howard, 2018).

Therefore, in addition to promoting a counter-paradigm in educational settings to shift students' knowledge, attitude, and beliefs regarding weight discourses, health promoters should work to foster multidimensional, ecological interventions to create a more lasting effect on the way in which we think about weight and health. At the interpersonal level, schools can work with children to determine the kind of physical activity they find enjoyable and meaningful rather than prescribing an activity regimen with the end goal of meeting BMI standards. Course designers and administers can push for creating intersectional curricula: courses in any disciplines can consider the multitude of ways that race, class, gender, ability, sexual orientation and more intersect with body size. At the community and societal level, health promoters should continue to work to incorporate media messages and policy initiatives that are weight-inclusive and holistic.

## Our own Experiences with Weight, Bodies, and Health Discourses

Our investment in and support of the arguments we included in this commentary are inextricably informed by our own experiences with health, weight, and bodies and how various institutional structures have shaped these experiences. Michelle recalls how that, for most of her childhood, she was "underweight." Clinically (according to routine physical assessments and lab results), she was considered to be in very good health. Still, her parents and teachers put a strong emphasis on a prescribed body weight and shape in order to be healthy. Over- *or* under-shooting this standard made her feel unworthy—as a body that did not fit into an ideal shape, but also as a student who was not able to meet expectations. She was ashamed to attend social functions like homecoming or prom because of a fear of being judged or not being able to "fill" her dress. In response, she began eating foods with high fat content in large quantities and became more and more sedentary for fear of losing weight. She did not feel the need to be concerned about any associated health outcomes because as someone who was underweight, she thought she was not at risk for things like high cholesterol or type 2 diabetes. However, she experienced serious mental (e.g., body dysmorophic disorder) and physical (e.g., a weakened immune system) health consequences over time. Gradually, Michelle became what she perceived as being "overweight." In 2019, Michelle was diagnosed with two different forms of cancer. She had heard—and continues to hear from her health care team—that being overweight is a risk factor for developing cancer and for the re-emergence of cancer. She blamed herself so much for her cancer that at one point, she stopped eating. Throughout her life, Michelle has felt so much pressure about her weight and wishes that instead, her feelings would have been honored.

I (Krishna) have experienced what I would consider "skinny privilege" for most of my life. To my recollection, my body has never been diagnosed as something that needs to be fixed (aside from the few comments I did receive about the round belly I was left with after giving birth to both my children). Still, I was keenly aware of and internalized the idea that "fat is bad," especially in secondary school. I remember routinely having my height and weight assessed and undergoing skinfold fat tests in my physical education classes. I also remember being asked to identify a "goal" body mass index in my "personal health plan," the assumption being that regardless of who we were, our weight needed to *change*. Needless to say, I decided one summer during high school that I was going to get rid of fat in my diet—and my body. I pursued this endeavor quite successfully for a few months until I lost the ability to menstruate and found myself more than 10 pounds lighter than I did when I began, when I was already borderline "underweight." After this (thankfully short-lived) experience, I gave myself the permission to at least be more critical of the health messages pervasive in the environment around me. Still, through reflection of my studies, scholarship, and teaching in the field of health promotion, I find that we—and our students—are far more often equipped with the tools to address taken-for-granted health issues than we are encouraged to critically evaluate if these are "issues" in the first place. For instance, in a behavioral theory course I recently taught, the team project assignment—which I inherited from a previous instructor—gave students the opportunity to apply theoretical principles to "look for workable solutions to improve 'obesity,'" which was presented to students as "largely preventable, costly, and devastating." Guidelines such as these are common, well-intentioned, and assumed to be necessary in the field of health promotion, especially given the volume of recommendations in policy, media, and scholarly literature

pointing to the dangers of overweight and obesity. Still, instructions like this communicate a problematic message to students regarding the personal responsibility and impact of having a certain body size. While this was not a perfect solution, I have since revised the guidelines to instead have students focus on applying health behavior theories towards addressing physical inactivity, rather than "obesity."

While we have interacted with educational frameworks that reinforce the dominant obesity discourse, Michelle and I have also been fortunate to have been involved—in direct and indirect ways—with counter-paradigms that challenge traditional notions regarding obesity. We find, though, that this has taken quite a bit of initiative on our part. As a result of Michelle's less than ideal experiences with her health and body, she started looking for opportunities to disrupt dominant ideas regarding weight throughout her Master of Public Health studies. For instance, when tasked with choosing a research topic or ethical issue to critically investigate in her coursework, she would write about subjects such as the stigma of "obesity." When I started my graduate studies in public health, I began pursuing internship opportunities and research assistantships through which I had the opportunity to learn more about emerging counter-paradigms such as the Health at Every Size movement (Bacon & Aphramor, 2011) and be exposed to the work of critical obesity scholars. As a doctoral student in Behavioral Health, I initially found it difficult to receive structure and support from within my department to pursue research which challenged the dominant obesity discourse. However, after taking it upon myself to form connections with faculty members from other areas of study, I was able to form an interdisciplinary dissertation committee to advise and evaluate my own research project which examined the dominant discourse through a critical lens. Now, as an educator in the field of health promotion, I find that with some careful nudging and empathic explanation, other faculty members are receptive to modifying coursework which instructs students to think of obesity as a problem that needs to be fixed. Efforts to disrupt the dominant obesity discourse through educational settings is perhaps most effective and successful when they transcend the walls of the classroom. Most recently, Michelle and I have been working together with the local health department, community members, and other faculty and public health students at our university to design and deliver a "Whole Body Approach" health promotion program. The health department's original goal in advocating for this project was to reduce the obesity rate in the county, but we have since shifted the program's focus away from obesity-fighting and towards a non-weight centered, holistic approach to health which encourages individuals to tune into their internal cues, practice mindfulness, and engage in enjoyable movement in order to have healthier relationships with their bodies, food, and physical activity.

## Closing Remarks

Educational institutions serve as important and effective forums through which to shift attitudes regarding weight and health. We require further empirical research to identify and evaluate the best pedagogical practices for disrupting the dominant obesity discourse; in the meantime, instructors should reflect critically on their pedagogical techniques, which is important when teaching content that is sensitive, and emotionally and intellectually charged. As hooks (1994) argues, classrooms—and as an extension, all aspects of an educational institution—are sites of contention because "much is at stake." While teaching to transgress can be painful for both students and instructors, there is so much to be gained.

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