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HOW DO YOUTH IMAGINE A HEALTHY LIFE?
UNDERSTANDING HEALTH THROUGH POSTMODERNISM AND CRITICAL RACE FEMINIST THEORY

by

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ABSTRACT

HOW DO YOUTH IMAGINE A HEALTHY LIFE?
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AND CRITICAL RACE FEMINIST THEORY

Clare Margaret Amoako-Parks

Enormous racial wealth and health disparities persist throughout the United States. There is evidence that health outcomes are a result of historical and contemporary forms of institutional racism (e.g., Roberts, 2012), but they are often framed as a result of individual behaviors in mainstream discourse (Fitzpatrick & Tinning, 2014b). Health education is one tool that can play a role in alleviating health disparities among adolescents, but traditional health and educational research tends to frame entire groups of young people as a monolith, categorized by their racial background, their family's income, and/or their sexual orientation. This framing positions youth who are placed in these categories as "at-risk," further pathologizing marginalized groups instead of attending to the role of the social structures that have created these disparities.

Combining postmodern tenets and critical race feminist theory (Evans-Winters & Esposito, 2010), this study employed a culture-centered approach (Dutta, 2007, 2010) to disrupt this framework by presenting the socio-historical context of health inequities, and by exploring the voices of youth who happen to belong to communities that are typically pathologized in the literature (Dagkas, 2014). I conducted one-on-one interviews with 24 individuals who attend or attended public schools in New York City, and 2 students who attended parochial schools, in order to understand how individuals imagine health in the context of our social categorizations.

Student-participants in this study shared stories with common themes, including the performativity of health (Webb & Quennerstedt, 2010), low school investment in health education, discourses of fear, risk, and shame in health class, and desires for openness and honesty from caring adults. Student-participants also shared unique or uncommon responses, including their ideas about health as an internal process, and the barriers that American cultural norms place on both individual and collective well-being. Additionally, some contradictions arose in the interview texts: between the importance of reaching out to community and focusing on oneself, and between students' desires for structural versus individual changes in their imagination for a healthy life. This study showed how challenging deficit lenses and consulting youth about their understandings and imaginations can shape health education research, policy, and programming.

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when I saw the contributions they made to their students, to their communities, and to the work.

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FOREWORD

> *Cultural humility is a practice of being okay with not knowing everything, recognizing that everyone is the expert of their own lives, and that others give us a gift when they trust us with their story.* (Carolyn Nguyen, Healing Justice, 2019)

As a White educator-researcher, my drive to work with and research the challenges of communities that face multiple layers of oppression is inherently problematic: I have never and will never have the same experiences as the Students of Color I have worked with, and my identity as a researcher-educator from the dominant racial group has the inherent potential, if not unchallenged, to exploit and impose dominant perspectives, thereby perpetuating White supremacist practices (Evans-Winters, 2011; 2019). It has been my intention to conduct research that is "critical, emancipatory and empowering to all stakeholders" (Esposito & Evans-Winters, 2007, p. 222), and that results in meaningful action, while consistently maintaining inquiry into my own identity with humility (European-American Collaborative Challenging Whiteness, 2005). I aim to educate and conduct research by intentionally challenging dominant epistemologies (Ladson-Billings, 2003), wherein I acknowledge that there are multiple constructions of reality, but I commit to the construction that the dominant beliefs about health disparities and the "problem" of teenage health, especially the teenagers whom the government defines as minorities, are oppressive and perpetuate stereotypes (Fitzpatrick & Tinning, 2014b). My goals as a researcher are not to gain credibility by exploiting the challenges of disenfranchised communities, but to work toward the promotion of health equity across all genders, racial backgrounds, and social classes by reframing health narratives. I

attempt to do this by centering and prioritizing youth voices, and contributing to the work of many researchers before me who seek to transform the academic language surrounding health disparities.

Chapter I

INTRODUCTION

Dominant discourses of health demonstrate that global health disparities persist, especially in the United States, where existing levels of economic and social inequality, caused and compounded by historical and contemporary forms of institutionalized racism, severely impact individual access to health preventive services and healthcare (Kawachi & Kennedy, 2006; Roberts, 2012). If the health and physical well-being of a society has emerged as “one of the essential objectives of political power,” (Foucault, 1980, p. 170) and education is used as a disciplinary tool to act on the body as Foucault (2000) argued, health education within and beyond the public school operates as a context in which this governmental control over individual health behaviors and bodies is enacted (Leahy, 2014). This study sought to shift the focus of health and educational research toward centering youth voices, and to offer youth the opportunity to reimagine health messaging and health education away from the pathology of health risks, issues, and disparities and toward themes that matter to young people in the current socio-political context.

Health concerns have spread throughout all social classes, yet the cost of health protective behaviors and healthcare can limit the choices of lower-income populations who are often most likely to experience health concerns due to historical disenfranchisement (Fitzpatrick & Tinning, 2014b). The increase in private remedies for

systemic inequality and the continued dismantling of social safety nets mutually reinforce themselves. Barbara Ehrenreich (2009) highlighted this correspondence when she wrote,

> The pattern is to curtail financing for services that might help the poor while ramping up law enforcement: starve school and public transportation funding, then make truancy illegal. Shut down public housing, then make it a crime to be homeless. Be sure to harass street vendors when there are few other opportunities for employment.

This paper explores how this correspondence works in health messaging: Do we systematically keep communities segregated by race and class, starve Communities of Color[1] of jobs, standard housing, adequate public services like clean air, clean water, and access to healthy foods, and then shame them, in research, in the classroom, and in the workplace, for their health problems? In order to explore these questions, I have critically engaged with traditional health education literature that focuses on pathology, deficits, and "risks" of youth, especially Youth of Color. This study sought to challenge the dominant narratives within health and educational research by eliciting the perceptions, opinions, and experiences of individuals who have been systematically pushed to the margins. Tenets of postmodernism and critical race feminist theory served as frameworks for this study, which involved one-on-one interviews with 24 students of NYC public schools and 2 students of parochial schools.

Intentionality Statement and Research Questions

This study sought to reimagine the power of youth voices, especially the power of youth who have been historically disenfranchised and targeted in the literature and through educational interventions, in order to interrupt the narrative of pathology, risks, and disparities. The investigation engaged postmodernism and critical race feminist theory through qualitative interviews and a brief demographic survey in order to explore

[1] See section, "A Note on Language."

what matters to youth about health in the current context of stark racial wealth and health disparities. The target population for this study was students who have taken at least one semester of health class in the school setting. A convenience sample of 26 youth participants was selected from an after-school program where the educator-researcher was employed and where students attended. Data were collected from 11th and 12th grade students to college freshmen and sophomores to address the following research questions:

1. What are participants' thoughts and feelings about health?
2. What are the ways youth navigate health?
3. What messages do participants recommend as being most important to communicate to youth?
4. How do youth imagine a healthy life, and what do they want or need to get there?

The following data sources were used to investigate each question: (1) students' demographic surveys, and (2) transcripts from audio-recorded individual interviews conducted with participants in person.

A Note on Language

Throughout this paper, I am intentional about the language I use to describe the students in this study. I problematize labels like *urban minorities* and *at-risk youth* that have long been used as euphemisms to insinuate a group's racial background without naming them, or identify racialized identities through a deficit lens. The language that I employ, therefore, is significant. I have chosen terms that place the burden of change on larger social structures as opposed to the individual: *historically marginalized*, *racially marginalized*, and *disenfranchised* are used interchangeably to describe communities that are often discussed as minorities (African Americans, LatinX, Asian Americans, Native Americans, for example). I am guided by Yosso, Smith, Ceja, and Solórzano (2009), who capitalize the terms *Communities of Color*, *People of Color*, and *Students of Color* in

order to challenge a deficit lens and position these groups “in a place of importance, where they do not exist merely in relation to the assumed white majority” (p. 681 footnote).

I also use the terms *race* and *ethnicity* with intentionality: I do this to challenge the idea of race as a biological category, while recognizing that it continues to be used as a political category with very tangible consequences (Roberts, 2012). I understand race in this document as a political category created for the purposes of separation and subjugation (Roberts, 2012). I understand ethnicity as the shared “social backgrounds and traditions” that are maintained across generations and “lead to a sense of identity” (Koffman, Morgan, Edmonds, Speck, & Higginson, 2012, p. 400). I prefer to refer to an individual or group’s ethnic background to subvert the assumptions made about young people’s experiences when they are placed into a racialized category other than White, but I am also often subjected to other authors’ persistent use of racial categorization due to the politics of the dominant culture. I use students’ self-identification of their racial and/or ethnic identities as they reported them in the study where it is relevant.

Significance

The health status of young people is a significant feature in both mainstream media and academic research (Fitzpatrick & Tinning, 2014b). A wealth of research focuses on social problems: adolescents, especially those who are defined in the literature as “urban minorities,” are increasingly labeled as “at-risk” for chronic health conditions or “lifestyle diseases” that result from smoking, over-consumption of unhealthy foods, and unsafe sex (Centers for Disease Control and Prevention [CDC], 2019a; Fitzpatrick & Tinning, 2014b; Freudenberg & Reuglis, 2007; Lawrence, Gootman, & Sim, 2009). In the U.S., homicide, suicide, motor vehicle crashes, and homelessness are additional public health concerns among adolescents that have been prioritized by the Centers for

Disease Control and Prevention (CDC, 2019a). Public schools and community-based organizations have become primary sites for teaching health knowledge in order to enhance health protective behaviors (CDC, 2018a, 2019b; Evans, De-Pian, Rich, & Davies, 2011). In order to raise the health status of an entire society, individuals are targeted in a variety of formats with moral obligations on how to “self-monitor, regulate, and medicate” themselves for their health; in schools, adolescents are targeted in the form of health education (Fitzpatrick & Tinning, 2014b, p. 1; Foucault, 1980).

When income inequality and institutionalized racism have the potential to severely limit an individual’s levels of access to preventive health services and healthcare (Roberts, 2012), health messages within and beyond the school walls that emphasize self-monitoring and self-improvement ignore the everyday reality of young people and have the potential to burden them with unrealistic expectations (Fitzpatrick & Tinning, 2014b). Indeed, contemporary health problems disproportionately affect non-White communities, as demonstrated in population health statistics, undoubtedly related to the substandard living conditions that persist as a result of histories of colonization and slavery (Dagkas, 2014; Hokowhitu, 2014; Roberts, 2012; Washington, 2019). The assumption that any person has equitable access to health protective behaviors disregards the social, cultural, and environmental factors that have been associated with health status (Fitzpatrick & Tinning, 2014b). According to Fitzpatrick (2014), “indigenous, migrant and black communities have … become targets for health interventions focused on obesity, diabetes and heart disease, as well as alcohol, drug, and sexual health campaigns in many places” (p. 180). The health messages that target members of these communities as being in dire need of behavioral change tend to dismiss indigenous and holistic approaches to health and well-being (Hokowhitu, 2014), and ignore the historical context that created the “stark racial gaps in health, welfare, and opportunity” in the U.S. and elsewhere (Roberts, 2012, p. 302). The mere fact that populations are most often distinguished by race when defined by federal agencies like the CDC reify the notion that there are biological racial

differences in health, when evidence continues to demonstrate that "within-group genetic variation is much greater than between-group variation," and when one's racial classification does not account for one's country of origin, or encompass the wide variety of living conditions or experiences that young people who fall into the same category may have (Roberts, 2012, p. 60). Indeed, this "healthist" idea of individual responsibility is especially problematic when it suggests that one's race is a determinant of one's health outcome without acknowledging that it is inequities in social structures that create health disparities (Azzarito, Simon, & Marttinen, 2017): the biological reality of health disparities by race overwhelmingly traces back to an individual's environment and stressors (Lauderdale, 2006; Washington, 2019), and there is little research on health education classrooms or health promotion messages that deconstruct that, aside from much of Fitzpatrick's work (for example, Fitzpatrick, 2013; Fitzpatrick, 2014; Fitzpatrick & Allen, 2019). Making racial classifications for the purposes of alleviating health disparities may appear benevolent, but it has the potential to perpetuate long-standing societal beliefs that certain groups are less healthy and hygienic than others, and are thus a greater burden to society (Hokowhitu, 2014; Roberts, 2012). This conceals the crimes that racism inflicts on Communities of Color, especially lower-income Communities of Color, and creates the false narrative that poor health is a personal failure (Azzarito, Simon, & Marttinen, 2017). It has yet to be explored how these messages are internalized by members of the groups that are labeled as at-risk of, or already in, poor health, and frequently targeted for interventions to fix that.

Why Health Education?

There are several definitions and goals of health education. Bensley (2010) believes the ultimate goal of health education is to "provide learning experiences" where students can develop "skills and knowledge to make informed decisions that will maintain or better their health" (p. 5). Rash (2010) roots his purpose for health education

in his definition of health as physical, emotional, spiritual, and social well-being, and states that the aim of the field is "intelligent self-direction of health behavior" (p. 10). Willgoose (2010) defines it as the "organization of learning experiences that ultimately influence health attitudes and practices" (p. 21). Teachers College lists as an educational goal of the health education program to provide students with an education that "effectively promotes health, prevents disease, and advances health equity" (Teachers College Website, 2019). The field of health education is often identified as a useful tool to educate individuals on their choices within a society, and depending on its definition, the approaches that schools take up to implement it are varied. When health education imposes morals, shame, or fear-based messages or neglects to acknowledge the social determinants of health, it becomes irresponsible and has the potential to perpetuate racialized ideas about health (Dagkas, 2014; Azzarito, Simon, & Marttinen, 2017).

Fitzpatrick and Tinning (2014b) argue that health education that uncritically takes up neoliberal discourses, regardless of its approach, due to its concern with the maintenance of the body and the development of "responsible" citizens "has the potential to reinforce an obsession with health, or healthism" (p. 5). Risk-based understandings of public health promotion ask individuals to consider and manage the environmental risks of modern life to maintain good health on an individual level in order to benefit and avoid burdening society, despite evidence refuting the effectiveness of these methods in health education and promotion (Fitzpatrick & Tinning, 2014b; Vander Schee, 2008a).

Many school-based health education classrooms indeed integrate the risky discourse increasingly used in public health and encourage students to plan for risky situations in order to reduce potential harm (Azzarito, 2010; Azzarito, Macdonald, Dagkas, & Fisette, 2017; Fitzpatrick & Tinning, 2014b; Leahy, 2014). Leahy (2014) argues, "Once students understand themselves as being at risk, health education then aims to provide the means by which they can voluntarily and prudently manage their risk so that they can live healthy, happy and productive lives" (p. 169). Fitzpatrick and Tinning

(2014b) argue that this increased emphasis on risk can be explained by the influences of neoliberal discourses within health and educational sectors (Apple, 2014). These interventions, framed within Western discourses of health and disease, have the potential to reinforce marginality and act as a process of recolonization, disempowering and dismissing the very individuals these benevolent interventions claim to empower (Fitzpatrick & Tinning, 2014b; Hokowhitu, 2014). While the U.S. government continues to disassemble the social safety net (e.g., Washington, 2019; Roberts, 2012), the field of public health, especially health education, deals with the tensions between individualistic interventions focused on behavior regulations, and socio-ecological approaches that critically examine the social determinants of health (Primdahl, Reid, & Simovska, 2018).

Traditional health education research has typically focused on teens' risk factors and school-based programs' ability to reduce health risk behaviors, targeting "urban youth of color" as "most vulnerable" to poor health outcomes (Fitzpatrick & Tinning, 2014b; Petersen, 1997; Petersen & Lupton, 1996; Leahy, 2014). Indeed, social science research often sustains pathology at its core, through lenses and approaches that are deficit-oriented and that neglect to view racism as central to the problem (Evans-Winters, 2011, 2019). There is certainly a need for equity in access to high-quality comprehensive health education programming and health services within an increasingly neoliberal society that demands individuals rely on themselves to meet their own needs while discouraging government aid for those who face systemic hardships (Fitzpatrick & Tinning, 2014b; Roberts, 2012). However, research and programming that targets groups by race tend to participate in "victim-blaming" of Youth of Color for engaging in what is deemed risky behavior, while neglecting to fully acknowledge the unique societal positioning and historical dispossession that contribute to such disparities by race, gender, and class in teens' health status (Azzarito, Macdonald, et al., 2017; Fine & McClelland, 2006; Hokowhitu, 2014; Tolman, Striepe, & Harmon, 2003). Relying on comprehensive health education programs to reduce adverse health outcomes and

disparities among teens assumes that provision of information is sufficient to change behavior, and subsequently places the burden of change on youth once provided with comprehensive, culturally sensitive curriculum.

The spotlight on improving health behavior among certain “at-risk groups” in the pursuit of a healthy nation prompts a need for the investigation of whether, and if so, how, large-scale health interventions in schools and community-based organizations further marginalize non-White populations (Dagkas, 2014; Hokowhitu, 2014). Local health initiatives, enacted with urgency in schools around the country, are complicated by low levels of investment by school administrations (Fitzpatrick, 2013). School-based health education is thus frequently plagued by teachers often teaching out of content area who may be unaware of the potential for neoliberal discourse to reify racialized categories and conform marginalized bodies to Whiteness (Azzarito, 2009a, 2009b; Azzarito, Macdonald et al., 2017; Fitzpatrick, 2013). As Howard (2010) asserts, the comparison of any group to White students perpetuates the idea that White performance and achievement is the preferred norm against which all other groups are measured; Hokowhitu (2014) and Dagkas (2014) have argued that the same phenomenon is true about health norms. This study seeks to shed light on whether and how such messages are received by those who may be other-ed both in and beyond the classroom.

Why Students’ Perceptions?

Few studies have directly examined students’ understanding and/or perceptions of health messaging, and even fewer have done so with qualitative methodology. Members of communities that are so often targeted by health programming provide a much needed perspective in helping health education researchers understand how the varied and multitudinous interventions on health messaging are received by their participants (Dagkas, 2014).

For many decades, science has been controlled by powerful social institutions and the men allowed inside them, which forced children from lower-income families, in addition to any child who fell into racialized categories "other" than White, to be measured against and compared to White middle-class boys (Evans-Winters, 2011, 2019; Howard, 2010). This practice has set those who find themselves outside of that group apart, making children who fall in the "other" category, especially children of African American descent, appear to be "abnormal," "culturally deficient," and burdensome in educational research (Evans-Winters, 2011, p. 11; Smith, 1999; Dagkas, 2014). In recent years, increasing numbers of researchers have called for public health efforts to disrupt the traditional "vulnerable" and "at-risk" narrative surrounding Youth of Color in the context of health (e.g., Acosta, 2010, Brockenbrough, 2013; Fiddian-Green, Gubrium, & Peterson, 2017; Peterson, Antony, & Thomas, 2012). Dutta (2007) posits that culture-centered approaches to health communication and education focus on attempts to transform social structures that impact health "through dialogues with cultural members that create spaces for marginalized cultural voices" (p. 305). Therefore, health-related research creates social change when "community lies at the core of the definition of the problem and at the development of solutions" (p. 311). Valerie Kinloch posits in her 2010 book, *Harlem on Our Minds*, that "inviting students to discuss their critiques of literacy within classrooms can encourage them to be responsible for their learning" (p. 34). Additionally, Sealey-Ruiz (2016) urges educators and researchers that it is vital to pay "attention to their humanity," referring to the humanity of Black girls in the current context of oppression in the United States (p. 291). Dagkas (2014) and Azzarito, Macdonald, and colleagues (2017) argue that the same ideas can and should be applied to health education research: It is increasingly important to explore students' perceptions of the messages they receive—especially populations identified as "at risk"—in order to legitimize their knowledge, involve them in the process, and include the intended

audience as the "locus of change," as Dutta (2007, p. 311) suggests is critical to disrupting oppressive social structures.

Gaps in Current Knowledge

Many researchers are indeed dedicated to alleviating adverse health and educational outcomes associated with structural disadvantages that Youth of Color face in urban areas (e.g., Basch, 2011; Crenshaw, Ocen, & Nadna, 2015; Evans-Winters, 2011, 2019; Sealey-Ruiz, 2016; Washington, 2019). Still, a wealth of research remains that neglects to acknowledge how traditional health education and communication practices perpetuate the hegemonic ideology that positions Youth of Color as "at-risk" of negative health outcomes, specifically research that centers youth voices. This study sought to challenge the pathology framework by enhancing the *historical literacy*—a coin termed by historian Khalil Gibran Muhammad (Gibson, 2017)—in the fields of health and education, and by taking into account the racialized, gendered, and classed experiences of young people's health education in the context of social institutions that have historically disregarded their needs (Collins, 2000; Evans-Winters, 2011, Ladson-Billings, 2009b; Lupton, 1994; Muhammad & Dixson, 2008; Tolman, 2012).

Fiddian-Green and colleagues (2017) built on Dutta's 2007 paper distinguishing between culturally sensitive and culture-centered approaches to health communication, writing that dominant approaches to health communication research typically take culturally sensitive approaches, which tend to perpetuate stereotypical messages about health disparities in marginalized communities and maintain the voices of outside health experts, thus silencing members of the targeted community. Failing to prioritize the voices of Students of Color in the context of health education research ultimately fails to recognize the role of "the intersections of race, ethnicity, identity, history, and housing and economic insecurity," in health disparities, and prioritizes the ideas and knowledge of the researchers over the community members, thereby failing to ask questions and set

goals that are most critical to the community (Fiddian-Green et al., 2017, p. 311; Dutta, 2018). Conducting interviews with members of the targeted communities can address these gaps by providing critical information from voices that have historically been silenced within the context of health education (Fiddian-Green et al., 2017; Dutta 2007, 2010). Indeed, Fiddian-Green and colleagues (2017) suggest that "uncovering previously silenced stories is the first step towards a culturally centered social change agenda" (p. 15). Although there are increasing numbers of researchers taking intentional steps toward critically communicating the experiences, voices, and needs of communities that have long been marginalized, there continues to be a need for culturally-based approaches in health education research to include the voices of marginalized community members (Dagkas, 2014; Azzarito, Simon, & Marttinen, 2017) and ensure that research agendas, questions, and goals are shared by targeted communities in order to challenge who we see to be experts of social change and disrupt the "dominant discourses of health interventions" (Dutta, 2007, p. 313).

Connection Between Aims and Long-Term Goals

This study aimed to critically examine the dominant paradigms of health education and interrogate the ways in which members of the target audience understand and reimagine health messaging. Sealey-Ruiz (2016) writes that "it is critical for educators to lead the charge to both understand that [structural] inequalities exist and to create strategies and actions to interrupt them" (p. 294). This study responded to this charge and intentionally highlighted the voices of Youth of Color, who have historically been placed in subordinate positions in their access to adequate social structures that promote health, and who have received negative labels in the context of health disparities, in the hopes that these voices may contribute to alternative educational strategies that consider these inequities and disrupt the status quo in the long term. The qualitative interviews conducted in this study may contribute to Dutta's (2007, 2010) proposal for health

education and communication researchers to shift the dominant assumption that experts of social change come from the academy, the funding agency, or the provider, toward the idea that community members are experts on their own experiences and should be prioritized in the development and implementation of health education and promotion efforts.

It is my goal that this study will add to the existing literature that challenges the dominant narratives within the context of health disparities, health education, and education as a whole by acknowledging that racism is embedded in U.S. society (Taylor, Gillborn, & Ladson-Billings, 2009) and that institutionalized racism directly leads to what the public perceives as racial differences in health (Roberts, 2012). It was written in part as a response to Lupton's (1994) call to examine and critically analyze "the ways in which hegemony, ideology, and power interplay in the way health is communicated" and taught, in order to reduce victim blaming (Dutta, 2007, p. 313). It sought to challenge the deficit-based research that "continues to reveal a 'separate and unequal' school system for Black girls," as suggested by Sealey-Ruiz (2016, p. 294), and so many other Youth of Color attending public schools in urban areas (Taylor, Gillborn, & Ladson-Billings, 2009). It is an attempt to commit to restructuring the ways we engage with all students in and beyond the classroom so that we as educators and researchers hold ourselves accountable by acknowledging the historical disenfranchisement of Black, Indigenous, and Immigrant Communities in order to create transformative and empowering health messages for all students. It is also an attempt to commit to my beliefs in the merging of theory and practice, or praxis, defined by Freire (2013) as both reflection and action toward the social structures that need changing. As a doctoral student who has spent the last seven years working full-time in educational programming during and after the school day, I have had access to the academy and to the practical aspects of education. This study aimed not to critique these social structures from afar, but instead to bring my critiques into action in order to make contributions to their transformation.

In the future, it will be crucial that educators and researchers continue to prioritize youth voices and make collaborative efforts to shift the language around health, challenging the traditional ways we assume so-called truths about health disparities in historically marginalized groups (Fiddian-Green et al., 2017), so that we can shift the research landscape toward the structural supports and conditions necessary for all individuals and communities to create social change (Dutta, 2007, 2010).

Chapter II

LITERATURE REVIEW

This literature review is organized into three sections. The first section is an overview of neoliberalism and health, the conceptualization of the body, and an overview of risk discourse in health education, health promotion, and health communication. The next section outlines the socio-historical context of health disparities. The third and final section presents the theoretical frameworks through which this study is presented.

Attending to Discourse in Health Education

Postmodern conditions require that educational research pay attention to discourse in order to disrupt hegemony, or what has long been perceived as common sense (Luke, 1995-1996). With the support of McCall (2014), I look to Luke's (1995-1996) articulation of discourse as defined by Foucault (1972): a pattern of words or thoughts that defines and places human subjects in larger social formations and in local contexts, shaping hierarchies for the "institutional categorization and treatment of people" (Luke, 1995-1996, p. 9). Discourses, then, become knowledge/power relations that are reached by the production of assumed truths about the world, which then become the terminology and groups "by which governments rule and monitor their populations and by which members of communities define themselves and others" (Luke, 1995-1996, p. 9). Luke attends to discourse in educational research in order to challenge taken-for-granted

assumptions about truth, representation, and narrative. This is especially important with regards to rethinking race: developing a worldview that strays from the dominant, Eurocentric model, requires an intentional examination of what we assume to be true (Ladson-Billings, 2003). In this chapter, I attend to mainstream discourses in health education to explore how narratives around the health status of particular racial and ethnic groups have been produced and perpetuated. It is important to explore how youth navigate their understanding of themselves, their potential health outcomes, and their subsequent health behaviors through the discourses of health in and beyond the school setting to which they are exposed.

Rationale for Disrupting "Risk" Discourse in Adolescent Health

Deborah Lupton, in her 1994 paper, "Toward the Development of Critical Health Communication Praxis," insists that traditional public health research and practices reinforce, rather than challenge, social inequities, until they ask some of the following questions: "In whose interests is the discourse operating? What (and whose) values, beliefs, and concepts are espoused, and what others are neglected? What pre-established knowledge or belief systems are drawn upon to create meaning? What types of social differences are established or perpetuated?" (p. 55). Lupton suggests that researchers should adopt a critical health communication approach in order to avoid victim-blaming by focusing our attention on language and discourse. Indeed, the language we use has a powerful influence on social responses to illness and disease. My intention in the following sections is to challenge the at-risk label, in order to shift the burden of "good health" away from the individual and toward social institutions, to improve social conditions in which individuals act out our health behaviors—"good" or "bad" as they may be labeled. While Lupton writes mostly in the context of the medical setting, in the next section, I, like other critical health scholars before me (see Ayo, 2012; Fitzpatrick &

Tinning, 2014a; Leahy, 2014; Vander Schee, 2009, etc.), apply this approach to health education, health promotion, and health communication research around adolescent health disparities—specifically, I explore whether and how the "risk" discourse in the context of adolescent health in the United States maintains the interests of some groups over others.

Introduction

The CDC (2019c) defines its mission, as the health protection agency of the United States, to save lives and protect people from health threats. It does so by conducting research, providing health information, and responding when health threats arise (CDC, 2019c). The CDC's Division of Adolescent and School Health states the following as its mission: "to promote environments where youth can gain fundamental health knowledge and skills, establish healthy behaviors for a lifetime, connect to health services, and avoid becoming pregnant or infected with HIV or STDs" (CDC, 2019a). The language of risk, especially risky sexual behavior, plays a prominent role in DASH's website and strategic plan: it is clear that the CDC has committed DASH to focus on "antecedent sexual behaviors that create risk for HIV, STDS, and hepatitis among adolescents" (CDC, 2019a). Additionally, the CDC's public health approach to school-based health promotion and disease prevention includes tracking and analyzing educational policies, school health education standards, and three school-based surveillance systems, including the Youth Risk Behavior Surveillance System (YRBSS), first initiated in 1991. The stated focus of improving school-based surveillance is maintaining rigorous surveys that keep track of changes in youth risk behaviors (CDC, 2019b). Priority health risk behaviors monitored in the YRBSS include: "alcohol and other drug use, unhealthy dietary behavior, injury and violence, inadequate physical activity, tobacco use, and risky sexual behavior" (CDC, 2016, p. 37).

In their Strategic Plan for Fiscal Years 2015-2020, DASH identified risk behaviors and their activities and refers to statistics about “sexual minority youth,” specifically “Black sexual minority males” and “Black transgender females,” being at increased risk for HIV. DASH has identified teens who are sexually active, and sexual and gender minority teens, as “priority populations” (CDC, 2016, p. 9) and outlines their comprehensive educational policy and funding efforts to address the unique needs of these students (CDC, 2016). These efforts, intended to provide guidance to local agencies on developing safe and supportive environments for all students, certainly intend to promote the healthy development of all teens and undoubtedly appear benevolent. While it is undeniably important to educate young people on safe sexual behaviors so they may make informed decisions, and take steps to intentionally undo disparities, the CDC’s website neglects to adequately acknowledge the social structures, including residential racial segregation and racialized policing practices, that contribute to disparities in HIV and STI rates in their assigned populations (Friedman, Cooper, & Osborne, 2009). DASH also neglects to define healthy sexual behavior beyond behavior that does not result in pregnancy or HIV and other STDs. In fact, DASH’s *Vision for 2020: Healthy Teens. Successful Futures* aims to “increase the likelihood that the majority of teens in the U.S. will have the knowledge, skills, and resources to avoid becoming pregnant or infected with HIV or STDs” (CDC, 2016, p. 22). DASH’s more recent snapshot, updated July 2018, begins by asking, “How healthy are today’s adolescents?” and answers, “Sexual risk behaviors are declining … health risks remain” (CDC, 2018b). It is clear through these goals and snapshots that the CDC’s definition of *healthy* centralizes risk avoidance, and that a healthy adolescent is one who is not pregnant or infected with HIV or another STD. Challenging this risk discourse requires an acknowledgment that the language surrounding adolescent health is indeed political (Leahy, 2014). Critical health scholars in the U.S., U.K., Australia, and New Zealand have long argued that such a focus on risk in the context of public health serves to individualize and moralize health behavior,

shifting the burden toward personal responsibility and away from social structures (e.g., Leahy, 2014; Ayo, 2012; Fitzpatrick & Tinning, 2014a, etc.).

Harrison and Leahy (2006) suggest that "the health field is still dominated by psychological models that focus on individual behavior change while paying lip service to the social determinants of ill-health" (p. 152; in Fitzpatrick & Tinning, 2014a). Risk discourse is indeed ubiquitous throughout Western culture, working with neoliberalism to shift responsibility away from the state and toward individual responsibility (Leahy, 2014). If risk is individualized, "it is then necessary, and indeed desirable, for individuals to manage and mediate their personal risk" (Leahy, 2014, p. 174; Fitzpatrick & Tinning, 2014b). The following section of the paper examines the discourse of risk and vulnerability in health education, promotion, and communication.

Neoliberalism and Health

Neoliberalism has been defined as the trend of shifting social supports from welfare states towards greater privatization of services, while increasing governmental support of corporate interests (Chomsky, 1999; Harvey, 2005). With the state's diminished power in our current society as a result of structural shifts that have moved toward neoliberal ideals, health management largely falls to the responsibility of individuals. According to Leahy (2014), supported by the work of Petersen (1997), "the current neo-liberal political, social, and economic order is characterised [sic] by marketisation [sic], choice, measurable efficiency, value-for-money, and enterprise" (Leahy, 2014, p. 788). Thus, the individual within this context is responsible for their own outcomes (Walkerdine, 2003; Webb & Quennerstedt, 2010). Those who are deemed unhealthy, especially those afflicted with "lifestyle diseases," are therefore often accused of being lazy, irresponsible, and a burden to our healthcare system (Fitzpatrick & Tinning, 2014b; Peterson & Lupton, 1996), since they did not fulfill their supposed duties in developing the skills necessary to succeed in this context and manage themselves in

ways that our society deems appropriate (Harrison & Leahy, 2006; Petersen & Lupton, 1996).

Indeed, the current model of a neoliberal citizen as it relates to health is one who is willing to consistently work on one's health and be responsible for the outcome in a performative environment, a term coined by Crawford (1980) and Petersen (1997) as healthism (Vander Schee & Gard, 2013; Webb & Quennerstedt, 2010). Ayo (2012) argues that these neoliberalist notions in the backdrop of our consumerist culture encourage people to "buy into" health to show their commitment to its lifestyle, demonstrating their responsibility through purchases of often expensive organic food, gym memberships, and fitness wear (p. 101). Further, positive and negative health outcomes are increasingly measured by local and statewide surveillance measures. The CDC's Division of Adolescent and School Health collects data on adolescents through the Youth Risk Behavior Surveillance System, and on school health policies and practices at the state, district, school, and classroom levels (CDC, 2018b, 2019b). Surveillance operates as a tool of power in a neoliberal society because it "perpetuates, creates, or prescribes" behavior from the dominant culture (Webb & Quennerstedt, 2010, p. 790). In this case, it is the CDC that dictates the definition and meaning of good health for all adolescents and monitors how their behaviors and the practices of their schools lead to their achievement of that or their failure to achieve it. Foucault (1980, 2000) wrote that surveillance has become a mechanism of power, and that individuals who felt surveilled or watched, "internalised [sic]" the dominant gaze and adjusted their "behaviors and identities towards a certain norm" (Webb & Quennerstedt, 2010, p. 790). If power is established through language, "social order, and the body," (Webb & Quennerstedt, 2010, p. 790; Rasmussen & Harwood, 2003; Foucault, 1980, 2000), and the health and well-being of a society is one of the "essential objectives of political power," (Foucault, 1980, p. 170), then such normalized monitoring practices of young

people's—and all people's—health, allows the dominant culture to exert power and social control through categorizing their bodies (Foucault, 1980).

Body Politics

Foucault (1980) asserts that governmental institutions, including educational institutions, have a political interest in making investments in the bodies of individuals so that they may contribute productively to society. It is useful to add scientific classification of the body to educational analyses, especially analyses of health education where the focus tends to shift to the student's physicality (Webb & Quennerstedt, 2010). Cultural and societal demands of our bodies are "powerful, ubiquitous, and invasive" (Bordo, 2004, p. xix). Koval (1986) asserted that many health promotion practices are based on the idea of the body as a commodity or good that can be adapted according to consumer trends, and to the individual's desire and willingness to buy into the range of information and resources that are marketed to fix it. The maintenance and control of the body undoubtedly pervades educational perspectives and aspects of teaching and learning, and this is especially complicated by our nation's history of imposing control over the bodies of non-White individuals, especially the bodies of enslaved Africans and Native Americans (Roberts, 2012): under the legally sanctioned institution of slavery, Black women's bodies were used to increase property through breeding more enslaved workers for White slave-owners (Evans-Winters & Esposito, 2010; Washington, 2006). It is important to pay attention to how that history plays out in the deficit framework surrounding health disparities wherein non-White communities are labeled as at-risk of disease and attempts to control their behaviors and bodies are thus strengthened.

Many school-based health courses assume the burden of teaching students *for* health rather than *about* health (Fitzpatrick & Tinning, 2014b). Critics of this approach contend that this focus leads to blame and shame among students about each other's physical appearance, ultimately reinforcing neoliberal notions of health and healthism

(Fitzpatrick & Tinning, 2014b; Webb & Quennerstedt, 2010). In school-based health education, the assumption that "health" is a lifestyle that is equally accessible to all people is taught through curricula, school policy, pedagogy, and social interactions (Petherick & Beausoleil, 2015; Vander Schee, 2008a). Fitness and an assumed-to-be appropriate diet are pushed while overlooking the role of cultural practices, history, and context in the pursuit of health, which typically means the pursuit of the "normal" White American body size and shape (Azzarito, 2009b; Hokowhitu, 2014). The power relations embedded within health promotion suggest that there are specific ways to live a healthy life, something that is taught to be necessary for everyone, and as a result, individuals who engage in practices deemed unhealthy are labeled as negligent and deviant (Azzarito, 2009a; Petherick & Beausoleil, 2015). Indeed, the so-called fit body is portrayed as more desirable; the disciplined, and therefore productive, body is constructed on dominant White ideals and presented to us through discourses of global health concerns regarding health disparities as defined by racialized groups (Azzarito, 2009a, 2009b). Comparisons against White perceived norms persist. Neoliberal discourses of health influence school cultures and teachers' subjectivities through "specific lifestyle practices" that "dominate the language and behaviours [sic] teachers use to convey ideas of health" (Petherick & Beausoleil, 2015, p. 5).

Risk Discourse in Health Education

Formal, school-based health education models tend to combine strategies of health education and health promotion, defined respectively as behaviorally focused interventions and empowerment-focused approaches that acknowledge social determinants of health (Fitzpatrick & Tinning, 2014b; Whitehead, 2003). Indeed, the drive for health education to facilitate "good" decision-making among young people persists (Fitzpatrick & Tinning, 2014b). Critical health scholars before me have argued that our contemporary neoliberal context has led to pedagogical practices in the health

and physical education classrooms that teach young people about health and their bodies through risk discourse, coupled with discourses centered around shame and disgust, which invites students into self-management and moralizes their health behaviors (e.g., Evans et al., 2011; Leahy, 2014; Petherick & Beausoleil, 2015). In areas where there is increasing anxiety around health risks, such as childhood obesity and teen pregnancy, there is a rapid increase in policies, interventions in curricula, and surveillance measures at the local level. Such surveillance has been described as creating and perpetuating "performativity" in health (Webb & Quennerstedt, 2010, p. 786; Evans, Davies, & Rich, 2008; 2009), which creates a focus on "judgements, comparisons, incentives, and sanctions" (Webb & Quennerstedt, 2010, p. 787). More recently, there has been an increase in online advocacy via social media that aims to disrupt what is deemed to be normative health culture away from White ideals and toward personal and collective empowerment (see Free Figure Revolution, 2017; Rashatwar, 2019).

The CDC (2012) states that health education "provides young people with the knowledge and skills they need to become successful learners and health and productive adults," and that "increasing the number of schools that provide health education on key health problems facing young people is a critical health objective for improving our nation's health." Schools are increasingly becoming sites of both health intervention and as measurement sites of health risks (CDC, 2018b; Webb & Quennerstedt, 2010). Indeed, in this neoliberal context, it becomes clear through these practices that failure to perform what is taught to us as "good" or protective health behaviors defines one as a bad citizen, one who ignores the "interests of the common good needed for a well-ordered society" (Halse, 2009, p. 51).

Leahy (2014) argues that "neoliberalism has shaped the possibilities for how people understand what health education is, what it should do, and how it should do it" (pp. 5-6). These meanings of health are complicated by dominant public health discourses of healthy students that ignore differences among cultures and that are linked to notions

of biopower that colonize "other" bodies—those typically deemed "at-risk"—as less healthy than the normative White and upper class (Azzarito, 2009a, 2009b; Hokowhitu, 2014). The anxieties around the "obesity epidemic" demand that students engage in protective health behaviors and urgently call for research on interventions and prevention strategies, placing lower-income communities and Communities of Color in the spotlight because they are believed to be at greater "risk" for contracting this "disease" than wealthier White youth (Azzarito, 2009a, 2009b). Health education courses at the school level produce certain meanings of one's physical health (O'Flynn, 2010). More specifically, health and physical education construct and reconstruct global health risks, such as STI contraction and obesity, at the local level, where teachers are asked to "save" students from these potential consequences (Evans et al., 2008; Webb & Quennerstedt, 2010). These desires to "save" or "protect" students from the consequences of what are deemed negative health behaviors are intensified by the racial dynamics of the teaching force compared to the ethnic makeup of the students in our public schools: educators remain largely White and female, accounting for anywhere from 80% to 90% of teachers (Miller & Harris, 2018). This remains true even while our students are increasingly diversifying: estimates for the 2019-2020 academic year project the Latin-American student population at 30%, African American students at 15%, Asian American/Pacific Islanders at 5.5%, and Native Americans at 1%, with White students in the minority (Howard & Navarro, 2016). White educators have been demonstrated to fall victim to "White saviority," which tends to isolate them from their students in communities where they teach (Matias, 2013; Miller & Harris, 2018), and it is possible that the risk discourse that is so prevalent in health education exacerbates this need to "save." There is also a threat, as Evans-Winters (2011) warns, that teachers, having read this research that typically places Students of Color in pathology, approach teaching from a fixation on morality, control, and surveillance (p. 10).

Critical health scholars have demonstrated that the health education classroom is a site where risk discourse is prominent (e.g., Ayo, 2012; Vander Schee, 2008a, 2008b; Webb & Quennerstedt, 2010; Wright, Burrows, & Rich, 2012), and where teachers use statistics to create "expert risk knowledges" combined with risks of shame, disgust, and embarrassment around becoming unhealthy or unfit in order to make engagement in specific health behaviors seem attractive (Leahy, 2014, p. 176). Evans et al. (2011) found that when risk discourses around obesity are employed in a school site that students perceive to be under-resourced, students are well aware that a slim body with ample exercise and eating habits is desirable by the dominant culture, but view these behaviors as largely out of their control because they require "opportunity and levels of investment of time, effort, and, critically, money that they simply did not possess" (p. 334). Students in these scenarios learn to define their bodies as inevitably bad, "in need of correction or repair but with no real possibility of achieving escape from the adversities and contingencies of community and home" (p. 336). Wright et al. (2012) found that health risk discourses in working-class neighborhoods in the UK created anxiety in some students, who felt they had no control over their food choices or access to exercise. Risk discourses in health education, though well-intentioned, thus have demonstrated the potential to pathologize children's behavior and physical bodies and to encourage students to internalize their behaviors as failures to do as their teachers and school suggest, reinforcing power relationships and social hierarchies (Evans et al., 2011; Wright et al., 2012). Due to the racist history of education and healthcare in the U.S. that has contributed to significant health disparities across racial lines, this discourse becomes all the more dangerous when it goes unchallenged.

Risk Discourse in Health Promotion

The term "health promotion" was coined in 1945 by medical historian Henry E. Sigerist, when he defined the four major tasks of medicine as "promotion of health,

prevention of illness, restoration of the sick, and rehabilitation" (Kumar & Preetha, 2012, p. 6). He stated that health was promoted by providing the population with an appropriate standard of living and working conditions, education, the "physical culture," and opportunities for rest and recreation, all of which demanded collaborative efforts of multiple sectors (Kumar & Preetha, 2012, p. 6). Public health debates within the field of health promotion since its beginning have not adequately acknowledged the interdependent relationship between the society and the individual, and have instead focused on finding the balance between the social measures taken to improve public health and maintaining individual freedoms (Lupton, 1994). Contemporary health promotion within the United States employs a neoliberal approach that places itself as expert and attempts to govern its people in so-called appropriate ways to behave without providing commands (Lupton, 1994). One major tool of contemporary health promotion is the discourse of risk, presented as "something to be avoided in the interests of preserving good health and well-being" (Lupton, 2013, p. 15). Indeed, the part of the "population with risk factors" is considered a population group needing to be targeted for interventions (Kumar & Preetha, 2012, p. 7).

The CDC's homepage for their National Center for Chronic Disease Prevention and Health Promotion states the following:

> It is our job to make it easier for all Americans to make healthy choices so they can enjoy life. We know that most chronic diseases can be prevented by eating well, being physically active, avoiding tobacco and excessive drinking, and getting regular health screenings. CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) helps people and communities prevent chronic diseases and promotes health and wellness for all. (CDC, 2019d)

Ayo (2012) applies Ericson et al.'s (2000) key principles of neoliberal rationality, which include "minimal government intervention, market fundamentalism, risk management, individual responsibility, and inevitable inequality as a consequence of choice" (p. 99) to contemporary health promotion strategies, in order to demonstrate how governmental

organizations strengthen dominant ideologies and the development of the "'good' and 'healthy' citizen," much like the CDC's description of its mission for health promotion quoted above (p. 100). It is demonstrated in their mission that the CDC's goal in health promotion is not to make "social and structural changes which impede upon the health and wellbeing of the population," or even to empower individuals to collaborate to make such changes, but to provoke the desire within these freely and independently operating individuals to choose to follow their guidelines (Ayo, 2012, p. 100; Lupton, 2013). This neoliberal tenet of personal responsibility, standing on American ideals of individual freedoms, shifts social issues into personal, and deeply moralistic ones, in the context of "health-related lifestyle behaviors" (Ayo, 2012, p. 103). Following the CDC's stated mission of its department that focuses on health promotion, health becomes a matter of choice: there will be those who listen to the experts and follow their advice of being active, eating healthy, and quitting smoking and excess alcohol, and those who choose not to. In today's context of health disparities in the U.S. that are divided along lines of ethnicity and income, this language has the potential to blame those who belong to the groups deemed "at-risk." It accepts "the inevitability of inequality as a side effect of the freedom of choice," rather than taking societal and governmental responsibility for structural inequities that result from this country's history of institutionally racist practices (Ayo, 2012, p. 104). Ayo concludes:

> Health promotion works not by way of making social structural changes which impede upon population health, but instead by inciting the desire within individuals to choose to follow the imperatives set out by governing health bodies (p. 104).

On the CDC's website for Racial and Ethnic Approaches to Community Health (REACH), where they specifically outline health disparities by racial and ethnic groups, they write that in 2018, they funded 31 recipients to reduce these disparities "through culturally tailored interventions to address preventable risk behaviors (i.e., tobacco use, poor nutrition, and physical inactivity" (CDC, 2018c). In 2018, the division funded

programs in 21 different states, allocating anywhere from $542,378 to the maximum $792,000 to each program aimed at preventing health risk behaviors. Many of these efforts include both individualized education to historically disenfranchised communities deemed at risk of health disparities and increased access to social structures that allow for better health, including access to affordable healthy food. This is indeed a positive direction for funding. The language used on the website, which refers to "racial and ethnic populations with the highest burden of chronic disease," does place some blame onto the communities and their health risk behaviors, so that it becomes the individual's responsibility to prevent poor behaviors to avoid unwanted health outcomes, instead of shifting focus toward the social structures that create inequities and have done so for centuries (Dutta, 2011). The CDC's page on Adolescent Health Disparities does acknowledge the following: "health disparities are inequitable and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources" (CDC, 2018a). This acknowledgment is followed by two paragraphs of information about protective health behaviors that help alleviate health disparities and health risk behaviors, including teenage pregnancy, poor nutritional choices, and inadequate levels of physical activity, that widen them (CDC, 2018a). While there are clear attempts to create a balance between acknowledging the social determinants of health in health disparities, there is more evidence provided to support health professionals on informing individuals how to improve their health behaviors than to redistribute social structures to make health more accessible for all populations, regardless of ethnic background or income. This follows Peterson's (1997) claim that contemporary health promotion specialists take on the role of experts, charged with alleviating the "endless parade of 'at-risk' populations" (p. 195). Indeed, DASH's action steps to address health and educational disparities among adolescents include guidelines for state and local education and health agencies with an extreme focus on addressing the needs of "high risk" youth. Such a focus on risk has the potential to create feelings of

anxiety in any individual that belongs to that group, allowing fear to become a normal part of their experience and making it much more likely that their "failure" to achieve what the CDC defines as good health as a personal failure (Peterson, 1997). Peterson writes that such normalized processes of risk management in the context of health promotion serve to privatize health by "distributing responsibility for managing risk" and "creating new possibilities for intervention into private lives," while at the same time asking individuals to contribute more actively to creating a healthy environment (p. 194). This requires an attention to health in ways that are "socially approved and politically sanctioned," while also relieving larger social structures that play a role in determining health outcomes of responsibility (Ayo, 2012, p. 104).

Risk Discourse in Health Communication

The field of health communication can be defined as "an active area of inquiry concerned with the role of human interaction in health and the health care process" (Kreps, 1989, p. 11). In our contemporary neoliberal context, public health experts implement health campaigns to share information with the public, which transform good health into a product or commodity where consumers are "persuaded to acquire it at some cost to themselves" (Lupton, 1994, p. 56). Indeed, health educators, and other public health professionals, typically engage in the paternalistic practice of "disseminating the 'right' message to the masses for their own good" (p. 56). Dutta (2010) writes that these messages are based on assumptions of universal truths that appeal to Western norms, and tend to overlook alternative understandings of science or truth that are "locally specific" or "cultural and structurally situated" (p. 536). The target audiences of health communication messages may be regarded negatively, at risk of disease if they do not engage (Lupton, 1994). These labels are amplified by the racial and ethnic context of communities that public health literature defines as "hard to reach" at worst, or "at risk" of poor health outcomes at best, as compared to their typically White health educators

who have the "right" message (Lupton, 1994, p. 57). Lupton writes that in this context, "the implicit assumption is that the information disseminated to patients or the general public on the part of those in authority is privileged over the lay beliefs of those not in authority" (p. 57).

Indeed, little attention has been paid to critical interrogations of the implications of health communication efforts or to how the general public makes sense of the "good health" that is being packaged and sold to them by public health experts, organizations, and social institutions from afar (Lupton, 1994, p. 56; Dutta, 2010). Historically, health communication theory is "limited to individualistic models of knowledge and behavior," disregarding the cultural dimensions of health (Lupton, 1994, p. 57). There is an emphasis on the "lifestyle" choices of individuals, and health status is measured by an individual's body instead of as a result of social determinants (Lupton, 1994), producing physical ideals that adhere to the norms of the dominant culture (Azzarito, Simon, & Marttinen, 2017). These individualistic assumptions implicit in health communication thus ignore cultural contexts and "sociocultural-economic contexts" (Dutta, 2007, p. 305) while reproducing Eurocentric biases in how health communication practices are employed (Airhihenbuwa, 1995). Dutta-Bergman (2005) holds that typical health communication campaigns serve hegemonic interests by the focus on individual, as opposed to social, change. Similarly, Lupton (1994) has long held the critique that dominant health communication interventions maintain current power structures and, along with Dutta (2007, 2010) and Airhihenbuwa (1995), suggests more culture-centered approaches to health communication where the dominant paradigm is disrupted and alternate voices, or those that have long been erased, are brought into the center (Dutta-Bergman, 2005). Dutta (2010) adds that the application of critical theory to the field of health communication might allow researchers to "deconstruct the dominant frameworks of risk" in the field and imagine new solutions (p. 534).

In response to immigration patterns into the United States, many health communication strategies have adopted cultural sensitivity approaches that attempt to address gaps in access to healthcare services by “crafting messages or training programs that respond to the cultural needs of communities” (Dutta, 2007, p. 307). These approaches, however, simply shift researchers’ and practitioners’ focus toward creating messages that acknowledge the variety of cultures within the U.S. who may be at risk of health issues and need to receive the message (Dutta, 2007). The messages are still created by outsider or institutional experts and attempt to change individual risky behaviors instead of attempting to transform social structures that create inequities (Dutta, 2007, 2011). Dutta (2007) asserts that moving forward, “the voice of the community is central to the articulation of health problems” and their solutions, and encourages the discipline of health communication to move toward culture-centered approaches (p. 307).

Conclusion

The majority of health education, promotion, and communication research on adolescent health and health disparities focuses on individual behavior and attitude changes—these have positively impacted health outcomes, yet have largely left out community voice and meaningful discussions of social structures that overlook the expertise of marginalized individuals (Fiddian-Green et al., 2017; Dutta, 2007, 2010; Dutta-Bergman, 2005). The intention in this section is not to completely eliminate an individual’s sense of their responsibility to their health, but to prioritize the societal determinants of health and the issues with labeling entire groups as “at risk” of poor health outcomes. It is detrimental to individuals in any community, let alone those that continue to be systematically disenfranchised, to belong to groups that outside public health experts deem to be “at risk”—this creates stereotypes that may ultimately hinder the desire and capacity to achieve good health, and it disregards a community’s ability to

create their own definition of health. Creating the pressure to live by the CDC's definition of what it means to be healthy strips a community of its expertise in defining health for itself and subsequently gaining access to creating it. It is yet another instance of U.S. governmental policies that create inequitable living conditions and blame the community for their inability to achieve what outsiders define as success.

Socio-historical Context of Health Disparities

> Dehumanization is the perfect word to describe the impact of current federal and state policies that are depriving communities of color of services, social programs, and economic resources while keeping them under brutally enforced control. (Roberts, 2012, p. 300)

Introduction

More than 15 years ago, public policy researcher Vicente Navarro (1993) brought to our attention that in the United States, "how people live, get sick and die, as well as the type of health care that they receive, depends not only on their race and gender, but primarily on the class to which they belong" (p. 19). Gabor Maté (2019) recently added to this idea, stating, "Whether or not the individual is healthy is primarily not an individual matter but depends on the structure of the society." There are significant differences in the quality of life that an individual experiences as a result of identity contingencies, and they cannot be understood without a critical and deep examination of the history of policies that have created such a divide. It is irresponsible to discuss health and educational disparities without critically examining the inequitable health and educational policies, shaped by racism and classism, and compounded by neoliberal policies, that have brought us to the present. This section is an attempt to bring historical literacy to the field of health education—a term coined by historian Khalil Gibran Muhammad (Gibson, 2017). It will examine the sociopolitical context of health and education in the contemporary United States by briefly reviewing the history of health

and educational policies that have created the racial and class divide in health and educational outcomes that we see today.

Race: A Political Category with Real Consequences

Race, as defined by Dorothy Roberts (2012), is “a political system that governs people by sorting them into social groupings based on invented biological demarcations” (p. 4). Race is a modern concept that is “physically, socially, legally, and historically” constructed such that some might benefit at others’ expense (Milner, 2015, p. 8). The United States as we know it today is entirely dependent on the longstanding belief that there are biological differences between races, starting with the White race and the Black race and delineating other races as a result of immigration patterns and ongoing changes in definitions of Whiteness (Roberts, 2012). The institution of slavery and, therefore, the development of the majority of American infrastructure on the backs of unpaid laborers, depended on the belief that Blacks were innately inferior to Whites, as demonstrated by flawed scientific understandings of the human brain and observations of physical differences, that have persisted despite their errors (Kawachi, Daniels, & Robinson, 2005; Muhammad, 2010; Roberts, 2012). Though Europeans, Africans, and Natives were initially enslaved in the colonies together, Africans began to be treated differently than other enslaved races by 1700, after Blacks and Whites revolted against leadership together in Bacon’s Rebellion (Painter, 2010; Roberts, 2012). European elites needed to prevent “future interracial solidarity,” so they created clear legal categories of “White,” “Negro,” and “Indian,” at the same time that they increased the importation of African slaves and began to rely more heavily on their skills than the skills of White indentured servants to make money (Roberts, 2012, p. 8). These legislative efforts set all Blacks apart from all Whites with regard to their power and privilege and damaged any chance of political harmony among the enslaved: White servants were allowed freedom dues when they completed their indentured servitude, while Blacks were not granted freedom

and were banned from carrying firearms; Whites without property were given special rights, including patrolling privileges and the right to enforce movement laws over Black slaves; and interracial sex and marriage became outlawed in several states (Roberts, 2012). These manufactured statutes set forth in the late 1600s and early 1700s continue to have tangible consequences on the experiences of power and privilege for Blacks and Whites in the contemporary U.S. (Roberts, 2012; Muhammad, 2010).

Race, however, is not a distinct biological category: there are no biological differences based on inherited traits in humans that can distinguish us from one another significantly enough to be considered different races (Graves, 2002). Though the evidence that "proved" these biological differences has long been discredited, the tradition of ascribing racial differences to biology persists: though the Emancipation Proclamation of 1863 freed slaves and granted citizenship rights, it did not change the larger cultural conviction of Blacks as an inferior race that had been manufactured in the courts and in local and federal policies for so many years prior (Muhammad, 2010; Roberts, 2012). Additionally, the Naturalization Act of 1790 limited eligibility for American citizenship to free White immigrants, further privileging individuals of European descent over all other ethnicities and legally justifying racial categorizations (Roberts, 2012). American cultural understanding became that oppressed racial groups were so because of their natural physical and intellectual weaknesses, instead of the "exploitation, coercion, duplicity, and genocide" that permeated policy (Muhammad, 2010, p. 24).

Political divisions of groups of people according to their appearance—a practice that humans have long engaged in since the invention of race in the 15th and 16th centuries—indeed have biological, and very real, consequences (Roberts, 2012). However, race has never been, and will never be a separate biological category: it has been strategically used by European elitists as a "political category… disguised as a biological one," so that they may maintain their power (Roberts, 2012, p. 4; Milner,

2015; Muhammad, 2010). Contemporary governmental categorizations of race remain part of a complex legal system that imposes racial inequities in several areas, including the educational and health care systems, creating very real consequences on Americans' understanding of each other (Roberts, 2012). As Roberts (2012) asserts, "When Americans see black and brown people doing most of the menial jobs, dying younger from most diseases, and filling most of the prison cells, it is easy for many to see race and believe it must be a part of nature" (p. 20). These beliefs shape health and educational research, outcomes, policies, and practices, though discussions of their depth are inadequate (Milner, 2015; Roberts, 2012).

Overview: Racism's Influence on Access to Education

> Educational outcomes for students of color are much more a function of their unequal access to key educational resources, including skilled teachers and quality curriculum, than they are a function of race. (Darling-Hammond, 2007, p. 320)

While human beings are not biologically divided by race, we have long been politically divided by it, and these political and social divisions have created very real consequences in the realm of education (Evans-Winters, 2011). This section reviews how the political division of race has determined disparities in educational outcomes. Tyrone Howard (2015) writes that many educators and researchers are much more comfortable discussing poverty than race. However, Milner (2015), along with Crenshaw, Ocen, & Nadna (2015) remind us that we cannot look at these issues separately: race is a significant factor in education, and it is imperative that we acknowledge that a disproportionate number of Students of Color are from lower social class backgrounds. It is not that one's socioeconomic status is caused by their race, but that experiences of financial deprivation are informed by race, due to our historical context (Milner, 2015).

Roberts (2012) demonstrates that the White majority in power has long pointed to illness, exhaustion, and low levels of literacy among the Africans they exploited "as

evidence of biological inferiority rather than white inhumanity" (p. 24). These beliefs have justified racism throughout a number of state-sanctioned policies, from chattel slavery to under-resourced and under-funded schools in segregated neighborhoods, and frameworks of pathology for Students of Color in educational research today: Children of Color and children from lower-income families have long been measured against White middle-class boys, which has inevitably defined the students who fall outside of this "norm" as lacking throughout educational inquiry (Evans-Winters, 2011; Howard, 2010). Educational theories and research have been advanced by racism, claiming that Children of Color from lower-income backgrounds were less capable of academic achievement at higher levels (Evans-Winters, 2011; Howard, 2010). Discriminatory practices have always found scientific evidence to back up their claims, dating back to eugenics: when a person's value was primarily defined by intelligence, eugenicists declared the IQ test as an objective measure of inherent intellectual capacity, and used it to "demonstrate that blacks and recent immigrants from southern and eastern Europe were intellectually inferior to Americans of Anglo Saxon or Scandinavian descent" (Roberts, 2012, p. 40). In 1969, a Berkeley psychologist, a Harvard psychologist, and a Nobel Laureate and physicist at Stanford argued that their finding of Black people's lower IQ scores and higher birth rates made public programs ineffective and threatened the welfare of the entire country in an article published by a journal as reputable as the *Harvard Educational Review* (Roberts, 2012). This paper clearly did not critically examine the use of the IQ test, which has been disproven as a measure of inherent intelligence wherein the results can meaningfully rank people (Murdoch, 2007). Later, in 1995, two scholars at the American Enterprise Institute argued that social disparities are a result of higher fertility rates of groups they deemed genetically intellectually inferior (Roberts, 2012). These views, uplifted by scientists and universities with ample prestige, have shaped public ideas about racial categories and subsequently influenced institutional decisions, including policy decisions about education (Milner, 2015; Roberts, 2012).

Segregation, racial hostility, and apathy have impacted the way educational policies have been developed and implemented since the U.S. Constitution (Roberts, 2012). The moral compromises made in the Constitution solidified White supremacy for many White Americans, while the rights and liberties of Blacks were compromised: under the belief that all men were created equal, education was one of many factors that allowed Whites in power to rationalize slavery and keep the inferior status of the Africans they exploited (Smith, 1999). Jim Crow Laws, Black Codes, de facto and de jure segregation, resegregation or "White flight," teacher bias and indifference, and continued disenfranchisement of Black children have all forced Black children to carry the weight of White Americans' assumption of their inferiority (Evans-Winters, 2011; Roberts, 2012). A number of scholars have demonstrated how Indigenous populations, enslaved Africans and their descendants, people of Latin and Asian descent, women, and Whites from lower-income backgrounds have been denied access to high-quality education and have therefore lived in a different America than the privileged groups (Darling-Hammond, 2018; Howard, 2010; Ladson-Billings, 2009a). During the 1920s and 1930s, Black and LatinX students attended underfunded, segregated schools, and were denied access to schools with more funding because of the racialized groups they fell into (Howard, 2010). Public resistance to meaningful integration depended on the belief that non-White students were cognitively inferior (Howard, 2010; Winfield, 2012). Brown v. Board of Education in 1954 brought an end to state-sanctioned racial segregation when it was decided that legalized racial segregation benefited Whites and actively rejected Blacks (Evans-Winters & Esposito, 2010). For a short time in the 1970s, post-Brown, the number of African American, Asian American, Native American, LatinX students and low-income Whites who graduated high school significantly increased, to the point where college attendance rates for Whites, Blacks, and LatinX students was equal (Darling-Hammond, 2018). Unfortunately, the Reagan administration began an era of educational reform that focused on high-stakes testing and reductions in social support, weakening

resources in many urban and rural public schools through decreases in per-pupil expenditures, tax cuts, and increased enrollments (Darling-Hammond, 2014; Milner, 2015). At the same time, student needs began to grow, as did rates of immigration, homelessness, and concentrated poverty, resulting in gaps in student outcomes again (Darling-Hammond, 2014). Students of Color are more likely than White students to attend schools in urban neighborhoods with high poverty, unemployment, and crime rates, and are therefore more likely to be negatively affected by these policies (Evans-Winters, 2011; Howard, 2010; Milner, 2015).

The statistics about Students of Color from lower-income backgrounds—which create generalizations about entire groups of people that may have very little in common with each other—minimize the impact of our country's history of racism and exclusion on educational outcomes and the discriminatory practices that are still present today (Evans-Winters, 2011). The words "urban" and "inner-city," throughout educational research, have become euphemisms for "Black" and "poor" (Evans-Winters, 2011, p. 11). Researchers, administrators, and educators have the potential to then respond to these words negatively, affecting their mindsets and behavior toward students and families they perceive to fall into these categories, which ultimately interferes with meaningful educational reform efforts (Evans-Winters, 2011; Milner, 2015). Black children are more likely than students in any other racialized category to be victims of verbal and physical assaults by teachers, more likely to be classified as having a learning disability or emotional disturbance, and more likely to receive punitive consequences like suspension or expulsion from school (Evans-Winters, 2011; Gillborn, 2009). Many public health and educational researchers (e.g., Crenshaw, Ocen, & Nadna, 2015; Steinberg & Lacoe, 2017; U.S. Department of Justice Civil Rights Division, 2014) agree that Students of Color are disproportionately affected by punitive consequences in public schools, which are associated with increased risk for incarceration (Parks, Wallace, Emdin, & Levy, 2016). Sealey-Ruiz (2016) concludes that Black boys and girls "are being educated during an

age of mass incarceration, zero-tolerance policies, and harsh treatment by security officers and other school personnel. All of these conditions directly affect their chances for academic and social success in school" (p. 293). There is also evidence that a disproportionate number of students who repeat coursework, or are retained in their grade, are Black and Latino males (Howard, 2010). Finally, students in economically disadvantaged neighborhoods—overwhelmingly Students of Color—are educated to be governed, or controlled: instructional practices in many high poverty schools treat knowledge as a skill to be taught by the supposedly expert teacher in order to receive a reward in the form of a grade, compared to students in more affluent, and often Whiter, communities, where teaching practices are more responsive to learners' needs and interests (Milner, 2015).

While education is a crucial element of upward mobility, the racial gaps in access to high-quality educational achievement force us to confront whether education in the United States is the equalizer we have long claimed and relied on it to be (Howard, 2010). Even when social class is held constant, there are still significant gaps in achievement between racial groups (Howard, 2010; Milner, 2015). It is important to point out that the communities that have been, and continue to be, excluded from adequate educational opportunities, are the same communities who are still regarded as at or near the bottom of the perceived social order today (Howard, 2010). Public schools can only do so much to create equity in student achievement: the academic gaps present in public schools are a symptom of the exclusion that occurs in the larger society, and they are only magnified in schools (Howard, 2010). Indeed, it can be difficult for students living in poverty to access high-quality health care, which ultimately influences their academic capacity, as discussed in the next section (Milner, 2015; Basch, 2011).

Overview of Racism's Influence on Health Disparities

> Race is not imaginary. Race is very real as a political grouping of human beings and has actual consequences for people's health, wealth, social status, reputation, and opportunities in life. (Roberts, 2012, p. 5)

This section reminds us how the political divisions of race have determined disparities in health outcomes in the United States through the works of Dorothy Roberts (2012, 2016) and Harriet Washington (2006, 2019).

The Black-White mortality gap is very real: although disparities in death rates have begun to narrow, they remain large, and endure across the life span in all age groups (Cunningham et al., 2017). Race as a political category matters at the end and the beginning of life: "Black infants are almost three times more likely than White infants to die before their first birthday" (Roberts, 2012, p. 81). Racial disparities in health have been found to be even more prominent at higher income levels, which some authors attribute to more frequent and severe experiences of discrimination and bias in health care (Golen, Ramey, Cooksey, & Williams, 2018). Such disparities have begged the questions, as posed by Roberts (2012): Are there genetic predispositions in non-White populations that make them more vulnerable to health issues? Or does being classified as a minority in the U.S. harm an individual's health?

White slaveholders intentionally defined diseases across lines of race, using research and practice to support their argument that the biological differences of Blacks made enslavement their only reasonable option to contribute to American society: Thomas Jefferson, for example, observed what he considered poor health of enslaved Blacks and attributed it to inherent racial differences, rather than the tumult of enslavement, and he used these observations as reasons why they would not benefit from being freed (Roberts, 2012). Similarly, the U.S. government altered data to suggest that enslaved people were mentally healthier than freedmen in order to maintain support for slavery (Washington, 2019, p. 3). Harriet Washington (2006) documents the history of medical experimentation on Black women in *Medical Apartheid*, in order to explain the

deep distrust for the medical community by African Americans as a result of a long history of exploitative, racially-based research, and the "experimental suffering of Black Americans" (p. 8). This distrust in part accounts for the persistent racial and gendered sexual health disparities, among others. Indeed, institutions of power have imposed reproductive control over Communities of Color, especially African Americans, at least since the 18th century: through tying a family's number of children to welfare benefits, forced sterilization of Women of Color, testing unsafe contraceptive techniques on young Black women without their knowledge, and finally, restricting access to birth control and/or abortion as women seek to gain control over family planning (Roberts, 2012; Washington, 2006). After slavery ended, Whites sought to improve in Blacks what they defined as racial differences in disease—namely, tuberculosis and syphilis, at the time—either through "benign neglect or coercive medical intervention" (Roberts, 2012, p. 85). Moreover, the ever-changing definition of race directly refuted racial differences in physical responses to disease, as W.E.B. DuBois pointed out: when Irish communities weren't yet considered White, they, too, were considered vulnerable to tuberculosis and other diseases, especially those associated with uncleanliness (Roberts, 2012).

Researchers and public health professionals often recognize the disparities in health profiles between White and Black Americans—a divide great enough to be considered a "medical apartheid"—without acknowledging the long history of medical experimentation on and exploitation of Black Americans that has led to a justifiable fear and distaste of the healthcare system (Washington, 2006). It is critical to remember the use of eugenics as justification for the forced sterilization of 65,000 individuals as a result of legal sanctions in 30 states, and how the popularity of eugenic beliefs permeated American culture (Washington, 2006). Additionally, we must highlight how historically, scientific claims of and larger cultural beliefs in racial differences in disease have justified coercive state intervention and preservation of segregation in Baltimore, Los Angeles, and our very own Lower East Side, back when Jewish immigrants were not

considered White, and were stereotyped for their potential for disease (Roberts, 2012). Roberts (2012) reminds us of our country's history of health discrimination that was upheld by the courts: Baltimore mayor James Preston aimed to protect White families from the risk of tuberculosis that integration with Black families was thought to bring; city health officials in Los Angeles targeted Chinese and Mexican communities as unhygienic and disease-ridden (Molina, 2006; Roberts, 2012). In 1886, San Francisco passed zoning laws that discriminated against Chinese launderers but were upheld by the California Supreme Court as necessary to protect public health (Molina, 2006; Roberts, 2012). In 1914, typhus outbreaks among Mexican residents justified the Los Angeles Health Department to launch a public health campaign, allowing them to inspect the private homes and classrooms of individuals who identified as Mexicans to identify those they deemed unhygienic and compel them to engage in individual hygiene practices, rather than improving sanitation conditions in their residencies and workplaces (Molina, 2006). As Roberts (2012) concludes, "diagnosing disease according to race was a powerful means of defining blacks as natural slaves, Jews as a contaminating threat to US welfare, and Chinese and Mexican immigrants as inherently unfit for citizenship" (p. 89).

Finally, African Americans have been overwhelmingly targeted for involuntary sterilization under state and federal laws, as well as outside the law, throughout history (Washington, 2006; Roberts, 2016). In 1935, 27 U.S. states had laws enforcing mandatory sterilization of the so-called "feebleminded," individuals on welfare, and those with genetic defects (Wasington, 2006, p. 202); by 1983, 43% of the women sterilized in family planning programs funded by the federal government were African American, at a time when Blacks made up just 12% of the population (Washington, 2006). Outside the law, involuntary and coercively performed hysterectomies on mostly poor and Black women were a common practice in both the North and the South as late as 1980 in teaching hospitals, medical schools, and health centers (Washington, 2006). Even obstetricians entrusted with child delivery, appendectomies, or gallbladder removals,

were guilty of sterilizing their low-income patients of color without their knowledge (Washington, 2006). Negative eugenics targeting, experimental reproductive health methods, and involuntary sterilization that have long targeted poor, largely Black communities, have indeed cast a long shadow on the perceived self-control over one's body for young African-American women (Washington, 2006; Roberts, 2012, 2016).

Medical doctors continue to take race into account when they treat patients, and their patients' race has an impact on the treatment decisions they make: a psychiatrist popularly confessed in 2002 to prescribing a lower dosage of Prozac to their Black patients than to their White patients, for example, because of research that supposedly demonstrated that Blacks metabolize antidepressants more slowly, and an anesthesiologist colleague of hers stated that he gives Asian patients undergoing surgery a lower dose of narcotics (Satel, 2002). In 2002, the Institute of Medicine released a report documenting widespread physician bias, prejudices, or stereotyping in healthcare that leads to disparities in treatment (Smedley, Stith, & Nelson, 2003). Still, doctors' use of race in determining treatment plans for patients is well-accepted and considered useful (Roberts, 2012). Roberts warns that racial disparities in health cannot be separated from racism: "Our healthcare system is structurally designed to give minority patients inferior treatment … that minority patients have access only to inferior medical services and are systematically barred from high-quality care " (p. 100). In fact, numerous studies have documented the negative impact of racial discrimination on individual health, mainly due to chronic exposure to racialized stress, segregation in neighborhoods that are deprived of jobs and resources that create healthy living conditions, and the material absorbed through the mother's environment—the air they breathe, the food they have access to, among others—during pregnancy (Barr, 2014; Washington, 2019). These are separate from and in addition to the impact of income inequality (Roberts, 2012).

An individual's health is best predicted by their "position in the social hierarchy" (Roberts, 2012, p. 128). Individuals with repeated exposure to stress, through racial and

class discrimination and institutionalized racism, have consistently higher levels of cortisol in their bloodstream, which dysregulates internal systems involved in the body's stress response and subsequently increases the risk of hypertension, asthma, and diabetes (Adler & Rehkopf, 2008; Roberts, 2012). Public health practitioners and researchers have a responsibility to bring the racist history of medical practice and healthcare in this country to the forefront of health education studies and practices (Washington, 2006). Health educators, especially those who are sent to "intervene" in what have been systematically defined as low-income or at-risk communities, should be taught this history and resulting discriminatory practices and beliefs. The field of health education emerged as a strategy to influence individual decisions regarding health behavior in response to widening health disparities (Fitzpatrick & Tinning, 2014b), and it is my hope that this section has highlighted the importance of raising the historical literacy in the field so that researchers and educators prioritize reflecting on their implicit biases that are shaped by this history and move the field toward health liberation for all communities.

Stereotype Threat

Steele (2011) defines *stereotype threat* as the threat or fear that "one false move" can cause an individual who is a member of a group outside the majority to be associated with a negative stereotype about their group and be treated accordingly (p. 7). The simple awareness of a negative stereotype about one's own social group is enough to affect one's performance at a specific task, because the pressure to disprove a stereotype is an additional task that requires mental focus (p. 111). Steele discovered the concept through his work as a university professor where he noticed his Students of Color underperforming academically, as compared to the White majority: even when Students of Color had graduated from high school at the top of their class, with marked academic accomplishments, when they came to a predominantly White institution, their grades suffered. He began testing his hypothesis by asking a group of women to take a difficult

math test: the researchers made the women in the experimental group aware of their gender in a survey prior to the test and told the women in this group that the test typically demonstrated gender differences in math; that is, he placed them under stereotype threat. The control group was not placed under stereotype threat, that is, they understood the test to show no gender differences. The women in the experimental group underperformed, time and time again, compared to the control group. Steele and his research team repeated this test with a multitude of groups over a multitude of skills and found repeatedly that just the knowledge of a negative stereotype about one's group, as defined by one of the many identity contingencies an individual belongs to at any given time, including race, gender, or class, can cause stress and distraction that lead to underperformance.

Steele (2011) uses these studies to explain demonstrated levels of underachievement by Students of Color in traditional school settings and female students in higher level math or science courses—when an individual is made aware of a cultural stereotype about one of the groups to which they belong, and they are told that the skills being tested will either fulfill or negate that stereotype, they perform worse than if they are not told that the skills being tested affect the known stereotypes about their group. This is true even when students aren't explicitly aware of their own anxiety over potentially fulfilling a stereotype (p. 117). Applying this idea to the ideologies found in health education that do not always acknowledge or embrace cultural definitions of health, it is possible that Students of Color in urban areas are less likely to be willing to engage in and/or maintain protective health behaviors if faced with the threat of being labeled "at-risk." This may be especially true when receiving health information from someone who has the characteristics of being an outsider to their community or who teaches by making generalizations about the groups to which the students belong in the form of statistics about health disparities, as Leahy (2007) found is common with health educators. Gay (2013) has documented that the cultural differences between Students of Color from low-income backgrounds and the majority White middle-class teaching force

have resulted in classroom incompatibilities that play a significant role in the academic achievement of these students. In other words, receiving health information from a White health educator, no matter how highly trained, may create more resistance for Students of Color to engaging in health behaviors that public health experts deem protective, not only if these health behaviors are inaccessible in every neighborhood, but also if students are aware of the statistics around health disparities and are trying to disprove the stereotype that they may be “at risk” or more likely to engage in risky health behaviors, according to the data—if they, in Steele’s (2011) words, are not only trying to learn, but “are also trying to slay a ghost in the room, the negative stereotype and its allegation about [them] and [their] group” (p. 111). Steele writes that the multitasking required when students are attempting to refute a stereotype causes stress and can distract students (and adults) from the tasks at hand, directly interfering with learning and, ultimately, their performance at a particular skill (2011). This study will attempt to explore whether the pathological framework of health disparities in which much of public health and educational research place Students of Color in contexts where stereotype threat presents itself.

Conclusion

By presenting statistics about health and educational disparities by race, the U.S. government has the potential to contribute to the revival of old beliefs about race as a biological category (Roberts, 2012) and may pander to savior complexes of individuals and organizations. When public and private funding is urgently funneled into targeted interventions, schools, and community-based organizations with the stated goal of alleviating health and educational disparities of individuals and communities who are grouped together almost arbitrarily and labeled as “at risk,” it perpetuates the power dynamic that was created to maintain White privilege, and that persists due to American residual beliefs about the biological inferiority of non-White racial groups, which ultimately disempowers and dehumanizes the individuals it seeks to empower (Evans-

Winters, 2011). Though the intentions of the interventions, individuals, and organizations who aim to alleviate health and educational disparities through targeted interventions for lower-income Communities of Color may be good, when they do not acknowledge the progression of beliefs around and practices toward marginalized groups, they have the potential to perpetuate the separation of people into “different kinds of human beings” and place people in groups that may have very little in common with each other (Roberts, 2012, p. xii). Race is the main way we classify health and educational disparities, and the use of a risk discourse is required in order to demonstrate a need for these interventions: they must create and rely on a deficit in a particular group in order to exist (Evans-Winters, 2011; Milner, 2015). This study aims to approach health education through postmodernism and critical race feminist lenses not to perpetuate the serious political consequences of dividing people into races, but to contribute to researchers’ and educators’ historical understanding regarding the exclusionary, sexist, and racist practices in public health and education that still impact our experiences today. It also aims to give voice to and empower the individuals that are so frequently framed in the literature as pathological. To this end, I conducted one-on-one semi-structured qualitative interviews with individuals who happen to fall into social categories that have long been disenfranchised in order to explore whether and how the intersections of race, class, and gender have on their understanding of health.

Theoretical Framework

In order to adequately recognize the role of unbalanced structural conditions and inadequate institutional supports imposed upon Students of Color in their experiences of health messaging, we must use a culture-centered approach (Dutta, 2007, 2010; Dutta-Bergman, 2005) that takes on tenets of postmodernism and considers perspectives from critical race feminist theory (Evans-Winters & Esposito, 2010; Lane, 2015). This section

presents background information on postmodernism and critical race feminist theory and provides a justification for their use.

Culture-centered Approach

Dutta (2007, 2010) and Dutta-Bergman (2005) call for a shift from culturally sensitive approaches to culture-centered approaches in health communication. Culture-centered approaches commit to three tenets:

> (1) a focus on local cultural contexts informing meanings and experiences of health, (2) prioritizing agency, which is predicated on a dialogic/process-oriented approach that engages participant voices and acknowledges the co-construction of knowledge, and (3) an acknowledgement of structural dimensions, which both constrain and facilitate agency, and, through a deep analysis of social inequality, politicize the endeavor of public health research (Fiddian-Green et al., 2017, p. 5-6; Dutta, 2008).

In an attempt to make this shift and ensure these three commitments, this study employed tenets of postmodernism and critical race feminist theoretical frameworks, while using a qualitative methodology that prioritizes student voices.

Postmodernism

As I have argued through the work of critical theorists before me, structural inequities have the potential to create and shape specific stressors in the lives of Students of Color (Evans-Winters, 2011; Taylor, Gillborn, & Ladson-Billings, 2009). Evans-Winters (2011) has called for a framework that "seeks to understand how structural forces and context-specific social conditions negatively and positively influence schooling experiences" (p. 15). The basic concept of postmodernism is that claims of knowing and truths should be questioned; it offers opportunity to "critique and reinterpret existing research" (Evans-Winters, 2011, p. 15). I found Mirón's (1996) work through the Evans-Winters (2011): Mirón (1996) suggests that due to the postmodern focus on "the understanding of the everyday, the meaning of marginality, its opposition to the

modernist assumptions of a unitary self and determinancy, and the possibilities of local cultures modifying material and ideological structures of domination," (p. 101), bringing postmodernism to educational research offers a way for individuals in the margins to subvert the traditional lens and share a picture of their own lives, in their own words (Evans-Winters, 2011). In this way, "researchers and the researched can begin to be understood as individuals who share distinctive historical and cultural experiences" (Evans-Winters, 2011, p. 15).

Though Thomas (1993) calls postmodernists "armchair radicals" (p. 23) who focus their critiques on shifting thought processes rather than taking meaningful action (Creswell & Poth, 2018), Mirón (1996) has called for the usefulness of postmodernism in educational research, specifically research in urban pedagogy, in both challenging knowledge in research and applying these deconstructions to pedagogical practices. By linking postmodern tenets with critical race feminist theory—guided by Evans-Winters' (2011) merging of postmodern tenets with Black Feminist theory—this study aimed to both transform ways of thinking in the field of health education and call for action for meaningful change in the lives of the students. Because postmodern perspectives typically use collaborative approaches, the methodology prioritized student agency through a dialogic approach with student participants.

Critical Race Feminist Theory

> The diabolical genius of making this political system seem biological is that the very unequal conditions it produces become an excuse for racial injustice. (Roberts, 2012, p. 24)

Grounding this research in critical race feminist theory deconstructs White middle-class definitions of femininity and heteronormativity within educational research, and looks to the intersections of race and gender (Evans-Winters & Esposito, 2010; Lane, 2015; Evans-Winters, 2011). Centering the voices of Students of Color intentionally challenges hierarchical structures and universally accepted epistemologies (Ladson-

Billings, 2003a), and attempts to shift the knowledge and expertise away from the academy and towards members of communities that are often pathologized, or “saved” by the research (Evans-Winters, 2011; Evans-Winters & Esposito, 2010; Lane, 2015). Feminist theory that focuses on the significance of gender in educational experiences is not enough to adequately explore the impact that the combination of class, race, and gender have on young people’s experiences in health education (Tolman et al., 2003): White feminism has overlooked or ignored the experiences of Women of Color, and antiracist efforts have emphasized the experiences of men (Evans-Winters & Esposito, 2010; hooks, 1984). Research based in critical race theory thus requires the added perspectives of Black feminist theory to formulate critical race feminist theory (Evans-Winters & Esposito, 2010) in order to sufficiently explore the multiple forms of oppression, characterized by a history of economic exploitation, political subordination, and racist and sexist ideologies, that are unique to Black women in particular, with the knowledge that to center stories of Black women is to attempt to liberate all marginalized groups (Collins, 2000).

As an extension of critical race theory, “critical race feminism complicates the feminist practice” of storytelling by placing power relations as the focus of the discourse on all forms of oppression, including gender, race, and class (Lane, 2017, p. 16); Evans-Winters & Esposito, 2010; Delgado & Stefancic, 2001). Critical race theory has five tenets that inform educational research, curriculum, and policy (Ladson-Billings & Tate, 1995): (1) that racism is pervasive in American life, deeply ingrained in our laws, our culture, and our minds; (2) CRT challenges dominant narratives and assertions of race neutrality, objectivity, color-blindness, and meritocracy; (3) CRT is activist in nature and demonstrates active commitments to social justice; (4) it focuses on the experiences of individuals who have been marginalized due to racism; and (5) it is interdisciplinary (Evans-Winters & Esposito, 2010; Delgado & Stefancic, 2001; Solórzano & Yosso, 2002).

While much of the public discourse in the United States focuses on by the Black/White binary, critical race theory and its extensions continue to expand this discussion to attend to a multitude of experiences of People of Color (e.g., Yosso, 2005). Critical race theory has historically been dominated by men's experiences, and therefore by itself is not enough to encompass the experiences of those living at the intersections of multiple forms of oppression, including Women of Color. Thus, using a critical race feminist framework in education may provide solutions for examining and eliminating race, class, and gender discrimination in education (Evans-Winters & Esposito, 2010).

The theoretical lens of CRF benefits research around educational issues through five principles: (1) Women of Color's experiences and perspectives are "different from the experiences of Men of Color and the experiences of White women"; (2) CRF "focuses on the lives of Women of Color who experience multiple forms of discrimination, due to the intersections of race, class, and gender, within a system of White male patriarchy and racist oppression"; (3) it "asserts the multiple identities and consciousness of Women of Color"; (4) it is "multidisciplinary in scope and breadth"; and (5) it "calls for theories and practices that simultaneously study and combat gender and racial oppression" (Evans-Winters & Esposito, 2010, p. 20). A critical race feminist framework in the exploration of students' educational experiences encourages the "avoidance of gender and racial essentialism," or the idea that there is a singular experience of being a woman, or a Person of Color (p. 21).

In the past, critical race feminist theory was used to analyze legal policies affecting People of Color, but has more recently been extended toward educational policies and research, answering the call for educational researchers to make attempts to center the experiences of individuals who exist at the intersections of race, class, and gender (Evans-Winters & Esposito, 2010; Lane, 2015). As this study aimed to highlight the voices of participants from groups that are frequently pathologized in public health and educational research as well as in the media, assumptions of knowledge and authority are

challenged, and their experiences are at the center of the research (Lane, 2015). Evans-Winters and Esposito (2010) assert that CRF studies in education may act as a protective factor against the destruction of spirit that racist patriarchal spaces impose on so many Women of Color, and as support for women navigating White middle class educational institutions. In using CRF as a theoretical framework, it is necessary to bring attention to Evans-Winters and Esposito's assertions of the following realities within Black girls' education: (1) there is a need for "theoretical frameworks that expose, confront, and eradicate race, class, and gender oppression in families, communities, and schools"; (2) "not enough is being done by scholars in the fields of education" policy or pedagogy to "develop and implement classroom practice and curriculum that directly relates to the needs of Black girls"; (3) "Black girls' psyches and bodies are being subjected to subjugation in the media, racist and sexist school policies that serve to exclude and silence them, and social and legal policies that dehumanize … the quality of life of low-income and working-class young women"; (4) "young women's existence at the margins presents both constraints and possibilities for all educational reform efforts and overall societal transformation, so research with and on behalf of Black girls benefits all of society"; (5) CRF in education "offers the most nuanced and straightforward framework for dealing with the social, economic, political, and educational problems that confront Black female students inside and outside school" (pp. 22-23).

Though this study sought to interview Students of Color of all genders, a critical race feminist framework was essential to understanding and uplifting the experiences that come with the multiple oppressions of race, class, and gender, and to challenge the essentialist notions of antiracist and feminist efforts alone.

The combination of these frameworks, using qualitative methods that seek to highlight student voices, "position[ed] them as experts of their own socio-political location and empower[ed] them as co-participants in the efforts to radically transform U.S. public education" (Lane, 2015, p. 170). At the same time, these frameworks guided

me as the educator-researcher through the self-reflection process, a crucial aspect of any research (Esposito & Evans-Winters, 2007). I am very aware of my culturally dominant role as a White educator-researcher seeking to explore and present the experiences of Students of Color: as such, I went to great lengths to ensure that the participants were well-informed, aware of what they were participating in, and allowed to weigh the possible risks and benefits of being involved in this project with consent, as Washington (2007) recommends.

Conclusion

The structural influences of racism, sexism, and classism collaborate to influence the behaviors and experiences of Black female students (Evans-Winters, 2011) and of all Students of Color (Taylor, Gillborn, & Ladson-Billings, 2009). A culture-centered approach to health communication requires a focus on local cultural contexts, a meaningful opportunity for dialogue, and an analysis of social inequities in order to achieve social and structural changes (Dutta, 2007, 2010; Dutta-Bergman, 2005). Postmodern tenets and critical race feminist theory (Evans-Winters, 2011; Evans-Winters & Esposito, 2010) thus informed the interview protocol, methodology, and analysis of the data. It is important to use these critically oriented frameworks to disrupt the traditional pathological narrative and understand how individuals who have been placed into social categories that have been marginalized and disenfranchised understand and reimagine health.

Chapter III

METHODS

Study Design and Rationale

This section describes my data collection approaches and decisions for exploring my research questions through semi-structured, qualitative interviews with current and former high school students. Evans-Winters (2011) argues that "traditional research questions and interpretations have not led to effective educational reform efforts" (p. 14). This exploration began with my commitment to deconstructing the idea of authority and to identifying community members, specifically youth, as experts in their experiences and as priorities in enacting social change (Dutta, 2007). The study used a qualitative design that sought to explore students' understanding of health as it relates to their varied identity contingencies and subsequent experiences through one-on-one semi-structured interviews. Data were collected from study participants using open-ended interview questions and a brief demographic survey. Data collection primarily involved 30- to 60-minute qualitative interviews with 26 current 11th or 12th grade students and recent (up to three years previously) high school graduates. Participants were recruited through a convenience sample at an athletics-based after-school program for middle and high school students from across Manhattan, Brooklyn, and the Bronx, where students were either current or former participants and where the educator-researcher was employed. A brief demographic survey was included in the informed consent/assent forms.

Using an interview protocol informed by Spradley's (2016) guidelines, the qualitative interviews were intended to gain insights from the perspectives of youth who happen to belong to marginalized social categories in order to explore how they co-constructed these meanings in their interactions with their surrounding social structures (Dutta, 2007). Open-ended questions were asked in order to focus attention on gathering data that would lead to a description of the experiences of Youth of Color in their understanding and imagination of health. The study took a culture-centered approach via semi-structured qualitative interviews due to the stated priority of highlighting the voices of Youth of Color and placing them at the nexus of social change (Dutta, 2007). Overall, the study was designed to center the experiences of Youth of Color and their understanding of health as it relates to social categories and structures, to identify how, if at all, their understanding of health influences their health-related behaviors, and to compare similarities and differences in perceptions across students' experiences and understanding.

I integrated the ideas of Evans-Winters (2011, 2019) and MacLure (2013a) throughout my analysis and interpretation processes, immersing myself in the data for the coding process while recognizing that neglecting to critically engage the coding process can reify marginalization. Both authors discuss the need for researchers to interrogate the assumptions of power and knowledge that create self-imposed certainty and authority in the institutions that allow the research. Inspired by McCall (2014), I later employed Luke's (1995-1996) critical analysis of discourse and Stake's (2006) approach for reading the data as separate interviews and as a combination of answers to the research questions.

Postmodernism and Critical Race Feminism

As I have argued through the work of Evans-Winters (2011, 2019), traditional research in health and education has worked to serve the needs of dominant groups,

especially elite social institutions. The tenets of postmodernism allow educational researchers and reformers to understand how knowledge is produced "in language and cultural practice", and to challenge traditional epistemologies (Evans-Winters, 2011, p. 15). According to Gloria Ladson-Billings (2003), a researcher's epistemology—more than a way of knowing, but a "system of knowing"—is linked to an individual's knowledge and experience of the world, and is shaped by the ways they live and their daily experiences (p. 257). The conditions under which we live make it difficult for individuals to develop worldviews different from the dominant ones imposed—this requires: "active intellectual work on the part of the knower, because schools, society, and the structure and production of knowledge are designed to create individuals who internalize the dominant worldview and knowledge production and acquisition processes" (p. 258).

I have spent significant time in earlier chapters arguing the importance of shifting the narrative about health and health education from institutional "experts," including academic researchers (Dutta, 2007), toward the perspective of youth, especially youth from communities who have been disenfranchised by governmental policy. This argument drew largely from Dorothy Roberts's (2012) delineation of U.S. health policy from the forming of the nation to contemporary times, and the health disparities we learn about in the academy. I have also closely relied on the work of Dr. Venus Evans-Winters (2019), who discusses the importance of using "dialogical approaches in Black feminist inquiry" if the goal of the research is to imagine social change (p. 23).

Evans-Winters discussed the usefulness of merging the tenets of postmodernism and Black feminist inquiry to "explain how African American girls' school experiences are related to their experiences as racialized, classed, and gendered subjects in society" in her 2011 ethnography, *Teaching Black Girls* (p. 20). As I am not a Black woman writer, I have chosen not to use Black feminist inquiry in order to maintain a respectful distance from co-opting this methodology. I instead incorporated Evans-Winters's 2019 work on

qualitative research into my postmodern and critical race feminist lenses in order to adequately understand how to employ a methodology that centers and respects youth voices without telling their story for them. Ladson-Billings (2003) argues that breaking away from traditional research methodologies can "demystify the research process in Communities of Color,[1] the members of which are often the objects but rarely the beneficiaries of research" (p. 268). Indeed, Evans-Winters (2019), supported by the work of Ladson-Billings and Tate (1995) and Evans-Winters and Esposito (2010), asserts that the rise in critical race feminist approaches creates "more awareness of the utility of counter-narratives in countering racial and gender oppression in ... educational research" (p. 23). Merging postmodernism with critical race feminism allowed me to challenge dominant discourses while exploring the interaction of race, class, and gender in students' experiences (Evans-Winters, 2011).

Mirón (1996) has encouraged educational researchers to embrace postmodern tenets in educational research: while Evans-Winters (2011) has engaged postmodernism within "critical urban ethnography" (p. 15), these tenets have also been useful in qualitative interviews that explore students' identities and cultures (Mirón, 1996). Postmodernism has the potential to be valuable for a variety of critical qualitative approaches as it acknowledges a "multiplicity of identities and subjectivities" (Mirón, 1996, p. 123); a plurality that is rarely extended to marginalized groups (Evans-Winters, 2011). This extends to participants the opportunity to present narratives of their own lives as individuals with distinct experiences, and allows them to participate in the production of knowledge (Mirón, 1996, p. 123). Pursuing qualitative interviews through the lens of postmodernism is suitable for the current study because it attends to discourses through critical analysis and deliberately employs procedures that prioritize students' agency (Evans-Winters, 2011). This may in turn allow the study to create a system of knowledge

[1]Capitalization is my own.

that stands in contrast to the dominant epistemology within health education, as Evans-Winters (2011) has done with urban pedagogy. In the case of this study, the meaning of health can never be separated from the political categories into which we have been assigned, including race, gender, and class. In health education research, just as in other disciplines that fall into public health and education and the intersections of the two, all bodies are measured against White middle class bodies and their knowledge of the world (Evans-Winters, 2011; Dagkas, 2014; Gardner, 2013). Employing postmodernism and critical race theory through qualitative interviews allowed me as the educator-researcher to take a culture-centered approach to understanding how students who live in the margins come to understand health in order to deconstruct dominant frameworks by exploring students' understanding and beliefs (Dutta, 2007).

My interest in interrogating power structures also required that I critiqued the ways in which I chose to structure the interview questions, as well as the interview processes I engaged in with my student-participants (McCall, 2014). With my chosen methodology, regardless of how much I refuse to support the assumption that the "critical thinker," or in this case, qualitative researcher, may act as judge or "moral arbiter" (Braidotti, 2002, p. 9), I am still the supposed authority selecting, organizing, and evaluating knowledge, which will ultimately be represented as findings based on my interpretations (McCall, 2014, p. 104). Therefore, in my attempts to challenge the assumed objectivity of knowledge, I chose to embrace the "messiness" of gathering data (Fitzpatrick, 2013) refusing to create categories of codes, following MacLure's lead (2013a, 2013b), and instead letting myself become "undone," using theoretical concepts to ask questions that open up meaning (Mazzei, 2013, p. 105). In this way, researchers approach our role as "transformers of thought and processors of insight as we provide direction" (Mazzei, 2013, p. 108). Further, I have also attempted to integrate many of Evans-Winters (2019) and Tuhwai-Smith's (2012) concerns with traditional research and, more specifically, qualitative methodology, in order to ensure that the research conducted is not exploitative

since, regardless of my relationships, I am still an outsider to participants' communities. Still, given my desire for my research to empower my student-participants, it was incredibly important to me that my approaches were as thoughtful toward and reflective of methodological concerns that these authors, who identify as Black feminist and indigenous respectively, have addressed.

The intentions and interests of White educators, researchers, and policymakers have long been elevated over the intuition of Students of Color (Evans-Winters, 2011; Evans-Winters, 2019; Ladson-Billings, 2000). Qualitative interviews can therefore work in collaboration with postmodernism and critical race feminist theory, as it allows researchers to examine the effects of social structures on marginalized students' health and educational experiences without placing the burden of racism, sexism, and classism on the individual.

I gathered data in the spring and summer of 2019 and analyzed and interpreted the data from each interview in the fall of the same year. I approached the interview transcripts one at a time, but, like McCall (2014), I was aware of the "tension" between the content of one interview and the entire group of interviews (p. 106; Stake, 2006). I was also aware that I could not separate my experiences in my four years of working with many of the student-participants as academic advisor and health educator from the interview process of the current study (McCall, 2014).

Personal Significance of the Topic, Methodology, and Site

Fitzpatrick (2013) writes that reflexivity encourages researchers "to interrogate their own position and the broader epistemological context of their research" (p. 71). For this reason and many others, in this section I attempt to present my personal experiences and training that contribute to my subjectivity so that I may expose the power relations inherent in research and interrogate how my chosen methodological framework

contributes to assumptions of knowledge in the field of health education (Fitzpatrick, 2013).

I pursued my doctorate degree in health education in order to address the health disparities that I read about during my undergraduate degree in psychology. I had an intuitive feeling that the health education classroom had an opportunity to be a place of liberation and empowerment, but that the pervasive racist and sexist ideologies were barriers to that. My subsequent core courses in my master's degree program at Teachers College emphasized addressing racial health disparities and the social determinants of health, but I felt ill-equipped to conduct research on using health education to address disparities without having any meaningful time in the classroom. As a result, I took time off from my degree to teach health in order to gain meaningful experience and a better understanding of the phenomenon of health.

I was hired as a school health coordinator by a non-profit organization that followed a popular educational model: hire and train highly educated recent college graduates and place them in the "highest need" communities, defining need by the percentage of students at the school who are eligible for free or reduced lunch. The stated aim of the organization was to empower high school students with health information and resources to develop good health behaviors for their adolescent and adult lives. I was placed in a small public charter high school that did not receive adequate funding, but was staffed by enormously dedicated teachers and administrators, and a vibrant student community.

I came in to my new position without training in critical frameworks and therefore without realizing that my intention to use what I perceived to be my "high quality education" to work in communities who were defined for me as having the "greatest need," without challenging these definitions, I was embodying saviorism (Matias, 2013). I followed the training that my new organization provided me with and incorporated my knowledge of health disparities from my master's courses. I memorized the lesson plans

and prepared my materials for my first day, and I took the mainstream definition of health at face value—I never thought to challenge it or reframe it depending on experiences of the students I was teaching. I walked into the classroom energized and prepared, and began to teach the lesson I had memorized on nutrition, with the underlying belief that if kids just had the right information, they would want to engage in behaviors that promote good health. I set the intention to make health exciting and interesting, and my energy and words matched my intention. After 20 minutes of minimal responsiveness from the students, I asked what was on their minds. One young woman raised her hand and told me, "That's all fine for you, because you probably live close to Whole Foods, but my neighborhood doesn't have any of the foods you just talked about." I don't remember my specific response, but I know I wanted to get her to see that health could be accessible to anyone. She tried to engage with me and kindly gave me the benefit of the doubt, but ultimately we came to the conclusion that maybe, with the current structures, it's not.

I went home and looked at all the lesson plans and activities I had been provided by my formal training, but I found nothing that was relevant to the realities my students lived in. I had gotten my education from institutions that our culture labels as prestigious, and I was considered successful and intelligent by my peers, but my new 11th graders had greater awareness of the structural inequities that facilitate health behaviors than I did—a fact not usually considered by educational reform efforts that send outsiders in to support communities or help "fix" a "problem." My institutionally-accredited "success" still left me ignorant of what my students wanted and needed. Luckily, my organization offered me and other health coordinators like me, placed in similar schools across the country, some autonomy and allowed us to edit lesson plans and create entirely new ones. I shifted my focus from the lesson plans I was given toward practical skills that students asked for, like cooking and gardening, and I borrowed lesson plans from other health coordinators that focused on empowering students to address structural inequities. I used my time, energy, and budget to coordinate long-term partnerships between the school and

existing resources in the area, especially with organizations run by local community members, and especially those that focused on shifting structural conditions, like subsidizing costs of fruits and vegetables at corner stores. I ran lunchtime and after-school clubs that focused on empowerment through community service and environmental health, and I consistently deferred to the expertise of the students and the staff who were already at the school when I arrived. I did all of these things that were a result of personal reflection and learning, and constant inquiry with community members, as opposed to the training from the organization that employed me. I left still feeling that the health education classroom could be the ideal place for empowerment and liberation, but I felt deeply that an outsider teaching health with an intention of fixing or saving a community in need was not going to create that space.

I returned to Teachers College to complete my doctorate degree in order to learn more about what students who have been systematically pushed to the margins need and deserve with regard to their health, and the methods by which we as educators and researchers can make that happen. I was hired by an after-school program as a full-time academic advisor and health educator for 9th and 10th graders who attend various public schools across New York City. I designed my doctoral coursework to ensure that I was learning information that helped me do right by my students, taking critically-minded courses with Monique Lane, Robert Fullilove, Yolanda Sealey-Ruiz, Stephanie McCall, and Christopher Emdin, supplemented by critical conversations with my advisor, Charles Basch. All of these courses, readings, and discussions, along with my prior experiences, continued to transform my worldview away from saviorism—slowly but surely, as I was a product of my culture—and empowered me with skills and resources from hooks (1994) and Ladson-Billings (2009), for example, so that I was more equipped to meet my students' wants and needs. It is the combination of these courses and mentors that was what I needed before I began my position as a health coordinator, but I didn't know to seek them out. The more I learned at work and in class, the more urgent it became to

develop a research project that focused on students' voices so that greater numbers of health educators have a richer understanding of the structural conditions that create health outcomes and learn how to apply that information in the classroom.

This topic is significant to me because many students who are labeled as high achievers academically are good at following the rules that are presented. If the rules state that certain groups are in need, and that need is to be "saved" from behaviors that lead to poor health outcomes, then educators will continue to go into classrooms and communities with the intention of intervening with a group they view, unconsciously or not, as deficient. However, if the rules change, and the social conditions and historicity of health are brought to the forefront of every field at the nexus of health and education, then it is possible that all students will be taught by the educators they deserve, who understand the structural conditions at play and who are equipped to empower students to dismantle them together.

I am drawn to the methodology of the current study due to my experiences wherein my training did not adequately meet my students' needs, in my investments in youth as the nexus of social change, and my interest in being challenged in my identity as a White educator-researcher. I am also drawn to it because of my personal philosophy and values that align with the methodology's openness and flexibility: my work in anti-racist and anti-oppressive education has taught me to explore the universal aspects of the human experience across racial, gender, and class lines, much like Dorothy Roberts's (2012) commitment to our common humanity across perceived categories.

In much of social science research, we are able to assume a level of comfort in our self-identity when we believe we're conducting research with altruistic intentions. Villanueva (2018) defines altruism as "doing things for others, unselfishly, without expectation of reward or acknowledgment, and maybe even at some cost to oneself" (p. 175). The motivation of this definition of altruism is surely what drove me to study health disparities in graduate school in the first place after I was first exposed to the

statistics, and indeed what motivated me to take the jobs that I did—before my "critical consciousness" was raised (Freire, 1970), I was attracted to the notion of communities and people that might "need" me, and gravitated toward jobs that used such enticing language, because it comforted me to know I was doing something "unselfishly." However, as the years went by—though I wish I learned it much earlier on—I saw how damaging such a pursuit of altruistic motivations was. This was a need to be satisfied in me, and not anybody else. As someone who has long benefited from great financial, educational, and White body privilege, I was gifted with the identity and the comfort of being altruistic, not because it is an expectation that we as individuals contribute positively to our communities, but because it fills a gap in us—"we reserve the term *altruism* for the privileged, fortunate, entitled people for whom self-sacrifice is a stretch, is unexpected" (Villanueva, 2018, p. 175).

I have long grappled with my choice to conduct interviews with students in fear that, upon analysis, I would be telling their story for them. It took me several weeks of pause and exploration into a variety of analytical approaches in order to move forward. However, given my interest in challenging the orthodoxy in health and educational research by providing counter-narratives alongside Roberts's (2012) delineation of historical literacy around U.S. health and educational policy, qualitative interviews with students from communities that have long been disenfranchised allowed me to shift the authority from my role as researcher to the students, the narrators of their own lives. I gave up, as Mazzei (2013) writes, on my compulsion, as a researcher, to fix all current qualitative practices in order to "become undone in ways that produce new practices and ways of thinking/doing/being researchers" (p. 105). I wanted to offer students who may be interested in the topic the opportunity to share their subjective experiences of how they came to their understanding of health, as well as their desires and imaginings for health and health education in the future. Interviewing the students one-on-one provided a space for them to be honest and unaffected by how their peers may perceive their answers. It

also allowed for their experiences to be heard and explored as valuable information to health education research. Politics of race and gender in health and education throughout the U.S. inspired this study, so it was important that I pay attention to how my subjectivities interacted with student-participants (Lather, 1992). I return to the concept of altruism at the end of Chapter VI.

Setting

Even in seemingly more progressive contexts like New York City, the majority of us live in "a highly segregated hyper-racial space" (Gardner, 2013, p. 12). The communities we live in shape our ways of knowing and being (Gardner, 2013). There are 1,665 district public schools across all five boroughs of New York City—Brooklyn, Queens, Manhattan, Bronx, and Staten Island. The student population is 15.3% Asian, 28.3% Black, 40.2% Hispanic, 14.5% White, and 1.7% are identified as "other." Almost 80% of students in the public school system qualify as living in poverty, according to NYC DOE data.

Students in this study were recruited from an athletic- and academic-based after-school program located in New York City and attended by majority public school students where the educator-researcher was employed during the time of the study and for the four years prior. At the time of the study, there were almost 200 students attending the program and just over 100 active alumni.[2] Demographics of all participants are left out to protect the anonymity of the program, but the demographics of the student-participants will be included in a later section.

While the large majority of the students who attend the program also attend public schools across New York City, the program does not provide public information on

[2]Citation not included to protect anonymity.

participant attendance at public versus parochial or independent school attendance. The program self-describes as providing long-term support to children, families, and schools in the NYC area, and does not set parameters for family income with regard to student recruitment, though the program is free for all attendees. Recruitment for the program takes place at community events and inside the classrooms and orientations of nearby public schools; students who do not attend those schools specifically are typically brought into the program by friends or family. I am only aware of the school attendance data for students whom I advised directly, and not for the entirety of the program, so I will not provide that information here.

Data collection took place on site at the after-school program, except for one interview that took place at a mutually agreed upon location. This site and population of students were accessible because of the convenience that I was employed there and the access I had to students who were interested in providing information about their experiences understanding health. Students who attend/ed the program also attend/ed a variety of majority public schools across New York City[3]: these varied contexts allowed a breadth of perspectives on students' experiences of health messages throughout their schooling experience.

I intentionally sought to conduct semi-structured qualitative interviews with students who are identified by external entities as marginalized so that their personal narratives can contribute to the literature, in order to challenge and reinterpret existing conceptions of knowledge (Evans-Winters, 2011), and co-construct their understanding of health, defining what they want and need from a health class and the larger cultural definitions of health (Dutta, 2007). Students were considered appropriate participants if they were willing to join me in an open-ended investigation of their perceptions of health

[3]Though the large majority of students who attend/ed the program attend public school, two students who participated in the study attended a parochial high school.

and were willing to commit to the in-person interview, willing to be audio-recorded, and willing for the data to be used in a doctoral dissertation.[4] Student-participants were not necessarily all academically advised directly by me, though the majority of participants had worked directly with me at some point during our shared time at the program.

Before data collection began, I received approval from the head of the organization, and IRB approval from Teachers College (Appendix A). I notified staff at the organization of the confidential interview process prior to conducting the interviews so that we were less likely to be interrupted and so that there were no concerns about student safety. I had the luxury of prior positive relationships with staff and students, as it was easy for me to gain support and take additional classroom space in order to complete these interviews. More details on the context of the after-school program can be found in the next two sections.

Sample Population and Recruitment

I used a convenience sample to recruit 26 current 11th and 12th grade students and alumni of the program, with whom I conducted one-on-one qualitative interviews lasting 30-60 minutes each, from April through August 2019. One additional interview was completed, but the transcript could not be used due to external noise. Current students were eligible to participate if they were in 11th or 12th grade and had taken at least one semester of health education at school. Eligible alumni were those who graduated from high school up to three years ago—no earlier than 2016—so that they had recent memories of health class in high school and/ or in our after-school setting. Students who

[4]Students who completed interviews with me before a certain date were also invited to present the answers to their interview questions at an informal workshop hosted at an educational conference held by a local college. Only students who were interested in attending the conference and sharing their experiences with workshop attendees came with me—six 12th grade students total. Because their discussions were repetitive of their answers in their interviews, this information was not used in the study. This invitation was simply made to provide students with the opportunity to participate in an educational conference in a college setting and to network with other academic researchers and college/graduate students.

did not give consent for participation or did not want their interviews audio-recorded and transcribed were ineligible for participation.

High school students attended the after-school program from which I recruited four days per week. In order to recruit current students (11th and 12th grade only due to their higher-level understanding), I made verbal announcements to the 11th and 12th grade students about the study three times each at the end of their academic sessions. I recorded the names of all students who had questions or expressed interest for follow-up. Once students identified themselves as interested in participating, I provided them with the summary guide for potential participants[5] (Appendix B), parental consent form (Appendix C), an assent form (Appendix D) for students under 18, and an informed consent form for students over 18 (Appendix E). I also offered to make a phone call home to parents or caregivers to inform them of the study if the student returned the assent/consent forms with any questions or concern from parents, though this was not requested by any participant. Once the signed paperwork was returned, I scheduled an interview procedure with the student at a time that was mutually convenient, and sent students a calendar invitation via email. Current high school students who participated were offered 50 "bucks"—a program-specific reward that students use to purchase athletic or academic gear from their after-school "store"—for their participation in the study. A total of two 11th grade students and fifteen 12th grade students participated in the study. Two of the 12th grade students were attending parochial schools at the time of the interview, while the rest (13) of the high school students were attending or just recently graduated from public school. There were three 11th grade students who I provided with paperwork and who did not return it. All others who expressed interest ultimately completed the interview.

[5] Initially, this document was titled "Summary Guide for Potential Co-Researchers." I made the decision not to meet with students after their interview to review themes because many of them were leaving for college, so I no longer refer to them as co-researchers in this study.

In order to recruit alumni of the program, I emailed alumni who had graduated from 2016-2018 (Appendix G), and I made verbal announcements at one alumni event that was already planned as a part of their regular programming. I also verbally notified alumni about the study when they visited the site on their own time. Three alumni responded via email or text message that they were interested in participating, while seven expressed verbal interest in person. Once alumni identified themselves as interested, I offered available times and dates for the interview and sent them a calendar invitation via email or text. Alumni who participated received an organization-specific item of clothing from the organization-store of their choice at the close of their participation. A total of nine alumni participated in the study, all college freshmen. One additional college freshman expressed interest in participating, but we could not schedule a time that was mutually convenient; one additional college sophomore agreed to participate, but the recording was unable to be used, as the interview took place at an external location and the background noise obstructed the participant's answers. All alumni participants had attended public high school. I assumed that alumni I did not hear back from or speak to directly in person were uninterested in or unable to participate in the study, and I did not follow up.

All student-participants—current students and alumni—were entered in a raffle to win a $100 gift card. All interviews were scheduled on a time and day that was convenient for the participants, either during my lunch hour or after my scheduled work hours. All interviews that were used for the study took place at the site of the after-school program, in quiet classrooms or meeting rooms. Demographic information was collected via open-ended questions attached to the informed consent/assent forms found in the appendices. Table 1 includes further information on students' self-identified demographics below. I included the exact language they used for all categories in order to adequately communicate how they chose to define themselves. The identities of the students who attend and have attended the program are significant to the study because

the CDC uses deficit language like *socially disadvantaged* to describe African American and LatinX students from low-income families (CDC, 2018a), and it is important to challenge this language by centering individuals from the communities it is imposed upon.

Table 1

Student-Participants' Self-Identified Demographics

Gender Identity	Age	Race/Ethnicity	Country of Origin
Students who identify as male/man – 7 Students who identify as female/woman – 19	16 year olds – 2 17 year olds – 5 18 year olds – 15 19 year olds – 4	Black – 3 Black/ African-American – 5 Black/ Jamaican – 1 African - 1 African-American – 3 African-American, Guyanese, Dominican – 1 Bengali / Antiguan – 1 Mixed (Afro Latina, Irish, Indian, etc.) - 1 Hispanic – 4 Hispanic /Latina – 1 Hispanic (Bolivian/Dominican) – 1 Latina – Puerto Rican + Dominican – 1 Mexican – 2 Asian – 1	Ecuador – 1 Ivory Coast – 1 Senegal – 1 Africa - 1 United States - 22

The large majority (24) of students and alumni who participated were those that I had worked with directly as academic advisor and mentor for several years and with whom I already had an established relationship. The other two students who participated had not worked directly with me, though we had an existing relationship through our shared time in the program. Though in certain methodologies, the idea of existing researcher relationships with participants has been "considered biased and undesirable for research outcomes" (Berbary, 2014, p. 1216), feminist methodologists who are committed to social change (e.g., Bloom, 1997; Glesne, 2011; Lather, 1992) have argued

for a reimagining of qualitative methods, particularly with regard to "research relationships that are built on sharing, reciprocity, and friendship" (Berbary, 2014, p. 1216; Glesne, 2011); as has Evans-Winters (2019). Berbary (2014) writes about her complicated experiences in ethnographic research wherein her ability to fit in with her participants "both opened-up doors *and* created consequences concerning [her] identity as a researcher" (p. 1219). In qualitative interviews, a researcher-participant relationship may have its benefits: Bloom (1997), for example, writes that "mutual trust and reciprocity are critical to the feminist project," as it allows researchers and participants to negotiate differences and gain a deeper understanding of each other (p. 118). Lather (1992), in her aim to develop a "critical social science" (p. 88) that empowers researchers and participants to both understand and change the world, points to Oakley's (1981) interactive interview processes as an example of a feminist research practice that "reinvent[s] qualitative methods" (Lather, 1992, p. 92). Indeed, Oakley (1981) advocates for the value of researcher-participant relationships in qualitative interviews as they allow researchers to validate participants' experiences. As a researcher who is intentionally employing critical race feminist theory in order to recognize the agency and humanity of participants (Esposito & Evans-Winters, 2010; Evans-Winters, 2011), an existing relationship with participants is useful to this study, as "personal involvement … is the condition under which people come to know each other and to admit others into their lives" (Oakley, 1981, p. 58).

I did not set parameters for any identity contingencies such as gender, age, or race in the recruitment process, as it was more important to me to engage with students who had some interest in the study, as opposed to convincing students why they "should" participate. It is important to note that there were far more female-identifying students (17) who participated than male-identifying students (8). This may be due to my gender identity: it is possible that more female-identifying students gravitated toward me during our shared time at the program due to my "self-presentation": Berbary (2014) argues,

with the support of Kvale's (1996) work, that "appearing similar or revealing similarity between a researcher and her participants" can operate as a methodological tool in rapport-building (p. 1206). Though I did not intentionally change my self-presentation or act differently from my usual self, it is possible that our shared experiences of identifying as female may have encouraged more female students to participate in the study despite my being racially incongruent to participants. Berbary (2014) writes that while similarities between researcher and participants may not produce "better" data, "it can help to elicit different types of data that one may not become privy to if more dissimilarities than similarities exist" (p. 1206). The similarities that come with being female, then, may have affected the gender ratio of the student-participants in this study, as well as the information that was shared. This also suggests the possibility that my interviews with male-identifying students did not elicit the same information that someone who shares more similarities of identity with (e.g., race, gender) might have elicited (Berbary, 2014; Sallee & Harris, 2011). Finally, it is also possible that social expectations of males and females played a role in the gender ratio of participants: Sallee and Harris (2011) discuss, for example, that gender may influence participants' responses to the researcher and affect the researcher's ability "to establish rapport with participants" (p. 411), while Oliffe and Thorne (2007) have found that it is significantly more difficult to recruit males to studies about health than females.

Ethical principles of human science research with human participants were maintained through establishing clear agreements, recognizing the necessity of confidentiality and informed consent, and developing procedures for insuring full disclosure of the nature, purpose, and requirements of the research project. Participants were free to withdraw at any time, though none did. One participant provided answers during the interview process that indicated he would benefit from a meeting with the on-staff social worker. Though the participant's needs were not immediate, severe, or urgent, I felt that they needed an opportunity to explore some of their feelings in a

therapeutic setting, so I stopped the interview in the middle and suggested to the participant that we continue once they had met with the social worker, and they agreed. Once I confirmed with the social worker that she had met with said participant, I reached back out to the participant, and they were eager to continue the interview. This only happened with one student.

Contextual Factors of the Research Site

> Shirley: What I like about coming here … it feels like home. It feels safe. I talk about my day and staff listen or give advice (5/1/19)
>
> Samira: I like coming here because there's a sense of community that I don't normally get at school. I get a lot of support in academics and I get to play a sport … and I know coming here will always benefit me in the long run. The people here love their job which makes me love coming here. (4/10/19)
>
> Sharon: I love coming here for the people. I think it's a people thing … apart from the sport itself, just being with my friends that I know I probably wouldn't be friends with without being here, and seeing staff. (4/12/19)
>
> Zadie: I really like being able to play a sport. Not competitively … it's just a fun sport to play. I also really like the adults here … you guys are very welcoming and very willing to listen to us. (4/22/19)

The site for the data collection was an after-school program with an independent site. In 2019, there were 632,076 students enrolled in an after-school program in New York City (Afterschool Alliance, 2019). Recruiting participants from an after-school program might result in different participant characteristics compared to participants recruited from a specific school or schools. In this section, I provide some contextual information about the program from which students were recruited so that readers have a better understanding of the students' characteristics who choose to enroll in the program.

The athletic-based after-school program at which I worked and conducted interviews throughout this study is a long-term program that students typically join some time in middle school, and remain involved in via regular practices, sporting events, and

academic sessions throughout high school. Students are recruited through classroom visits to public schools in the same neighborhood as the program and try out for their team, which is divided by grade at school. Students who attend regularly and demonstrate interest in the sport and in their academics during their tryout period make the team; their eligibility is not based on their grades or their athletic skills, just interest, effort, and attendance. Academic support, college and career preparatory education, social work groups, and health education, in addition to regular athletic practices and tournaments for interested and eligible students, are regular aspects of programming. Students are eligible for sporting events based on their attendance and overall interest in the sport; they must also be passing their classes or doing something to show they are working to improve a failing grade: this means that if a student is failing a class, they must complete one additional hour of tutoring for that subject within the program, or office hours with their teacher, in order to remain eligible for sporting events. While some students remain in the same schools from which they were recruited throughout their time in the program, others transfer out to other public (or in rare cases, parochial or independent) schools across the boroughs of Manhattan, Brooklyn, and the Bronx. Some students who attend the program live very close; others live up to two hours away.

Many students in the program matriculate into a two-year or four-year college program after high school; others join a workforce training program. All students who join an educational or workforce program receive access to a small scholarship and an alumni support counselor. The program's methodology is not without its flaws, but I provide this information for the purposes of context. I believe since the students shared their positive experiences with the program, quoted above, it is important for me to honor that. It should be mentioned, though, that it is unlikely a student would feel that a formal interview about their health experiences is an appropriate place to share their issues with the program, and that several student concerns have been voiced outside of the context of these interviews.

The quotes above demonstrate the four students' perceived benefits of being involved in the program, which for many students are access to a supportive and nurturing community that their schools cannot or do not always provide. The program is not without its inconsistencies or complications: it is housed in a multi-million dollar site in the middle of a historically Black community that is now facing rapid gentrification. Valerie Kinloch (2010) writes about the challenges and concerns that many young people who live and attend school in gentrifying neighborhoods deal with, and some of these issues came up in this study. The site is across from a public housing community in which very few program participants live because of the school partnership model: students are recruited from their schools, not their proximity to the site. This discrepancy and lack of relationship with the immediate community has in the past projected an air of exclusivity to neighbors, which has resulted in students in the program being targeted for violence. In recent years, program staff have opened the building to community block meetings and other community events in an attempt to improve relationships.

Many sporting events for this specific program and the larger network are held at private universities with reputations for prestige and exclusivity. For this reason, many students who attend the program become interested in attending private schools for their college experience. Throughout the building, the college flags of program alumni are displayed prominently, and stories of "successful" program alumni—most typically those students who continue to play the sport in college—are shared regularly with students, families, and funders in promotional materials and on the program's social media networks.

Until the spring prior to the study, there were no individuals from the community where the program is located on the board, and the majority of the board was White. In the spring leading up to this study, two program alumni and one teacher from a partner school joined the board. During my four years of working at the program, students have shared how they feel when board members or potential funders visit the program: due to

the lack of relationships that some of the board members have and their appearance as being outsiders to the community due to their racialized identities and dress, several students expressed the feeling of being put on display as opposed to meeting a member of the larger program community.

Staff at the organization have conflicting viewpoints about the purpose of the organization: some see it as a tool to support students in gaining access to college; others see it as a community-oriented program that provides opportunities for fitness, competition, and academic support. Many staff recognize the complexities and contradictions of students' experiences and the range of interests and desires among the student body, and therefore attempt to incorporate student voice as much as possible in the development of programming. Staff have implemented monthly book clubs and discussions regarding issues relevant to students' and families' lives as a part of their cultural competence initiative, which began three years prior to the start of the study and met on a monthly basis with all staff. In recent years, college preparatory workshops shifted to meet student-participants' needs to include career preparation, since not all students in the program were interested in or ready to matriculate into college immediately after high school.

The recruitment and advertisement for the programs attract unique students and families: some students attend throughout middle school and high school because they enjoy the sport and their school does not offer it. Other students join or are encouraged to join by their families due to the college and career preparation piece—the students self-identify as high-achieving or ambitious, or their families identify them as such, and join the program for the additional support advertised in the promotional materials and initial meetings. These specific interests make for a unique population from which I collected my data. It may seem conflicting that I focus so deeply on equity in a competitive-based program that originally sought to support students in college access, but I agree with Azzarito, MacDonald, et al. (2017) when they write that a focus on equity in health and

physical education is important during times when ideals of democracy and social justice are under threat. Centering student voice in an attempt to pursue and explore emancipatory practices in health and education is my goal.

Data Collection

In the sections below, I have outlined the procedures I used to collect the data and a description of the instruments used to collect the data.

Procedure

Procedures for the study involved providing a summary guide to potential participants, obtaining informed consent from parents and assent from students under 18 and informed consent alone from students over 18, conducting face-to-face interviews, and recording and transcribing the interviews. Each of these elements is outlined below. Originally, I had planned to stop data collection in June 2019, but in order to conduct as many interviews as possible, I extended the dates to August 2019.

Summary guide of study for participants. After making verbal announcements during students' academic sessions to current students and sending recruitment emails to alumni, I provided a brief set of instructions to potential student-participants that explained the purpose of the project (Appendix B), attached to the informed consent/assent forms. At the outset of the study, this document was titled "Summary Guide of Study for Co-Researchers." However, because it was not feasible to meet with each study participant after their interview to review their transcripts, as the majority of participants were preparing to graduate from high school and matriculate into college, I have changed the title from *Co-Researchers* to *Participants*.

Informed consent. Written informed consent was obtained from the parents or caregivers of all student-participants under 18 (Appendix C), and informed assent was

obtained from the student-participants (Appendix D) before the data were collected. Written informed consent alone was obtained from students who were over 18 (Appendix E). The informed consent and assent forms explained the study in detail, including the confidentiality of the data collected. No study participant is identified, and no data linking the participant to the data they provided are reported. All student-participants were assigned a pseudonym, and a master list of pseudonyms was saved in an encrypted spreadsheet for reference on my password-protected computer. All audio-recordings were deleted after transcription.

The informed consent and assent forms specifically described the details of audio-recording and transcription for the study (described above). Student-participants and their parents/caregivers were asked for verbal as well as written permission to be audio-recorded, and there was a separate line on the written informed consent and assent to indicate this permission. A third-party vendor was used to complete all transcriptions.

Demographic survey. hooks (1984) writes, “There is much evidence substantiating the reality that race and class identity creates differences in quality of life, social status, and lifestyle that take precedence over the common experience women share—differences that are rarely transcended” (p. 4). I extend this notion not just to women but to all genders. This assertion demonstrates the need to record student-participants’ demographics in order to explore how their multiple categories of identity may or may not affect their understanding of health. The demographic survey was attached to the end of the informed consent/assent forms and asked students about their age, race, gender identity, and country of origin, in an open-ended format. These were the only categories of identity asked due to my stated focus on race and gender through my use of critical race feminist theory. An open-ended format was employed so that students had the opportunity to self-identify their race or ethnicity without having to select categories that were provided for them. As such, their identities will be presented exactly as they wrote them in order to acknowledge their chosen representation.

Interviews. After obtaining informed consent from students or from their parents/caregivers, and obtaining assent from student-participants, depending on their age, I used the interview protocol (Appendix G) to conduct one interview with each participant (27 total; 26 usable) in person. Interviews ranged in length from 30 minutes to 60 minutes, with two interviews lasting over 60 minutes. Study participation took place in private meeting rooms or classrooms at the site of the after-school program where student-participants attend or attended, except for one interview with an alumni of the program. Unfortunately, the transcript for this interview was not usable due to outside noise. Interviews that took place on site with current students happened outside of each student's scheduled program time. I explained to students that their answers to the interview questions had no bearing on their standing in the program or within our existing relationship, that they did not have to answer any questions they did not want to answer, and that they were free to leave the interview at any time. Due to my time working at the program, I had an existing rapport with the high school participants and alumni of the program and maintained those connections at the start of each interview, answering any questions the participants had about the project and the interview process. In my preliminary instructions to student-participants, I conveyed to them that I would remove all identifying data, including their name, and that they were free to withdraw from the study at any time. More details about the interview process are included in the next section.

Audio-recordings and transcriptions. All interviews were audio-recorded and transcribed for data analysis. As mentioned, pseudonyms were used to protect the participants' confidentiality. Upon transcription, all audio-recordings were deleted, and transcriptions were stored on the researcher's password-protected personal computer for the protection of the participants' confidentiality.

Instruments

Interview protocol. The initial interview protocol was piloted with three alumni of the program in November and early December 2018. The original protocol followed an in-depth, phenomenologically based three-interview protocol established by Seidman (2013) where interviewers use primarily, but not exclusively, open-ended questions that are intended to have the participant "reconstruct [their] experience within the topic under study" (p. 15) (Appendix H). Unfortunately, while the interviews generated engagement from alumni, they did not produce an open-ended conversation that allowed participants to explore their understanding of health through stories and narratives: the questions did not encourage students to elaborate on their experiences, and some interviews lasted as short as 13 minutes. As a result of the pilot study, the interview questions and methodology were revised.

The updated interview protocol (Appendix G) is modeled after Spradley's (2016) guidelines for ethnographic interviewing in qualitative research, and informed by postmodern tenets and critical race feminist theory. The interview protocol was written loosely following Spradley's protocol, which included three "grand tour" questions, and several probing sub-questions, that opened the conversation ("Who is the healthiest person you know?"). Next, I included repeated explanations, as encouraged by Spradley, in order to remind students of the purpose of the conversation ("As I said earlier, I'm interested in health class. I know you have to have a health credit for graduation."). The interview protocol then moved to a "mini-tour" question that aimed to give the interviewer a sense of the students' perceptions of health class ("What are some of your experiences in health class? Tell me a story about it."). The protocol then asked for specific examples about teaching and messaging ("Is there anything you remember about what your health teachers did or said that made their messages stick with you?"). Following these were questions about experiences ("What were some key factors or experiences that led to your understanding of health?"). Finally, I ended with a question

to help me understand the language students use to describe health and what's important to them ("What is one message you would give a younger sibling or family member about taking care of themselves?"). Once the initial version of the protocol was developed, I sat down with two dissertation committee members to review it in order to ensure the interview questions answered each of the research questions. The protocol was revised twice more before finalizing it.

After conducting the first seven interviews, I revised the protocol further, adding one question specifically focused on the impact of the health teacher's identity, however the students chose to define it. The final interview protocol included six questions, each with two to four probing sub-questions, including all of the same questions as the prior versions. See Appendix G for the final interview protocol.

Interviews were conversational and open-ended, and misunderstandings were clarified as they occurred. The importance of self-reports in data collection was emphasized so that participants knew their contributions were regarded as valuable, new knowledge on the subject matter. I selected this model because it prioritizes informal, interactive processes with student-participants, since their stories and understandings are the focus of this study. Evans-Winters (2019) asserts the importance of offering space for narrative, as "narration in the form of storytelling, metaphors, and analogies is more relational in nature; thus, inherently dialogical" (p. 22). The significance of narration was also supported by my use of storylines in the analysis process.

Challenging the Interview Process

Evans-Winters (2019) problematizes the idea that researchers can ever fully represent youth voices, experiences, humanity, and agency in the way I claim this study does. She asks researchers to reflect on the "ethical and moral dilemmas of attempting to represent another human being in writing" (Evans-Winters, 2019, p. 105). She writes that researchers and community members can have a mutually beneficial, as opposed to an

exploitative, relationship, if it is non-hierarchical, and made of "mutual understanding, solidarity, and responsibility" (p. 116). In order to avoid exploitative practices that have historically been acceptable in social science research, researchers must deliberately interrupt traditional methodologies (Evans-Winters, 2019). This provides further evidence as to why my existing relationships with student-participants are significant and useful to this study due to my political investments.

For these reasons and others, I decided not to follow textbook procedures with regard to interviewing youth and interpreting their data. It was unreasonable to me to assume that typically employed practices did not have exploitative views of students as mere sources of information. My involvement in health education for the six years prior to these interviews, and in these students' personal and academic lives for the four years prior, had led me to reassess my relationship with academia and with traditional White patriarchal educational paradigms. I sought, through these interviews and this dissertation as a whole, to bring about change in the mainstream academic treatment of Youth of Color, through the guidance of critical race and feminist theorists before me (e.g., Ladson-Billings, 2003, 2009; Evans-Winters, 2011; 2019; McCall, 2014). The texts and lectures I had been exposed to from prominent transgressive academics demanded that researchers re-evaluate the basis of their relationship to the researched (e.g., Oakley, 1981; Evans-Winters, 2011, 2019; Ladson-Billings, 2003, 2009). Critical health and physical education scholars (e.g., Dagkas, 2014; Azzarito, Simon, & Marttinen, 2017) have also advocated for interviewing youth who fall into categories that academics typically pathologize and problematize as a strategy for relocating their knowledge and experiences as valuable and legitimate.

As I argued in previous sections, it is possible that my role as interviewer was made more effective by the fact that I had an existing level of trust with students who chose to participate—an anonymous interviewer to whom they had no prior exposure may have been a less effective tool in eliciting honest conversations. Learning about

people's lives and offering space and time for them to share their experiences, or, as Evans-Winters (2019) describes it, "the embracement of a dialogical voice in the conception and pursuance of knowledge" (p. 22), is more effective, as Oakley (1981) argues, on the basis of trust and a positive relationship than in a formal interview with a stranger.

Ann Oakley (1981) writes that traditional social science methodology requires researchers to view certain aspects of the interview process as "legitimate" or "illegitimate," assuming a "masculine model" of both the research and of society, and undervaluing more feminine modes of practice (p. 31). Textbooks warn, for example, about the problem of building too much of a rapport, and of the dangers that arise when interviewees ask questions back (Oakley, 1981). Traditional paradigms, she argues, promote depersonalization of both the interviewer and interviewee, when it is a requirement or expectation that the interviewer must treat participants as sources of data, rather than as people (p. 37). I, like Oakley, found traditional expectations to be difficult in the practice of interviewing, both because of the existing relationships I had with students prior to the interviews, and because it was my goal to engage in a more interactive, dialogic practice (Evans-Winters, 2019; Lather, 1992). Oakley (1981) argues, among other things, that in most cases of interviews, "the goal of finding out about people through interviewing is best achieved when the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own personal identity in the relationship" (p. 41). Similarly, Evans-Winters (2019) asserts that sharing stories in either oral or written form "requires mutual trust between (1) the person sharing the story, (2) the listener of the story, (3) and the audience receiving the story," in this case the dissertation committee (p. 70). This advocacy for mutual trust suggests that my existing relationships with student-participants was beneficial for the research process with regards to the stories that students may have felt comfortable sharing.

Throughout the interview process, several students asked me questions about my thoughts on the topic. I asked them to redirect their questions to themselves (for example, responding with, “What do you think?” or, “How do you define it?”) during the bulk of the interview, and when all interview questions were completed,[6] I answered any questions that had come up to the best of my ability. Oakley (1981) has suggested that interviewers may be more likely to learn about their participants when they “invest [their] own personal identity in the relationship” (p. 41). My practice was to answer any personal questions, health-related questions, and questions about the research honestly, whether they took place during the interview or afterwards. I did not, however, take on a health educator role during the interview process, meaning that I did not correct any misinformation—I only answered questions that were directly asked. Additionally, my existing relationships with students, given the years that I had been employed at their after-school program and working with them as advisor and mentor both directly and indirectly, established a level of personal involvement that was difficult to avoid, though as I have argued, was useful to this study due to my theoretical investments. I have maintained relationships with many students who participated in this study in the form of mentor and friend, just as I have with those who did not participate, which is atypical of researchers employing traditional methodologies to do with their study “participants,” though not atypical of researchers employing feminist frameworks (e.g., Berbary, 2014; Oakley, 1981), or critical race theory (e.g., Ladson-Billings, 2003, 2009).

I expressed to student-participants that the goals of this study were not to exploit their experiences, but to shift the narrative to writing about young people, especially young People of Color, to talking *to* young people. When explaining the process of audio-recording to students, I explained that only I and the transcription service would

[6]One exception arose with the participant with whom I stopped mid-interview, mentioned previously: I did not wait until all interview questions were completed to answer questions; instead, I chose to stop the interview so we could discuss other matters before continuing.

ever listen to the recordings or see the transcripts, and I clarified that their names and personal information would not be used in the paper. I also explained that I would send them any information they wanted about this study and paper, and five student-participants expressed interest in the research after completion of the interview, specifically in reading the final product of this dissertation. My expression that I was not interested in constructing a hierarchical or authoritarian relationship, may or may not have influenced students to feel more comfortable sharing personal information about their experiences. Still, it is important to recognize, as Berbary (2014) argues, that "unbalanced power relation[s]" between researcher and participant do exist, no matter how comfortable the researcher-participant relationship is (p. 1215).

The success of my interviewing style is difficult to judge from these paragraphs. Indeed, despite my prior relationships with students, as a White academic-researcher, I still present as a cultural outsider, encouraging my persistent focus on challenging traditional social science research in order to adequately understand the realities and desires of student-participants. More generally, the depth of the information that participants provided can be assessed below in Chapters IV and V.

Oakley (1981) writes that the tensions between the demands for building rapport and the "requirement of between-interview comparability cannot be solved," making the pursuit of perfection in the interviewing process futile (p. 51). My position on the interview process, as described here, accepted the challenges and ethical dilemmas that are generic to all research involving interviews, and I anticipated some "messiness, contradictions" (McCall, 2014, p. 106), and the impossibility of ignoring my identity and my involvement in the interview process (Oakley, 1981). I used critical discourse analysis (Luke, 1995-1996) to observe language and uncertainty in order to adequately engage in a "witnessing" (Evans-Winters, 2019, p. 22) of students' experiences.

Reflexive Notes and Data Management

I was directed to Scheurich's (1997) work about reflexivity through McCall (2014): Scheurich (1997) provides a critique of conventional interviewing and presents a framework for the interview process within the postmodern framework. Reflexive processes are important to postmodern research as they illuminate the "conscious and unconscious baggage," (Scheurich, 1997, p. 73) that researchers bring to the interview process, including their training and positionality, and allow the researchers to document their emerging understandings and analyses of the data (McCall, 2014). Dutta (2010) asserts that "reflexivity implies turning of the lens inward" (p. 538). Indeed, Berbary (2014) writes that "researcher reflexivity has become relevant and even expected as part of rigorous research practices" due to the fluidity of qualitative methods (p. 1215). At first I printed each transcription and table of notes (Appendix I) to take these notes by hand, but found it was simpler to make reflexive notes digitally by copying and pasting the typed transcript into my table of notes and typing my responses. These notes helped me pay close attention to my own subjectivities and the prior assumptions, thoughts, or feelings I brought to the interview process, and, as Ladson-Billings argued (2003), helped me to "stand in a different relationship to the research (and the researched)" (p. 268). I saved each interview's notes in a file on my personal computer with the interview's date. Re-reading the transcripts and taking reflexive notes allowed me to see more patterns among the narratives students provided, and see "how the same phenomenon can be told in different and multiple ways depending on the storytellers" (Ladson-Billings, 2003, p. 268). I securely stored all printed materials, including transcripts and signed IRB forms, in a binder that I kept in a locked drawer at my home, and all digital materials on a password-protected personal computer for future reference and cross-checking. I was the only person with access to the study materials, and I maintained the use of pseudonyms for all participants throughout the duration of the study.

Analysis and Interpretation

Theoretically, critical race feminist theory and postmodernism provide approaches that subvert assumptions about societal norms (Evans-Winters, 2011). In this section, I provide a description of my analysis and interpretation in order to impose some rationality onto an irrational process. I want to share with the reader my theoretical sources for this section: MacLure (2013a, 2013b), Evans-Winters (2019), and Ladson-Billings (2003). I used MacLure because of her self-identification as a promiscuous feminist methodologist and her problematizing of uncritical coding processes. I combine her ideas with those of Evans-Winters and Ladson-Billings in order to prioritize the methodological perspectives of critical race and critical race feminist inquiry—in the past, the refusal of mainstream feminism to attend to and dismantle racial hierarchies ignored the existence of the individuals living at the intersections of race, class, and gender (hooks, 1984). As this study features the voices of Youth of Color, it is essential to include the analytical suggestions of academics like Evans-Winters and Ladson-Billings who are explicitly committed to the liberation of Black youth and all Youth of Color. The ideas of these authors are quite complementary and are integrated into a description of my analysis and interpretation processes in the sections below in an attempt to make sense of the complexity of presenting pieces of a participant's story. Later, I closely follow the guidance of McCall (2014) to describe my use of critical discourse analysis (Luke, 1995-1996), followed by my approach to exploring storylines as I read the data both as separate texts and as part of a collective of texts (Stake, 2006). These analysis and interpretation processes respond to Dutta's (2010) call for critical research into health communication that "deconstructs the interplay of power and control, co-constructs possibilities for changes in health policies, and seeks out redistributive justice and structural transformation" (p. 538). I extend this call to action to research in health education here.

Background

Central to postmodern inquiry is uncertainty (Lather, 1992; McCall, 2014; MacLure, 2013a), which allows postmodern researchers to challenge objectivity and assert that truths are always partial, "produced by and for particular interests, in particular circumstances, at particular times" (MacLure, 2013a, p. 167). Conventional qualitative research coding, where researchers must look for patterns or themes in a group of data by identifying recurring categories, conflicts with these key tenets of post-structuralist approaches and reduces their complexity (MacLure, 2013a). One piece of data—in this case, one story from an interview—can have multiple interpretations; researchers give meaning to that data based on our societal positions (Evans-Winters, 2019; Ladson-Billings, 2003). Evans-Winters (2019) writes that Black feminist data analysis processes must prioritize the humanity of Black women; as this study employed a critical race feminist lens and participants represent a range of ethnic backgrounds and all genders, centering the humanity of each student-participant was the focus of the data analysis. This was done in an attempt to challenge the largely Eurocentric methodologies and epistemologies, even in qualitative inquiry, that may reify marginalization (MacLure, 2013b; Ladson-Billings, 2003).

Analysis Procedure

My analysis was one that prioritizes, like MacLure (2013a) before me, difference and heterogeneity in students' responses, and that shirked the "representational thinking" that "establishes hierarchical relationships among classes," and among categories of codes (p. 165). Something always exceeds the categories of coding, falling outside of the dominant codes, and "thus presenting a threat to order and stability" (MacLure, 2013a, p. 167). Indeed, the practice of inquiry is in itself messy, challenging "what counts" as research (Childers, Rhee, & Daza, 2013, p. 509). Conventional coding has the potential to position the researcher at an arm's length from the data, and it does little to interrupt the "essentially colonial relation of researcher to subject (MacLure, 2013a, p. 168). A critical

race feminist lens in qualitative analysis intentionally disrupts power relations and the Eurocentric epistemologies that claim to be "the only legitimate way to view the world" and have long gone unchallenged (Ladson-Billings, 2003, p. 258; Evans-Winters, 2019). I thus chose to take up a critical race feminist lens through my analysis and interpretation with the intention of exposing and challenging these typically "exclusionary practices" in qualitative inquiry (Evans-Winters, 2019, p. 15).

I placed the social construction of both race and gender at the center of my inquiry, combining advice from Lather (1992) and hooks (1984), alongside an "inevitable critique of economic exploitation" in order to understand the social circumstances imposed on participants (Evans-Winters, 2019, p. 15). My goal through this analysis process was to disrupt traditional modes of analysis in order to shift conversations about Youth of Color in the fields of health and education away from pathology, victimization, and powerlessness—as Ladson-Billings says, "the scholarship that would dehumanize and personalize" people in the margins (2003, p. 272)—toward one that recognizes their humanity and agency (Evans-Winters, 2019). Evans-Winters calls for researchers to develop a "mosaic," or a piece of artwork with "diverse elements, patterns, and forms," (p. 15) in their analyses, and Maclure (2013a) calls for coding that resembles a "cabinet of curiosities" or wonders (p. 180). It made the most sense to combine the advice of these authors in my analysis and interpretation processes because they discuss the urgency with which researchers must work to interrupt the "boundaries of power and knowledge" that create self-imposed certainty and authority in the institutions that allow the research (MacLure, 2013a, p. 181).

I understand the challenges in taking up such inductive methods of analysis, but I don't feel I have a choice: I resonate deeply with a quote from Sara Daza in Childers et al. (2013): "When I speak up against the academy or against male and/or white hegemony, it's because, after all I've learned, I can't not speak" (p. 515). After all I've learned about the government-sanctioned policies that have created and continue to

perpetuate such health and educational disparities that we then use to label our youth as problems, it wasn't an option for me to employ traditional analysis and interpretation strategies that don't challenge or question power relations. It was too important to me to continue the dialogue about the complexities of power relations in research that I began in my earlier chapters throughout the entirety of the paper.

I did not abandon coding entirely: I viewed my coding process as an open-ended and ongoing "experiment with order and disorder," of making sense out of the data as opposed to a static representation of information (MacLure, 2013a, p. 181). I immersed myself in the data (MacLure, 2013a) in order to build a mosaic that represents pieces of participants' stories in a way that is respectful to all implicated by them (Evans-Winters, 2019). I began by reading my interview transcripts as written texts in chronological order. I printed out hard copies of interview transcripts in order to fully give myself over to the data. First, I typed reflexive, analytic, and methodological notes (McCall, 2014) about the interview in a word document on my personal computer labeled with the date of the interview (Appendix I). Then, I separated the demographic data from that participant's signed IRB form, reviewed it, and paper-clipped it to the back of the printed interview transcript. I made notes in margins and continued onto separate pages when necessary (MacLure, 2013a). I wrote the date of the interview clearly in the top left-hand corner of the printed interview transcript, and used pen to annotate and underline words and phrases of the transcript that seemed to answer the research questions. I recalled what other theorists have written from critical health, race and feminist lenses throughout the coding process, and jotted them down, and my decisions about which words and phrases I annotated or noticed were closely related to my commitment to critical theory (McCall, 2014), outlined in previous chapters. Like MacLure (2013a), I was able to embody the coding process more deeply when using pen and paper as opposed to a computer-assisted qualitative analysis program such as Dedoose.

Critical Discourse Analysis

My analysis process was closely inspired by McCall's (2014) use of critical discourse analysis (Luke, 1995-1996). Discourses are "embodied by individuals' ways of thinking, being, acting, and making decisions in everyday life" (Azzarito, 2009a, p. 20). Critical discourse analysis is, according to Luke (1995-1996), "an intervention in the apparently natural flow of talk and text in institutional life" (p. 12) that seeks to disrupt assumptions of knowledge. Embedded in spoken texts like interviews and conversations are moments "where cultural representation, social relations and identities are articulated through language and other sign systems" (p. 18). Luke asserts that the task of employing critical discourse analysis is "to see how broader formations of discourse and power are manifest in the everyday, quotidian aspects of texts in use" (p. 11). In this study I sought to explore students' experiences with and understandings of health as affected by their race(d), class(ed), and gender(ed) societal status through an analysis of their discourse, defined as recurring statements across texts that are related to ways of knowing and labeling the world around them (Luke, 1995-1996). This is appropriate for the current study because, as Luke (1995-1996) writes, critical discourse analysis is used "to generate agency" (p. 12); I employed it to explore how discourses of health contribute to participants' subjectivities and stories about themselves and their experiences. Luke argues that it can also be used as a tool "to critique and challenge dominant institutional practices" (p. 10).

I explored the data critically looking for "patterns, breaks with patterns, and contradictions in patterns" (McCall, 2014, p. 119), using MacLure's conception of "hot spots," or moments that didn't fall into any categories at all, but that urged my attention (2013a, p. 172). McCall (2014) writes that this process is more accurately described as a critical analysis of discourse. For the present study, this meant examining students' language around health, including *eating well*, *mental health*, and *healthy*. I also looked for any potential for students' "political and social investments" (McCall, 2014, p. 118)

related to race, class, and gender in their conceptualizations of health that may have suggested the knowledge/power relations that create unchallenged definitions "by which governments rule and monitor their populations and by which community members define themselves and others" (Luke, 1995-1996, p. 9). In other words, I explored whether and how students internalized or dismissed the mainstream assumptions about social categorizations to define themselves and their understanding of health. In reading the texts of my interview transcriptions, I analyzed the texts looking for relationships between discourses of health and larger social structures (Luke, 1995-1996, p. 6), and for assumptions about health.

Storylines and "health." I mirrored McCall's (2014) use of critical analysis of discourse in order to identify "storylines" (Søndergaard, 2002, p. 191) in the texts. A storyline is a "set of sequences of actions and positions saturated with cultural meaning and therefore offering potential interpretations linked to characters and practices" which can be considered more "precise" than a general narrative (Søndergaard, 2002, p. 191). Storylines can be used in analysis to explore how participants "locate their own positions within the social and collective subject positions and storylines that are offered" (Søndergaard, 2002, p. 194). They allowed me to explore, in other words, how participants' stories about themselves with regards to their health were developed in relation to collective storylines about young people, specifically Youth of Color, and their health status or behaviors. In the case of this study, I looked for students' storylines about what makes a person healthy, and how that definition affected their stories about themselves, their families, and their communities.

As I discussed in earlier chapters, discourses of risk, fear, and shame are used to communicate taken-for-granted assumptions about adolescent health, and the behaviors that adolescents "should" or "should not" be engaging in. The concept of storylines helped me identify the ways in which these discourses encouraged student-participants to develop stories about themselves and their behavior as well as the behavior of their peers,

and how their health behaviors shaped their conceptions of themselves. Exploring storylines in the data analysis process allowed me to create a “mosaic” (Evans-Winters, 2019, p. 15) or a “cabinet of curiosities” (MacLure, 2013a, p. 180) out of the data, locating “fractures and fissures” in students’ stories (McCall, 2014, p. 121). Storylines about health are relevant to this study’s postmodern commitments because they “show some of the nuances of the of the deconstructive potential of analysis” (Søndergaard, 2002, p. 196).

Interview texts as both individual and part of a collective. I discussed earlier that I read each individual transcript as a separate text, first by typing reflexive notes about the interview in a Word document, and then by printing out each interview transcript and making notes in the margins. I began the analysis processes hoping to present students’ narratives through their differences, in order to allow student-participants the opportunity to have their own individual experience that is separate from the monolith usually ascribed to them (Evans-Winters, 2011). Though this study was not initially presented as a case study, it was useful to the analysis process to see the similarities in the interview texts as well as their differences, and to view the students’ interview texts as a “selection of cases” that can be compared with each other and understood together (Stake, 2006, p. 1) as they all share something in common: they all come from students who attend or have attended the same after-school program and who have taken at least one semester of health class. This is particularly relevant to the concept of exploring storylines with regard to health, as this concept allow us to “study how personal storylines are build up in relation to (internally, in opposition to, partially in continuation of) collectively constituted storylines” (Søndergaard, 2002, p. 196). I therefore applied pieces of Stake’s (2006) methods of multiple case study analysis, as inspired by McCall (2014), to organize the data, allowing the interview texts, then, to “interact” with each other, “playing different roles, vying, and complying” (Stake, 2006, p. 3).

It was helpful to me to explore common relationships across the interview texts, while also identifying contradictions (McCall, 2014)—ideas that are similarly reminiscent of Evans-Winters's mosaic and MacLure's cabinet of curiosities, and as a result, useful to this study due to the frameworks through which I have worked. Therefore, through McCall's guidance,[7] in addition to the interview transcripts that were printed initially, I created a new, separate document with the interview questions, and copied and pasted all student-participants' answers to each question into one large piece. I also printed and stapled this document together. The two printed and stapled documents I read separately and as part of a collective, then, were each interview transcript as an individual entity in chronological order, and all student-participants' answers to each interview question in order. In this way, each interview was read both as a text that could be understood by itself, and understood across the collection of texts in relation to the others: as Stake (2006) suggests, "the single case is meaningful, to some extent, in terms of other cases" (p. 4). Reading and coding the interviews together allowed me to organize common themes under each interview question and, as a result, under each research question, which is how the findings are presented. I also included several responses that stood out as "hot spots" but did not fall under any particular theme (MacLure, 2013a, p. 172).

It is important to note that this study cannot be viewed as a multi-case study because I did not follow Stake's (2006) prescriptions that the researcher present "a picture of the case and then produce a portrayal of the case for all to see" in my chapters that present the findings from the interviews (p. 3), except from two students in detail due to their descriptive responses. This is due to my commitment to Evans-Winters's (2019) assertion that a researcher can never fully represent another individual in writing. I also kept to one data source—the interview texts—while Stake writes about observations,

[7]In-person meeting, October 23, 2019.

interviews, and document reviews, among other sources. Stake's (2006) methods were simply useful for my organization and analysis of the data.

Interpretation

Data interpretation was where I found myself stuck with the data for some time. My hesitations can be captured through Scheurich's (1997) critiques of interpreting the interview:

> When we think we "interpret," through various data reduction techniques, what the meaning or meanings of an interview are, we are overlaying indeterminacy with the determinacies of our meaning-making, replacing ambiguities with findings or constructions. When we proceed, then, as if we have "found" or "constructed" the best or they key or the most important interpretation, we are misportraying what has occurred. (p. 73)

I was fearful of misrepresenting the students' experiences with the knowledge that I bring my own biases to the texts. With McCall's guidance,[8] and guiding text (2014), I was able to move forward engaging Luke's (1995-1996), assertion that critical discourse analysis has the potential to model the possibility of alternative interpretations, especially those overlooked by social institutions that have long upheld a particular position as knowledge; these are undoubtedly useful to the present study wherein my stated interest in critical theory seeks to uncover opinions that have been silenced or ignored. Within the texts, I located discourses of health, of risk, shame, and fear, and I placed these discourses in the context of larger social structures, especially the intersections of race, class, and gender, in addition to locating storylines about what constitutes a healthy person. Still, in these explorations, I was concerned about overlooking what matters to student-participants and their experiences in and beyond the health classroom. Each time I typed up an interpretation, I imagined how each student-participant would receive it—would they feel the same way about it as I did? How would they respond to my

[8] In-person meeting, October 23, 2019

interpretation? Would they feel supported or dismissed? Evans-Winters (2011) writes that the postmodern tenet of deconstruction can present challenges for, in her case, Black feminist theory, and in the case of this study, critical race feminist theory, because it "does away with social identities and structures like notions of race and culture" (p. 17). I felt this challenge throughout the interpretation process: there were many times that I was tempted to move closer to postmodernism, and away from critical race feminist theory, in order to do away with social identities and allow students to be unburdened by societal pressures. However, I acknowledged in previous chapters that though we are aware concepts like race and gender are socially constructed, they still have very "real-life consequences in our society" (Evans-Winters, 2011, p. 17). I therefore also located "complexities, paradoxes, and tensions," (Dutta, 2010, p. 538), and the contradictions and even "self-contradiction[s]" (MacLure, 2013a, p. 171) that students or I made, and I noted in the margins interactions that made me want to deconstruct our social identities altogether. I included these "hot spots," which didn't appear to fall under any particular theme (MacLure, 2013a) in each chapter, as they contributed to the larger mosaic of students' experiences.

Positionality: Limitations of a White Educator-Researcher Using CRFT

The disenfranchisement of Black, indigenous, and immigrant students can be traced to the U.S. Constitution (Smith, 1999). The students who were recruited to be student-participants in this study live in a world that is organized by category, positioning "White over Black, male over female, and wealth over poverty" (Evans-Winters, 2011, p. 22). Transracial teaching is defined as the prevalence of White teachers teaching Black students as a result of government actions since desegregation that replaced Black teachers in Black neighborhoods (Evans-Winters, 2011); in fact, all Students of Color in urban areas are more likely to be taught by a White teacher than a teacher with whom they are racially congruent (Howard & Navarro, 2016; Miller & Harris, 2018). Due to

centuries of disenfranchisement, Ogbu and Simons (1998) theorize that students who are "involuntary minorities," or people who have become a part of U.S. society unwillingly (i.e., due to enslavement and colonization), tend to reasonably critique dominant culture, in large part due to their mistreatment in social institutions like schooling (Evans-Winters, 2011, p. 29). For this reason and many others, it is critical for White educators and researchers to critically engage with their own subjectivities and understandings of themselves and their students in order to avoid further contributing to the disenfranchisement that continues to occur systemically. In the case of this study, this required my understanding that I had the potential to bring damaging lenses to my interpretation of students' interviews unless I paid careful attention to critical race and feminist theorists before me who have effectively centered students' agency.

In my practical experiences, I have had many conversations with my students and coworkers about the implications of our racialized identities throughout this work, and have spent years engaging in consistent reflections, excavations, and direct action to ensure that I am educating effectively and challenging frameworks and practices that perpetuate hegemonic ideologies.[9] It is important to me as an educator-researcher to excavate my own baggage and challenge the way stories about students who are systemically pushed to the margins are told so that we can push back against the pathology that is so common to the research and training processes that perpetuate the patterns we claim we are trying to dismantle. Although I have problematized my identity as researcher and educator throughout this process, my role as researcher of a sample of Students of Color remains open to critique.

Earlier, I referenced Berbary (2014), who noticed the research potential that arose when researchers shared characteristics and similarities with their participants. Ochieng

[9]I must thank Dr. Yolanda Sealey-Ruiz for exposing me to so many of these texts, conversations, and activities that allowed me to do so.

(2010) similarly reflected on the complexities that present themselves when researchers share ethnicities with their participants, noting that shared identity contingencies might encourage participants to share more personal information, while identity differences might encourage other unique perspectives. There can indeed be benefits and drawbacks to both similarities and difference between the researchers and the researched, as long as research subjectivities are explored and presented as informing the data collection and interpretation processes. Gill (2008) calls for critical inquiries that examine and present "the complex ways in which we are all entangled in the relation between culture and subjectivity" (p. 443), and I have attempted to do so here by engaging with the contradictions that arise from my researcher identity as both an outsider due to my racial incongruence with students and my position within academia, and an insider due to my presence in their lives for four years prior to the research. It is indeed possible that my identity alone kept students from feeling comfortable sharing pieces of their honest experiences. It is also possible that my existing relationships with students encouraged a vulnerability that encouraged them to "forget" their answers would be a part of a subsequent research project (Berbary, 2014). These complex aspects of my relationship to the research are out of my control, yet contribute to the information shared and my interpretations regardless. As Berbary writes:

> Although these negotiations can trouble boundaries, force methodological adjustments, and challenge researcher notions of self, they also remind us of the situational contingent, and partial nature of all relationships and positionalities, and lead us to always at least remain engaged with our participants, our research, and ourselves. (p. 1222)

I am not the expert of my students' experiences, and I do not intend to speak for them; instead, my intention as researcher in this study was to deconstruct assumptions of knowledge about health and the presumed objectivity of societal and classroom messaging. I also want to be sure to challenge my supposed authority in presenting knowledge. Framing my study with tenets of postmodernism requires that what I report to

be “findings” are understood to be partially as a result of my own worldview and experience, and the theoretical investments that I have laid out. I drew my understanding of this from Evans-Winters’s (2011) assertion that educational researchers who employ postmodern tenets “admit to being involved in a political endeavor and writing partial and complex truths” (p. 16). Ladson-Billings (2003) similarly asserts that “along with the gender of the knower [researcher], the race, ethnicity, language, class, sexuality, and other forms of difference work to inform his or her relationship to knowledge and its production” (p. 266). Like Evans-Winters and Ladson-Billings, I recognize that my presentation of findings is shaped by my contextualized identity. Scheurich (1997) writes that though we can never name all of the “conscious and unconscious baggage” we bring to the interview and interpretation process, we can inform the reader’s understanding of our interpretations by presenting our positionality, epistemologies, and training (p. 73). I have attempted to do so throughout this chapter. My goal, therefore, is not to presume objectivity through my presentation of findings, but to inform research, policy, and practice in health and educational domains by acknowledging my own reflexive processes and by presenting the experiences and suggested solutions of historically problematized youth as valuable to our understanding of the field.

My interest in deconstructing knowledge and objectivity in order to “co-construct possibilities for changes” and seeking “redistributive justice and structural transformation” (Dutta, 2010, p. 538) allowed me to elevate the importance of students’ understanding and suggestions in order to inform the field of health education. My chosen methodological frameworks also encouraged me to attend to issues of power relations in my own discourses of health, especially in my own practices of researching, mentoring, and educating. This is reflective of St. Pierre’s (2000) assertion that educational researchers who understand power relations are “more likely to present complex and subtle analyses of social life” (Evans-Winters, 2011, p. 16). The approaches and frameworks presented in this chapter encouraged my consistency in challenging my

researcher role and deconstructing assumptions of authority that traditionally position academic researchers over participants (Scheurich, 1997) or educators over students (Evans-Winters, 2011). Like Fitzpatrick (2013), I have not been able to change the power relations inherent in research, but I have attempted to "try deliberately to see and to name them" (p. 38).

Validity and Reliability in Postmodern Frameworks

As I mentioned in the section above, my intentional methodological choices to employ postmodernism placed limits on my study and precluded me from presenting any findings as truth (Evans-Winters, 2011; McCall, 2014). I agreed to explore "partial and complex truths," that seek to challenge existing assumptions in response to decades of studies that presented pathology and deficit as a fact of life for youth in urban areas (Evans-Winters, 2011, p. 16). Instead of claiming that my "findings" can be replicated across populations, I practiced validity in this study by committing to reflecting on my positioning and questioning supposedly "universal 'truths'" (Evans-Winters, 2011, p. 15) I have attempted to make clear how my values and subjectivity have led to my chosen methodology, my participant selection, and my interpretation of the data (Fitzpatrick, 2013).

I have questioned the construction of authority and challenged "how knowledge, truth, and subjects are produced in language and cultural practice" (St. Pierre, 2000, in Evans-Winters, 2011, p. 15) throughout the research process and the years leading up to it as a student-educator. Throughout the data collection, analysis, and interpretation processes, I acknowledged and confronted myself and my positioning, specifically within my role of perceived or supposed "authority" as researcher, though this is never sufficient in identifying all of the pieces of my identity that create my worldview (Ladson-Billings, 2003): as Scheurich (1997) writes, "that the written result, the final interpretation, of the interview interaction is overloaded with the researcher's interpretive baggage is,

therefore, inevitable" (p. 74) This study, therefore, like all studies that embrace postmodernism, cannot be defined as valid or reliable in the way that traditional qualitative research methods suggest is possible—though Scheurich (1997) takes great pains to challenge that possibility. Instead, it is a deliberate reinterpretation of existing presumptions of truth in the field of health education.

Transformative Research

Evans-Winters (2011) writes that "theory must be linked to political action" (p. 16). The context in which she states this suggests that to theorize about deconstructing knowledge and challenging power relations requires us to employ research methods and practices that do the same in both our personal and professional lives. She continues and builds on these concepts in her 2019 writings, when she states that emancipatory qualitative methodology must be action-oriented or outcome-based:

> the outcome(s) can be a witnessed change in attitude (e.g., becoming aware that Black girls are punished in schools at higher rates than their White male and female counterparts), behavior (e.g., reducing the number of Black girls receiving out-of-school suspensions), or policy (e.g., removing police officers from school buildings). (p. 22)

I stated to each student-participant that the results of this study will be used to inform and improve health programming, either within our very own after-school program or beyond it. Though I am no longer working at the same program, I still plan to share the findings of these interviews, supported by recommendations for overall health programming, with the organization in a way that is conducive to their needs. As of now, I am not interested in pursuing positions at the top of hierarchies in health or educational institutions as a result of whatever external rewards this completed study can bring me, but I do plan to use the interview processes laid out in this study as a framework and a foundation for free and accessible community education for health educators to engage their communities—this, to me, is political action that can rightfully be taken as a result of employing this methodology.

Ethical Dilemmas of the Current Study

In this section, I present the potential ethical dilemmas with this study. First, I chose what questions to ask, what frameworks to use, and what information to present as it related to my interview questions. I framed this study as an opportunity to present a counter-narrative to the traditional research that typically pathologizes and problematizes youth (Evans-Winters, 2011). I wanted to give the student-participants involved, all of whom I have positive, long-term relationships with, the opportunity to share their own stories about their understandings of health, but I am very aware that throughout the entirety of this study, I am selecting which knowledge will be presented in the findings. Berbary (2014) refers to this tension as the “ethical guilt” of researchers developing relationships with participants while knowing, eventually, they will be presenting pieces of their lives to others (p. 1214). I am in the social position of a doctoral student writing their dissertation with intention to defend, and am therefore expected to follow the expectations of academia, where I have to “claim legitimacy for my work” (McCall, 2014, p. 125), even as I challenge the supposed authority within academia and other social institutions, even as I problematize my identity and what that means for the research, even as I question whether a researcher can truly ever represent the story of another (Evans-Winters, 2019). Yet my approaches aimed to deconstruct assumptions of truth, as well as the role of researcher and educator *authority*. My study, and this document, therefore contain ample tension, and are open to critique, just as I critique hegemony and discourses of health (McCall, 2014). Berbary (2014) suggests that researchers respond to these tensions by consistently reminding participants that research involves the values of the researcher, and that “the researcher’s subjectivities put a specific spin on the data analysis and representation” (p. 1218), and I did not do that consistently enough.

Further, Evans-Winters (2011) and McCarthy (1988) argue that race, class, and gender are not dichotomized, and that students’ educational—and I suggest by extension,

health—experiences are affected by their status within these categories. I have agreed with this and taken on this understanding, but in this study, I may have reified the notion that students who fall into the same racialized categories experience life as a monolith. My frameworks may have limited me to understanding notions of race and gender in their uncritical and unchallenged definitions. The experiences of students whose families made intentional decisions to move to the U.S. and those who did so out of necessity or force are very different, and there are undoubtedly differences in the experiences within and between these groups as well. Limiting still, I did not ask students directly how these pathways may or may not have affected their experiences of health because I was curious to see if these ideas were in the forefront of their mind already. I also chose not to collect demographic information on students' income level, yet continue to reference class as a social category—the assumption that students' attendance at public schools indicates a specific classed status should be challenged, as there are a variety of income levels for families who attend the after-school program in question. Throughout Chapters IV and V, I will be intentional about referencing class and finances only when students name it. Further, in choosing to use a convenience sample of students where I worked, I limited my chances of comparing and contrasting the experiences and understandings of students who do not attend the program. As I stated previously, the choice to stay involved in an athletic program over a long-term period attracts a unique set of individuals.

Additionally, I employed critical race feminist theoretical frameworks in order to center the experiences of youth who live at the intersections of these categories, under the assumption that centering those at the margins of several layers of oppression subsequently liberates those under fewer, yet still complicated and significant, layers (Evans-Winters, 2011). Coincidentally or not, as mentioned previously, far more female-identifying than male-identifying students elected to participate in the study, and interviews with female-identifying students lasted significantly longer than those with male-identifying students. Whether this is a factor of socialized habits around

conversation, of my gendered identity, or of the fact that my focus on intersections of race and gender over my years of working with students and throughout the research process naturally attracted more young women to the study, is unclear.

Katie Fitzpatrick (2013) writes about her ethical dilemmas as a White researcher conducting a critical ethnography that explores the health education experiences of Kikorangi students and teachers in New Zealand, wherein a colleague challenged her position and suggested her research was inherently unethical due to her and her participants' differing identities. She wrote about the tensions and dilemmas involved in her role representing their stories, and still concluded that she was "confident in the strength and integrity of the relationships [she] formed" with her participants (p. 68). I must make a similar conclusion: though I attended consistently to my positioning and I challenge the ideas of representation of student voice, despite the potential dilemmas, I believe in the methodologies, the existing relationships, the theories and literature employed, and the protocol followed, that make this research ethical.

Presentation of the Study

The findings of each interview are presented in Chapters IV and V. This allowed me to organize my interpretations by the research questions: Chapter IV is organized by students' answers to research questions 1 and 2, and Chapter V is organized by students' answers to research questions 3 and 4. After the two chapters of my interpretations of students' interview texts, Chapter VI presents my summary of findings, and a discussion of implications for research, policy, and practice.

Conclusion

Merging postmodern tenets with critical race feminist theory, this study sought to explore how young people who have been pushed to the margins of society understand and reimagine health in the contemporary context of stark racial wealth and health gaps through qualitative interviews. I acknowledged the irrational process of coding by taking it up with a critical lens and employing admittedly messy methods of analysis and interpretation. I viewed interview texts as both separate entities, and part of a collective with commonalities (Stake, 2006; McCall, 2014), I employed a critical analysis of discourse inspired by Luke (1995-1996) and McCall (2014), and I explored storylines of what makes someone healthy (Søndergaard, 2002). The analysis process illuminated students' shared understandings, as well as their uncertainties, contradictions, and "hot spots" that did not fall into any categories, but stood out to as significant (MacLure, 2013a, p. 172). I am not yet sure what social change, if any, will come of this study, but I hope to contribute to the efforts in the development of a critical health education curriculum that seeks to dismantle hegemonic ideologies about adolescent health, by employing subversive research methodology and placing postmodernist thought and critical race feminist theory in conversation with students' stories (Evans-Winters, 2011).

Chapter IV

FINDINGS I

Samira: My grandmother…. Oh my God … it can't get better than that. She eats well, but not only does she eat well but she doesn't believe in medicine. She does not believe in pills, she thinks everything should be natural. So people call her an herbalist. I think she's more than that. I think it has a lot to do with her spiritual side. So she sends over, I don't know, it's like she has her own business, but it's not really a business. It's something she dedicates her life to. I don't really talk about it that much because I don't understand it myself. I just know that she creates medicine a lot for pregnant women. Even the other day, she sent over some cream because my brother has a rash. She's really good at mixing things together. She has her own little farm, kind of, in the backyard, and she grows a lot of things. That's why I really wish I could get into it. She's in Africa and she doesn't really like to call people. She's just about her business, but I know she's healthy. Even when you look at her, I think she's healthy, she's very healthy….

I think she got it through her mother…she's her own person, so she doesn't believe in a lot of things and what she believes in…I don't know, I really want to know. That's what I want to ask her at some point, yeah…yeah, how'd she get that way. I'm still trying to figure that out as well. She's very different, she's herself….

Yeah, I think my grandma is very healthy and she's very ... How old is my grandma, I don't know how old she is. I wish I could talk to her more, but I know she's healthy. I see photos of her all the time and yeah, my mom always tells me about her.…

She cuts out sugar and she's so strong. I don't know, you get strength from eating, right, and she doesn't eat a lot of meat. For me, I define eating well as eating the right amount and eating good food. And where … we don't live in the village, but in the city, she grows her own food. I think that's amazing…. She makes her own

> food, everything. Nobody likes it, but it works for her. Everything she eats is good for her body and stuff. (4/10/19)

The concept of health for many students in this study seemed to revolve around their ability to eat "right" and exercise. Opposing discourses arose with regard to students' reasons why they either did or did not engage in these activities: some students named their individual behaviors and characteristics alone as their determinants of such behaviors, while others identified the social, political, and structural determinants; others still, like Samira, named the combination of both personal successes or failures along with their socialized experiences as the cause of their challenges with regards to reaching their definition of health or maintaining their health behaviors. Many students in this study easily identified themselves as healthy, while others saw themselves as works "in progress." Many felt constrained by their identities as students, by the access (or lack thereof) to what they defined as "healthy" behaviors in their neighborhoods, and for some students, like Samira, by their regional context in the United States.

In this excerpt, Samira expressed her admiration for her grandmother as the healthiest person she knows. Samira is a 12th grade student who was born in the United States and maintains a close connection with her family and their home country in West Africa.[1] She discusses her grandmother's practices for growing and making both food and medicine, and views it as bigger than herbalism, as something that integrates her "spiritual side." In later excerpts, we'll see Samira's anxiety about the health habits she feels she is unable to maintain, due to a combination of what she perceives to be personal failures in discipline, as well as the constraints of American culture. Her expression of admiration for her grandmother, who grows her own food, minds her own business, and takes care of others with the medicine she makes, as the pinnacle of health, points to the distance Samira feels between the behaviors she deems integral to maintaining one's

[1]It is incredibly important that we deconstruct mainstream notions of Africa as a monolith. In order to conceal the student's identity, however, I decided to leave the name of the country out.

health, and the lifestyle she leads as a student in the U.S. at the time of the interview. When asked about her friends' habits, Samira shared the following:

> Samira: I think some are, my friends, some of them are worried about their health. Some of them choose to go to the doctor. Some of them choose to do some research about what's going on in their body. They're worried about how they look, some are worried about what's going on on the inside, some are worried about how they look, appearance, and some just don't care about what they put into their bodies. Some of them, like it's just not anything important to them. Some people, they put their health first and I see it in my friends sometimes, only like three friends I know care about their health really. And some wait until they go to the doctor and like, "Oh gosh, I need to get this done." (4/10/19)
>
> Clare: Can you tell me what it means to be someone that puts your health first?
>
> Samira: Just to be comfortable enough to make sure that everything is going on. I mean just to be comfortable enough to make sure that your body is functioning well and having enough confidence to bring it up to people. So like even the littlest things like, I need cream for my face, like I feel like not a lot of people can go up to their parents, or they just wait until their next appointment or something. So to put your health first is to know that there's something wrong with me, or I'm not eating well, or my stomach keeps hurting. It takes a lot for somebody to confront it, like bring it up and get help. (4/10/19)

Critical health scholars (e.g., Azzarito, 2010; Evans, De Pian, Rich, & Davies, 2011; O'Flynn, 2010) have explored the way individuals in general, and young people specifically, constitute their sense of themselves in response to health imperatives. Burrows and Sinkinson (2014) theorized that students' various interpretations of public and school-based discourses of health, which encourage performativity and an increased focus on making sure the body looks good and works well, impact their perceptions of themselves as individuals with self-worth and resilience in ways that are not always positive. Some studies have found that mainstream public health messaging creates anxiety among young people (Burrows, 2011), as reflected in Samira's statement that some of her friends are "worried." Samira expresses that some of the main health

concerns for her friends revolve around their "looks," while for others, their concerns focus on "the inside," and whether their bodies are "functioning well," and that the main challenge is to attend to the body and "get help." For others, though, "it's just not anything important to them."

Walkerdine (2009) argues that people experience what becomes global knowledge and imperatives, in this case health "knowledge" and imperatives, as they "flow across continents and enter into different relationships and communities of practice" (p. 201)—the way students experience these health messages will depend on their personal and cultural values, their biases, their socialized identities, and the variety of ways that their schools and the other social institutions with which they engage reinterpret and reproduce these messages (Evans et al., 2011). Integrating these ideas into critical race feminist theory insists that the structural inequities shaped by racism and sexism in the U.S. will influence these predispositions and experiences in a multitude of ways.

Samira stated the following understanding of health, influenced by her experiences with her immediate and extended family in Africa, in Europe, and in the U.S., throughout her upbringing, towards the end of her interview:

> I don't think, especially in America, living a healthy lifestyle is not priority. It's not a priority. Everyone wants to chase the American dream, and I don't think that's living a healthy life. Whereas in Africa, a lot of people turn to health and being healthy like my grandmother. (4/10/19)

Her excerpts are noteworthy because they include several discourses of health that I laid out in previous chapters—personal responsibility, cultural and social norms, the production of a "healthy" person, and access to student-defined health behaviors. Samira described her ideas of health both through stories about her grandmother in Africa, and about her friends in the U.S., that she perceives to be worried about their health, or not. Students in this study conceptualized their health in a variety of ways, some similar and some very different; some shaped by larger societal discourses of health, and some completely independent of mainstream systems of knowledge.

Purpose

This chapter presents my analysis and interpretation of students' answers to the first two research questions: (1) what are participants' thoughts and feelings about health? And (2) what are the ways youth navigate health? I looked for discourses of health, of risk, shame, and fear, and I placed these discourses in the context of larger social structures, especially the intersections of race, class, and gender. I also located "storylines" about what constitutes a healthy person, and how students' experiences of health, health class, and health messaging throughout their upbringing has shaped their idea of themselves (Søndergaard, 2002). In addition, I identified "fragments of 'data' that refuse to settle under codes," (MacLure, 2013a, p. 171) where storylines and discourses seemed to come "undone," (Mazzei, 2013, p. 96) which contributed to the larger "mosaic" of students' experiences (Evans-Winters, 2019). These processes have allowed me to develop an understanding of how students' socialized identities and experiences have led to their understandings and navigation of health.

In Chapter III, I demonstrated the usefulness of critical discourse analysis (Luke, 19995; McCall, 2014) to identify storylines and explore how students "take up and further develop various subject positions in their everyday lives" (Søndergaard, 2002, p. 194). In this chapter, I used Søndergaard's and McCall's ideas of storylines in my analysis, to ask the question, how are participants understanding themselves with regards to health in their daily context, against the definitions of selves imposed upon them by the external world? I also applied lenses of critical race and critical race feminist theories in order to challenge deficit thinking about Communities of Color that are common in mainstream health and educational research, and prioritized the sharing of students' stories to demonstrate the complexities of their experiences and the valuable insights they have to share.

Thoughts and Feelings about Health

In this section, I aim to present findings relevant to the first research question: What are participants' thoughts and feelings about health? Students' responses are organized into the following categories: health as an external process or performance, and mental health.

Health as an External Process or Performance

In this study, many discourses of health appeared simultaneously. Even in messier understandings of health, the dominant discourse from many students, was health as something to be achieved and viewed externally, and that one's achievement of health, or lack thereof, was determined largely by their diet and/or exercise. Students appeared to absorb larger cultural narratives about the "healthy body" in their own definitions of their health, which in turn affected the stories they told about themselves. The healthist discourses—health as something that can be viewed externally or as something that is produced through diet and exercise—that appeared in these interviews, where students all identified themselves in racial or ethnic groups that have been historically marginalized, can function as "an extension of discourses of morality and uncleanliness" that were used to justify colonialism (Hokowhitu, 2014, p. 36). Contemporary manifestations of healthism are not used to assert superiority of one race over another, but to support the "production of a healthy body:" to avoid "otherness" (p. 38).

Fitzpatrick (2014) writes that the intersections of healthism and individualism cause us to view our bodies as a visual display of our health and the ways we take care of ourselves, thus making our own health and well-being a commodity (p. 12). Indeed, Hokowhitu (2014) asserts that healthist ideas are fashioned as a desirable lifestyle with the so-called "healthy body" as a manifestation of that lifestyle. This "healthy" body is produced through "packaging on food labels," material wealth, "statistics on childhood obesity … exercise regimes, daily and weekly schedules," culture, and race, among

others (p. 34). Healthist discourses appeared many times throughout the interview when students were asked to define health or describe a healthy person. Andrew, for example, described himself as the healthiest person he knew, and explained that he got that way because, "I was fat as a kid … and people used to bully me, so I worked out (7/25/19)." Similarly, when asked if she considered herself healthy, Viv responded,

> Not really. I'm athletic, but healthy? Healthy? No, because my doctors just keep saying I'm losing weight. But I feel like weight has to do a lot with my definition of healthy. So because they're just telling me, 'You're losing weight, and you need to gain weight.' And I just had that stick to my head that I'm not healthy. (5/22/19)

Patricia, too, was ambivalent about describing herself as healthy, because although she likes to walk a lot, she doesn't do exercises consistently: "I think in my head, maybe I'm going to do some sit ups today to get rid of my stomach but it's like when I have the time, I'll just do it tomorrow, and when tomorrow comes, I'll do it tomorrow" (7/29/19). These comments capture the ways students learn about their health—as a process of objectifying their bodies in order to ensure they're "fit," potentially so they can avoid the perceived difference or "otherness" of an unhealthy body (Hokowhitu, 2014, p. 35). For the female students in particular, they reflect the neoliberal ideologies of "new femininities:" young women who know how to manage themselves, who are "resourceful, productive," (p. 267) and motivated to be their best selves, alongside healthist discourses (Azzarito, 2010, p. 266). Azzarito (2010) argues that these ideologies have the potential to result in "highly complex and troubling" (p. 269) ways in some young women who don't feel they fit into these categories and may attempt to homogenize young women. I do not read the quotes above for girls' troubling feelings about themselves, but this is an important perspective to note regardless.

Foucault (2000) writes that one way an individual comes to understand oneself is through our responses to power—our subjectivities, therefore are not static, but produced by our the discourses we are exposed to, which "describe and define how the world is,

and how one might act in it" (O'Flynn, 2010, p. 432). These discourses of what makes someone healthy as something that can be viewed externally, or as something that can be performed, created complicated storylines about student-participants' feelings about their own health, and about themselves. Many students seemed to have the understanding that what makes someone healthy is the food they eat and their level of physical activity alone – external processes that they either perform well, or not. This discourse produced the storylines that students used to determine whether they think of themselves or others as healthy, which in turn impacted the stories they told about themselves, as either being "good," or "bad," or as someone who could "be better." Aissatou, for example, felt unable to describe herself as healthy because, "It's just in eating. I can't fix my diet" (7/26/19). Makayla, as well, lamented the fact that many of her peers seem to base their perception of themselves on their size: "a lot of people feel like, if you're skinny, you have nothing, or if you're big-boned, you have nothing. Or even if you're the 'right' size, if you don't have a certain measurement, it's like you're nothing" (6/12/19). Similarly, Samira expressed her perception of health as something she can always be "better" at in the excerpt below:

> I think I could be better with ... Oh my gosh, oh my gosh, I don't think I'm healthy. I try my best, I literally try my best to pick up healthy habits, but I don't think I'm too healthy. I've been getting there. I know when I get to a certain age, but it takes a lot of discipline and strength, mental strength…. My habits, eating habits, not so healthy and I know why. I have a bad sweet tooth, really bad. Sometimes as a kid I never could control it. But I think that with discipline that can happen….
>
> For me, just being healthy for me has a lot to do with eating. I eat well sometimes, but it doesn't last long. So hopefully moving forward I can try to improve that, but I do little things…. But I really want to be healthy, health is very important. I really want, like that's my goal, to be healthy. It's not perfect, like we're not perfect. It's not going to be perfect, and people that I know, the healthiest people I know aren't perfect. So you try to be healthy, but life is not like that and it's so sad. Like you want to be healthy. Okay, I don't know, you just can't be perfect. You can be healthy in one department and in the other department you're not healthy. It's either or. (4/10/19)

Samira's description of herself and her habits as something she's never doing well enough echoes Hokowhitu's (2014) assertion that the pursuits of healthism depend on the idea of constant failure. He writes, "The desire to be healthy, to avoid being the unclean, leads to a continuous tension, a continuous unease with one's own frail humanity, a continuous disease." (p. 35). This tension can be felt in Samira's description of her "bad" sweet tooth, her perceived lack of control, her sadness over not reaching perfection in eating habits.

These responses further beg the question as to whether Samira, Aissatou, and Makayla's peers may have absorbed the hierarchies of the body covertly created by health discourses that encourage the performativity of healthiness and tend to label young people, especially Young Women of Color, as "unhealthy and inactive, or at-risk" (Azzarito, 2010, p. 262). Webb and Quennerstedt (2010) assert that this "culture of performativity" is a result of the discourses of health risk and the increasing anxiety about health issues that are prevalent in mainstream societal messaging (p. 787). While whiteness as a construct was not specifically mentioned by students in this study, in critical scholarship, it is common for critical race theorists to associate Whiteness with the performance of actions and fabricated identities (e.g., Gillborn, 2009), which is why many critical health scholars suggest that traditional health messaging idealizes Whiteness and White bodies (e.g., Azzarito, 2009; Fitzpatrick, 2013; Fitzpatrick & Tinning, 2014), and "others" the bodies of Individuals of Color (Hokowhitu, 2014), especially Girls of Color (Azzarito, 2010). Additionally, there is evidence that feelings of guilt and disgust for oneself—or for others around them—follow the purchase or consumption of "forbidden" food, to the point where some students have expressed feeling like they are being watched when they do so (Burrows & Sinkinson, 2014, p. 242).

These discourses of health as a performance or achievement—"healthist" notions that health is the responsibility, and in the control of, the individual (Crawford, 1980)—

produced disappointment in themselves for many students, even though some of those students expressed a seemingly conflicting awareness that access to these behaviors is not equitable. It is recognized among critical health scholars, though, and among some students in this study, that a constant pursuit of health is impossible for most people due to the privilege and power it requires, and unsustainable for even those who have those privileges (Hokowhitu, 2014). Kimberly, for example, largely used her eating habits to define her health, while recognizing that many of her habits have been determined by what she has access to:

> I don't think I'm healthy…Nutrition-wise, I don't think I, well I've been getting, well that [trip I went on with my after-school program,] that week was horrible. It was like most unhealthy. Even when I just think about it, I'm like, "Oh my God." But I allowed my body to do that. But that's because again, accessibility. I was offered that so I'm just going to take it. You know? (4/15/19)

Additionally, Sade demonstrated self-awareness around the fact that she defined herself as healthy or not based solely on her physical health, which affected the way she felt about herself in ways that were unrealistic:

> I think I'm healthy. I think I can try to be more healthy, especially with my eating habits and physically. My thing is, I'm always associating health with physical stuff so when I don't exercise or when I feel like I'm not walking enough, it's like, "Oh, I'm unhealthy blah blah blah." And stuff like that, that's not usually the case when you stop to think of it. (7/1/19)

Both Kimberly and Sade used diet and/or exercise to determine their self-definition as healthy, but due to issues of access, in Kimberly's case, and self-reflection, in Sade's case, did not allow their perceived shortcomings to affect their opinion of themselves in the long-term. I saw this as well in Zadie's description of herself as "a work in progress" (4/22/19) and Makayla's recognition that "I still have some things I need to tweak, but compared to the last four years, I think I'm doing really good for myself" (6/12/19). Still, the students' descriptions of themselves with regards to their "healthiness" point to the healthist discourse that has affected the understanding of the general population, wherein

the students in this study responded in ways that suggest they have taken up the "devotion" to producing a healthy body (Hokowhitu, 2014, p. 39), or the health consciousness that has become a part of our social norms (Ayo, 2012), and in the case of many of the girls in this study, are affected by notions of the ideal feminine body (Azzarito, 2010).

Mental Health

> In more ways than one, I've grown and I've developed thoughts on how to better myself. Mentally, I'm pretty sure I still have a lot to work on, because I still suffer from bursts of depression. I still suffer from severe anxiety, I still suffer from low self-esteem. Which kind of all is linked together because I'm anxious, I kind of am unsure about myself, which can lead to low self-esteem. If I have low self-esteem, I don't really have the proper emotions for it, and then I'm just kind of in a slump which can down the line lead to much more severe depression. It's not to say that others don't have things to work on, but I know that I myself definitely have grown in different ways. Mentally, I still have so much more to work on. (Gloria, 7/31/19)

Mental health issues have seen an increase in public interest in the last ten years, since the World Health Organization (2009) began public efforts to normalize conversations around mental illness and to recognize the role that mental health plays in producing citizens who can actively contribute to society (Burrows & Sinkinson, 2014). Critical race theorist Tony Brown (2003) has written about how racial stratification impacts the mental health of all people—as all of us are racialized in U.S. society—and that there are specific mental health issues that can only be understood by examining the impact of inequitable social structures, and can only be alleviated if racism is eliminated. Many students in this study shared a variety of thoughts on their internal processes related to their health: some appeared to absorb neoliberal discourses of mental health that focus on individual choices as the cause of, and subsequent answer to, mental health issues (Evans, Rich, Allwood, & Davies, 2008; Wright & Harwood, 2009), while other

students discussed their understanding of mental health in relation to their socialized identities.

The World Health Organization (2018) defines mental health “as a state of well-being in which every individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.” Specific to our context in the U.S., the CDC (2018c) states that mental health “includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices.” For New York City health educators, the topic of social, emotional, and mental health is included “to ensure that students learn how to manage emotions and behaviors, develop relationships, and build social and self-awareness skills” (NYC DOE, 2019a). Each of these definitions share the underlying idea of mental health as a “state of wellbeing” that can be acquired through skills and strategies (Burrows & Sinkinson, 2014, p. 158).

International increases in depression among adolescents and teenagers in the last 50 years have led to an increase in schools teaching skills that focus on personal responsibility to create more opportunities for wellbeing (Burrows & Sinkinson, 2014; Seligman, Ernst, Gillham, Reivich, & Linkins, 2009). Burrows and Sinkinson (2014) write that neoliberal discourses in health promotion and education can produce feelings that might harm as opposed to support young people’s mental health, and that these messages affect students differently. The ideal of mental health as something one can develop skills and strategies to improve is reflected in Gloria’s comments above about her own mental health as related to her self-esteem, and her repeated statement that she has some things to “work on.” It is unclear whether her conception of her mental health is supportive or harmful, but her use of the word “suffer” twice and the descriptor of her “severe” depression suggest that she categorizes herself as a “bad subject”—an unintended, yet common, consequence of neoliberal health discourse (Burrows &

Sinkinson, 2014, p. 163). Kevin, too, shared his challenges with mental health: "I have a lot of problems that I don't want to deal with. Sort of shove them on other people, and I don't feel good about it" (7/23/19). The "shoving" of his problems as opposed to identifying a different way to respond has affected his conception of himself—it's a behavior he's not proud of. Both Kevin's and Gloria's understandings of their mental health raise questions about the "assumptions of normality" and "morality" that bolster messages about mental health in and beyond schools (Burrows & Sinkinson, 2014, p. 162).

On the other hand, Sharon identified herself as the healthiest person she knows because of her growth with regard to her internal processes. She stated, "I feel like in terms of introspection, even though I kind of chide myself sometimes, I think I'm really good at that, and I'm proud of myself, in terms of always thinking about my actions as much as I can" (4/12/19). Sharon expressed throughout the interview how much she has prioritized self-reflection throughout her high school years, after her challenges with her mental health, and that's why she considers herself so healthy. She rarely touched on aspects of her or others' physical health as it relates to diet and exercise at all, perhaps due to her lived experiences.

Additionally, Mia shared an increase in her personal capacity to make a wise health choice as a source of empowerment. She shared: "I started meditating and stuff, and I feel like that has been a huge part in my health, because I just realized that if I'm not feeling right emotionally, then it doesn't matter what I do to eat" (5/4/19). This same student was described by her friend Shoshanna as someone who "wants to understand things" (5/5/19), and seeks alternative understandings, like astrology, for the way things work—it is possible that her penchant for learning and exploring allow her to try on new behaviors as a form of "self-determination" (Evans-Winters, 2011, p. 120) that protect her from internalizing potentially harmful discourses. She later shared that she thinks of herself "as a plant." She continued:

> No, seriously. I think that I'm really like a plant, and I can choose to water myself with nourishing fresh water or not, you know. It's not anyone else's responsibility to kind of, like, water me. It's my own. Food, good food, water, healthy environment, safe environment. Environment where people are open to learning and helping each other (5/4/19).

This incredibly unique way of viewing health was unmatched by any other students' ideas or definitions. She takes responsibility for taking care of herself and acknowledges the impact that the world around her has in how she feels. She demonstrates neoliberal discourses of personal responsibility in her "choice" to nourish herself with good food and a healthy environment, her language does not suggest stress around these choices.

More recent conceptions of mental health have identified it less as an individual characteristic and more as a result of one's social and community support; these ideas are less likely to relegate individuals' poor health to their carelessness, and more likely to promote positive pursuits of social support (Burrows & Sinkinson, 2014). Chris, for example, happily shared, "If I'm going through something or I'm stressed, I've got to make sure I take a mental break and make sure I stay physically active and ask for help from people if I'm not feeling mentally there" (7/29/19). Similarly, Zione shared that she takes care of her mental health with the help of peer support:

> I have a friend who, she also has depression, so … we're very similar in that sometimes we'll only eat once a day, and we have to check up on each other and ask each other, "Did you eat? Do you want to go get some food?" Even if it's 8 or 9 o'clock, we haven't eaten all day, we have to eat something. We always check in on each other. She messaged me once because I was posting [about] it [my depression] online, and she was messaging me and saying, "you're not going to sleep by yourself, first of all." She came to my dorm and told me, "Look, get your stuff." I packed my stuff and I slept in her bed, and she slept on the floor. (6/5/19)

Both Chris's and Zione's understanding of their mental health point to studies of personal resilience that have suggested that mental health is connected to an individual's relationships with other people, including their family and their community (Burrows & Sinkinson, 2014). Their willingness to reach out to their support systems in response to challenges may act as a protective factor for their mental health. Kevin also discussed the

pursuit of social support in maintaining one's mental health as positive, yet not without its challenges:

> I know some people who, are sort of like, they talk out about their problems. And I know others who kind of keep it in and don't tell anyone and fix everyone around them. I think when you hold everything in, you sort of lash out. I don't really want to get too per.... I'll do it, why not. I was kind of angry at some people. I was not upfront with them, and I felt a lot better when I was upfront. But at the same time, that brings up complications too. I think it's better to be honest, but it's not easy. (7/23/19)

While mental health is typically theorized to be a function of internal and individual factors, critical race theory emphasizes the meaning and impact of racial stratification on mental and emotional health that often go beyond mainstream discourses and definitions (Brown, 2003). Brown writes that "racial stratification produces mental health problems to the extent it generates stressful circumstances and cognitive states conducive to emotional distress" (p. 295). He states that societal racism directly and indirectly creates specific mental health issues. This is echoed by Fanon's (1963, in McGee & Stovall, 2015) understanding of racism on the mental health of Black people specifically: "Today, we know very well that it is not necessary to be wounded by a bullet in order to suffer from the fact of war in body as well as in mind" (p. 496). McGee and Stovall (2015) add that current individualist conceptions of the often "racially neutral" (p. 499) terms "grit" and "resilience" do not adequately explain the burden of societal racism on students (p. 492). In describing her thoughts and feelings about health, Maria named the impact of racial stratification on the mental health of her community:

> Oh my god, like the drugs in the communities and Spanish and Black communities, that's mostly happening there. It's so upsetting. That's stress. Honestly, these kids do not deserve this. Or, you know what? Also that's stressful where I was watching about these exonerated five where I think they were framed just because of the color of their skin, that adds stress because I can't go outside if I could just be criminalized for something that I didn't do. That adds stress. A lot of things just add stress, and everyone, and it's like how can I live? As a person of color, how can I live? And that's scary. It is, because all this news I'm seeing all these kids dying going outside and they're just kids. (7/30/19)

She continued later,

> I remember I complained to you a lot about the system failed me and whatever, and that's … had a huge impact on my academics and for me thinking about my value. Am I smart enough?... I felt like, "Oh, no matter what I do the society wants to fail me." Since I was born this way, I'm not born with a silver spoon … it could just affect your mind because you think you can never make it nowhere. (7/30/19)

Here, Maria reflects on the impact that racial stratification has had on where she and other historically racialized young people live, on their lived experiences as Young People of Color at risk of racism with severe long-term consequences, on where she goes to school, on her sense of her own value, and on her perceived lack of opportunities for social mobility—all factors that Brown (2003) suggests are impacts of racial stratification on mental health. She recognizes that "the idea that women, People of Color, and/or folks from lower-income groups can control their own destiny is an oxymoron in U.S. culture" (Evans-Winters, 2011, p. 113), and that racially marginalized individuals experience additional stress due to their societal positioning (McGee & Stovall, 2015); these acknowledgments affect her understanding of mental health—"that's stress" that she and kids in her neighborhood "do not deserve" (7/30/19). Her reflections remind me of Venus Evans-Winters's (2011) question: "What happens when a student acknowledges she faces different obstacles from others but rejects the idea of deficiency?" (p. 81). Maria acknowledges the injustices and the stresses of racial stratification as they affect her mental health and that of other Youth of Color, but does not absorb these inherited differences as a sign that she is lesser than anyone else. Instead, she reflects on the injustice that she and other Youth of Color in similar positions to her must work through the impact that these experiences might have on their conception of their own value.

Another student who acknowledged the impact of one's socialized identity on their mental and emotional health was Zadie, in her description of her friend:

> I have this friend. His name is Josh [a pseudonym]. I feel like he doesn't do the best of jobs at being like just healthy in the emotional way. But I feel

> like it's mostly because of his culture. Being a Black male. I feel like it's those things. And he's very knowledgeable of the fact that these things have contributed to the way that he just is in regards to emotional stuff. But when it's his time to cry like he'll do it. Like afterwards he'll be like ugh, like he's a totally, like, bitch, you know? But he'll say it jokingly and I feel like that's more of like a cover-up. Like joking is his way of dealing. So I feel like he does do a good job of letting himself feel even if it's just, even if it's limited. (4/22/19)

Instead of addressing racial stratification like Maria, Zadie recognizes her friend Josh's difficulty in expressing himself due to his racialized and gendered identity of being a Black male. The idea that Black people have an "inherent mental toughness" has its roots in racist ideologies that were used to justify colonialism and slavery (McGee & Stovall, 2015, p. 502). Further, some research has suggested that traditional notions of Black masculinity may require individuals who are socialized into these categories to express their emotions through verbal and physical aggression as opposed to more feminized behaviors, such as crying and seeking social support (Ward & Collins, 2010); others have found that contrary to previous findings, the supposed stigma of mental health is not a barrier to seeking support among Black men (Ward & Besson, 2012). Zadie recognizes the difficulty her friend has in challenging these stereotypes and celebrates his ability to release his feelings in a healthy way, even when it's "limited." Maria's and Zadie's comments support Ginwright's (2010) argument for the development of a critical consciousness of social oppression, as well as Fitzpatrick and Allen's (2019) argument for a focus on developing students' critical consciousness in health education, so that students are not forced to internalize their own experiences as personal failures.

Finally, while Shirley did not name the stresses of racial stratification or identity specifically, she described life as innately damaging when she named her younger sisters as the healthiest people she knows. She shared:

> They're so young and so energetic. And I don't think there's anything wrong with them. They're so pure … they're not damaged yet. When you're so young, you still don't know what can hit you in the future. As people get older, they start to realize how hard life is. (5/1/19)

Shirley continued to express many times throughout the course of the interview how she hopes to support and protect her sisters from life's threats and challenges. Shirley's conception of health may point to her personal experiences with mental health, and/or to the impact of her socialized identity on these experiences, but since she did not name these factors explicitly in her interview, I hesitate to impose my assumptions.

Navigating Health

In the following section, I present findings relevant to the second research question: What are the ways youth navigate health? Students' stories and experiences indicate that the three major contexts in which they navigate health are at school and in their communities. This section is therefore divided into the following categories and subcategories: (1) school-based health—positive experiences, teaching out of the textbook, fear and risk, shame, and what's missing; and (2) community—peers, parents and families, and environment.

School-Based Health

The United States is one of many Western countries that attend to lifestyle diseases at the state level through "health promotion" and within schools through "health education" (Fitzpatrick & Tinning, 2014b, p. 3). Critical health scholars have argued that Crawford's (1980) concept of "healthism," or the delivery of health messages that carry the expectation that good health is the responsibility of the individual, transcends the goal alleviating health issues and moves into governmental "maintenance" and "control" of the body (Fitzpatrick & Tinning, 2014b, p. 1). Petersen and Lupton (1996) added to this idea, stating that public health messaging in the modern era requires individuals to attend to risks in our environment, which are pervasive. Individual attention to managing one's risks assumes that individuals have equal access to the same resources, be they material

or cultural, to make educated decisions about their health (Azzarito, Macdonald et al., 2017; O'Sullivan, 2012), and also assumes that everyone defines their health in the same way. Azzarito, Macdonald, and colleagues (2017) have suggested that such neoliberal approaches dismiss the structural barriers that marginalized groups face in making the so-called "right" choice, and that the continued expectation of individual responsibility in maintaining health status has an "othering" effect that places individuals and communities who do not identify as White as outside the norm, and upholds inequities in access to health and health outcomes (Azzarito, Macdonald et al., 2017, p. 209; Bowleg, 2012). Explicating this idea further, when specific bodies that have been labeled *at-risk*—typically a country's racial or ethnic minority, and/or lower-income communities—do not achieve desired status of good health or health maintenance, individualist and moralistic methods of personal responsibility create feelings of internalized blame for "deviating" from the White norm, and contribute to continued social segregation when specific groups are labeled as negative or aberrant (Azzarito, Macdonald et al., 2017, p. 209; McRobbie, 2007). Still, individualistic approaches that involve risk, fear, and shame are used commonly in health promotion, and in school-based health education (Fitzpatrick & Tinning, 2014b).

Schools are typically placed under pressure to respond to the public anxiety of heightened health issues, and health disparities, by educating its students in order to monitor and change their behavior (Fitzpatrick & Tinning, 2014b; Gard & Wright, 2005; Powell & Fitzpatrick, 2013). According to the New York City Department of Education website (2019a), all students that attend New York City public schools must take health education, which includes HIV/AIDS lessons every year, in order to abide by New York State law. Students K-5 must have health instruction every year, and K-6 must have five HIV/AIDS lessons per year; middle school students must have health education every day for one semester with instruction time adding up to 54 hours, including five HIV/AIDS lessons for 6th graders and six HIV/AIDS lessons for 7th and 8th graders; and

high school students must have health education every day for one semester, with instruction time adding up to 54 hours (NYCDOE, 2019a). New York City public schools follow New York State learning standards for health education, in addition to the CDC's National Health Education Standards and National Sexuality Education Standards. New York State standards for health, physical education, and family and consumer sciences include the following:

> Standard 1: Personal Health and Fitness. Students will have the necessary knowledge and skills to establish and maintain physical fitness, participate in physical activity, and maintain personal health.
>
> Standard 2: A Safe and Healthy Environment. Students will acquire the knowledge and ability necessary to create and maintain a safe and healthy environment.
>
> Standard 3: Resource Management. Students will understand and be able to manage their personal and community resources. (NYSED, 2014, p. 1)

In earlier chapters, I supported Evans-Winters's (2011, 2019) assertions that students' educational experiences are impacted by their raced, classed, and gendered identities. In this section, I explore students' navigation of school-based health, and whether and how it is shaped by these identities, organized into the following categories: positive experiences, teaching out of the textbook, fear and risk, shame, and what's missing.

Positive experiences. Fitzpatrick (2014) points to critical pedagogy in the health classroom as having the potential to "unravel discourses of healthism" (p. 185) that potentially harm young people, but there are few examples in the literature that highlight the complexities of connecting health and education in the classroom (Leahy & Simovska, 2017). Fitzpatrick (2019) provides one example of such research, identifying five aspects of critical pedagogy in the health classroom (Fitzpatrick, 2013; Fitzpatrick & Russell, 2015): "building the environment," "deconstructing power," "playfulness" "studying critical topics" and "embodied criticality" (Fitzpatrick, 2019, p. 1135-1136).

These aspects can be merged with Ladson-Billings's (2009a) conception of "culturally relevant teaching" for African American children—extended here and elsewhere to other racially marginalized groups—which is about "questioning (and preparing students to question) the structural inequality, the racism, and the injustice that exist in society" (p. 140) in order to adequately capture the teaching strategies needed to support marginalized students in the health classroom. Though students did not name critical pedagogy or culturally relevant teaching strategies specifically, their stories demonstrated connections to these aspects. Students who shared their positive experiences in school-based health typically did so by sharing what they liked about their health teacher, or memorable activities from health class. Students named playfulness, care, deconstructing or distancing from teacher power, and expertise as qualities of a health teacher that made their experiences positive.

Fitzpatrick (2013) asserts that health teachers who enact playful pedagogical approaches are able to deescalate tension or conflict and, as a result, are more easily able to introduce sensitive topics, and, potentially, to subvert power relations. Several students' comments supported this argument. Samira, for example, had nothing but good things to share about her middle school health teacher, and the ways she used playfulness to relax and comfort the students:

> She would just be like, something like, "It's life," or "That's how it is," or "It's natural."… She would always, when she felt us being uncomfortable, when she felt like we weren't comfortable, she was just like, "Hey look," in a playful manner. (4/10/19)

Similarly, Gloria enjoyed her health teacher's attempts at humor, which facilitated her learning and engagement:

> In school, when I was taking my health course, a lot of the times my health teacher would reference movies. Sometimes the examples would kind of be severe. They were pretty funny. So kind of like having a good laugh, and seeing that we don't have to be so serious all the time in class. I'm pretty sure that helped me know about these different things better, especially because there was a variety of things to learn. It did help to know that not

> only did I have a good time in health class, but there was some sort of way for the teacher to make sure we stayed engaged in the class. It helped us participate a lot. (7/31/19)

Makayla also shared about her health class, that “adding a little twist of fun helps, because when you just do lecture style it’s going to be boring, and I feel like as humans we always love something creative (6/12/19).” hooks (1994) writes that there is controversy around the idea that learning should be exciting, or even fun, but Ladson-Billings (2009a) asserts that culturally relevant teachers “exemplify the creative aspect of teaching” and embody playful practices that keep students engaged (p. 45).

Fitzpatrick (2013) and Fitzpatrick and Russell (2015) also argued that building relationships with students is an important feature of critical health teaching approaches. hooks (1994) echoes this sentiment when she writes that teachers “must build community in order to create a climate of openness and intellectual rigor … a feeling of community creates a sense that there is a shared commitment and common good that binds us” (p. 40). Chris, for example, reflects on the positive experiences with his health teachers when he felt like they really got to know him: “I hadn’t known my teachers for that long but they always helped me out, whether I’m going through something, or whether I need help (7/29/19).” Maria added that the feeling of community and extended family that her health teacher created in the classroom made her and her classmates feel safe, both in and beyond the classroom:

> She’s always known for people to come to her during lunch and everything, and she's our health teacher. And I noticed a lot of boys go up to her and talk to her about feelings and she's like, “These are my kids.” And she would do anything. If they get in trouble with a teacher or they're going to call that person’s mom, she's going to understand, but she's going to be like, “Oh, if you tell me what's going on at home....” Or something like that, she's someone to go to. She's always someone to go to, which is nice. (7/30/19)

hooks (1994) writes that “many students, especially Students of Color, may not at all feel ‘safe’ in what appears to be a neutral setting” (p. 39) and that, therefore, teachers of historically marginalized students must take extra efforts to ensure feelings of safety and

community. Ladson-Billings (2009a) adds that in culturally relevant classrooms, students are treated like members of an extended family and are therefore more likely to support and encourage each other, while trusting that their teacher's care for them extends beyond the classroom. Maria's health teacher created this sense of extended family, which allowed her to introduce sensitive topics effectively. Maria shared,

> It was this topic about suicide and she was like, "This is going to be very serious. Whoever laughs or make a joke, you can step out." It got serious, and everybody was talking about their experience about bullying, and it became more emotional, but it felt like you was like family because everybody been there. (7/30/19)

Samira shared a similar appreciation for her teacher's expression of care: "Ms. B [pseudonym], she was so nice. I feel like she acted like a motherly figure/health teacher. So that helped … she would actually act as an advisor to some people (4/10/19)." Because of her establishment of care for her students, Samira's health teacher was able to teach personal health topics to middle school students effectively, as illustrated with the following story:

> So Ms. B, one day we were excited as well. I think it was seventh grade she brought in fake contraception, like demos and she had a banana. She was teaching us how to use condoms and everyone was engaged. And I remember she was like, "There's nothing to be ashamed of." She brought out a fake, she brought out this fake … a penis so everyone could see what it looks like. And then we were all laughing and she let us laugh, and everyone was like laughing and we weren't even being immature. (4/10/19)

Fitzpatrick and Allen (2019) write that health teachers' efforts for relationship building and connection with students are fundamental to building trust, which is essential when discussing sensitive or more personal health topics. Students' expressions of feeling known and cared for as individuals and treated like family by their health teachers engaged them in topics that might otherwise be difficult to teach.

Some students also expressed an appreciation for when their health teachers deconstructed or distanced themselves from their power as teachers, which is another aspect of both critical health approaches (Fitzpatrick & Allen, 2019) and culturally

relevant teaching (Ladson-Billings, 2009a). There seemed to be a resentment for teachers of any subject who acted as an all-knowing authority; students connected with their health teachers more easily when they engaged in practices that subverted their authority. Students' appreciation for teachers who enacted more egalitarian relationships with them is reflected by hooks (1994) when she writes that "students are much more willing to surrender their dependency on the banking system of education than are their teachers" (p. 40). Jupiter, for example, shared the following about her gym teacher, who also taught her health: "I was able to be honest with him because he spoke to me like an adult. Treated me how I was supposed to be treated, I guess. But he was honest to me and I was honest to him, and he was cool" (8/1/19). This echoes Ladson-Billings's (2009a) assertion that "questioning the hierarchical relationship" between teacher and student is one way to employ culturally relevant teaching strategies and, in Jupiter's words, to create trust (p. 137). Kevin took this idea further when he shared the following memory about his positive experiences learning about health:

> When they tell you what actually happens, I think it makes you less susceptible to doing those things. They'll tell you that, not that it's bad necessarily, but why it's bad, you tend not to do them. I don't know, when people are honest about certain things…. I know that's sort of big but what I mean is, people tell you things, like everything's going to be okay, or just say sort of clichés. It just kind of turns me off and I space out. (7/26/19)

What Kevin is expressing here is an appreciation for honesty from his teachers, which requires vulnerability—a tool that undoes teachers' performance or identity as an authority figure (Fitzpatrick & Allen, 2019). Ijeoma builds on this desire for honesty and openness from teachers with the following description of her health class:

> I used to hate health class…. But then this year, my health class this year, I loved it. The new teacher that came in, I even forgot his name. We have people [in the class], like, that love to have conversation. It was really good. We all had different topics. We had a whole research project to teach to the class. Whenever he would come in, he was like [here's] the basic topic, blah blah, blah. Do now. And then we have discussions instead of just him sitting up there and just going through the pages. We had conversations.

> He loved when we spoke about our personal experiences with things. And then he didn't care if the conversation went off topic, if it was related to health. But he loved when the conversation was just us students talking about it instead of just him just going off, whatever. He always showed different Ted talks about health. After that, we'll have discussions.
>
> We talked about alcohol and drugs and sex, and all those talks that I didn't care about before. It didn't feel like I was being forced to learn about it. It was so casual conversation to a point where I enjoyed it … he just made it an open conversation. It wasn't forced. Or just books that you just have to read. He didn't make it seem like, "Oh, you're doing this wrong. You're doing that wrong. Use a condom blah, blah, blah. Don't drink." He didn't make it seem like that. He was more of like, "You make your own choices but here are the healthier options" kind of thing, if that makes sense. He literally taught everybody in the class not to be judgmental about anybody's situation. The class feels like such as safe place. He talked about his personal experience all the time. Like about his wife, his kids, and healthy communication skills, about everything which made us feel connected to him, because he was so open about everything. (7/24/19)

hooks (1994) writes that "it is often productive when professors take the first risk, linking confessional narratives so as to show how experience can illuminate and enhance our understanding of academic material" (p. 21). In fact, she asserts that students should never be expected to share confessional narratives if their teachers wouldn't offer to do the same. Though here hooks is referring to college professors, Kevin's and Ijeoma's stories illustrate that this can be extended to high school teachers as well, in a strategy for subverting teacher authority in the health classroom and creating trust. Ijeoma's story illustrates that her teacher's shared stories opened the students to share their own opinions and experiences, allowing them to learn new things and practice new levels of empathy. Her teacher's deconstruction of power was coupled with the intentional creation of a non-judgmental community, making it "a safe place" for her and her classmates.

Finally, though expertise is not identified as an aspect of critical health education approaches, Samira highlighted her admiration of her middle school health teachers' knowledge about the subject:

> So a teacher in my middle school, Ms. B, that lady knows everything about health. You know her, right? Oh my gosh, so she basically hammered

> all the terms, all the contraception, everything that I needed to know. Every time I think about health I just think about her because everything was repetitive, but it was useful because everyone in the class knew about health, they knew about contraception, different types of birth controls. I don't know how she did it, but from sixth grade to eighth grade, we knew everything….
>
> Even at sixth grade, coming in as a new middle schooler I was like, "Okay, well they're just going to talk about this?" And like we were uncomfortable, but she made us feel comfortable learning about it and it was like, "Wow, this lady has no...." Like you can tell she's had a lot of experience. It was actually funny, she was saying that every student that she's had has never gotten pregnant. She doesn't say it to shame or put others down, she says it because she's happy that she's able to provide us with that knowledge, prevent things. I always think it helps. So she really makes sure everyone in the classroom knows what they do because it is important. (4/10/19)

Ladson-Billings (2009a) writes that "effective teaching involves in-depth knowledge of both the students and the subject matter" (p. 136). Ms. B.'s effectiveness is reflected in Samira's excitement about her knowledge and expertise—it made her feel like she and her peers "knew everything" by the end of their time with her. Gard and Leahy (2009) assert that health educators struggle with the contradictions between whether their job is to teach their students to be healthy or to teach them about the academic discipline of health (Fitzpatrick, 2014). Though Samira's stories make it clear that her teacher was excited to be educating her students for health rather than about health, Samira says she taught without imposing shame, and instead provided knowledge and skill-building as a source of support for her students. Fitzpatrick and Allen (2019) suggest that it is possible for teachers to both employ traditional health teaching approaches while critically engaging with the knowledge. Samira's excitement about her health teacher suggests that traditional approaches are welcomed as long as they are not accompanied by shame, and instead by care and support.

Additionally, Ladson-Billings (2009a) writes that while culturally relevant teaching strategies are crucial in helping students learn to think critically and challenge hegemony,

in culturally relevant classrooms, “instruction is foremost” (p. 135). Shirley also shared an appreciation for her teacher’s knowledge and teaching strategies:

> What my teacher does in the beginning, we go over what we did yesterday, which I really love that about her. I noticed it today. I'm like whoa, I just realized she talks about it, she asks questions, people participate. She expresses her point. She's like, "Okay, we need to know this and this for the test. We learned this. All right. You guys get it? You guys have any questions? Good. Boom. Boom. Boom. Next topic." We talk about current events. So I think we were talking about the epidemic of opioids … that's really interesting because we're on the topic of drugs now and how some, the purpose of drugs probably can be medicinal or just they could abuse drugs sometimes. (5/1/19)

hooks (1994) writes that “the classroom should be an exciting place, never boring. And if boredom should prevail, then pedagogical strategies were needed that would intervene, alter, even disrupt the atmosphere” (p. 7). Shirley’s expression that “people participate” and that her teacher discusses “interesting” topics suggest that her teacher’s expertise coupled with her pedagogical strategies keep students engaged in the material.

Students’ stories about their positive experiences with health class reflected an appreciation for teachers who exhibited playfulness, care for their students, a deconstruction of power, and expertise in health content. These qualities are mirrored in Fitzpatrick (2019) and Fitzpatrick and Allen’s (2019) aspects of critical health education approaches and in several of Gloria Ladson-Billings’s (2009a) suggestions for culturally relevant teaching strategies that effectively support African American children and other racially marginalized groups.

Teaching out of the textbook. Unfortunately, several students also expressed similar experiences with their health teachers teaching out of the textbook or otherwise not employing engaging pedagogical practices. Some research suggests that time constraints and lack of teacher preparation, among other disruptions, may hinder school-based health education efforts (Rajan, Roberts, Guerra, Pirsch, & Morrell, 2017). Several students’ stories about their school-based health class exhibit a multitude of experiences

with teachers they perceived to be under-qualified and/or teachers who were not passionate about the subject of health. The excerpts below are from students who mostly attended four different high schools; four students quoted below attended the same high school (Zione, Patricia, Makayla, and Chris).

> Zione: We didn't really do anything, to be honest … they didn't want to be bothered. It was just textbooks. [She elaborated later that as a result of this lack of care from teachers,] health is treated as a burden … just something that people don't want to do because it's not treated as something important. (6/5/19)

> Tim: I stepped in, on the smart board she had a textbook and she said copy that down. That moment was basically every day for the rest of the school year … it's really not worth the class. I'm just taking the class for the credit. (4/18/19)

> Bryant: It was basically like, maybe 14 kids to 20 kids max, but I usually had pretty small classes. It was personal, but the teachers weren't into it. They would just show you videos. They weren't as interactive, and inquisitive, That's what made it so memorable, because I was just like, this is when I realized, I was like, "Oh my God, I'm wasting my time here. I came to school first period so early just for health class. I'm ready to graduate. I had my credits, and this is what I'm here for" I'm just like, "Can you make this more interactive? Can you give me different scenarios?" (7/1/19)

> Chris: And then, for school, we mostly just read from a textbook, so we were mostly just reading from that. (7/29/19)

> Patricia: It wasn't very informative on the stuff that I felt it should have taught, the about the human body. It's more of, you're gonna read this and then you're gonna watch this movie this day so it wasn't consistent with the topics so it wasn't very helpful to me. (7/29/19)

> Makayla: Especially with the instructor when you feel it's their job to educate you rather than … it's their job to just get you this information. You can easily just throw a textbook at me. It doesn't mean I'm going to absorb any of the information. (6/12/19)

> Zadie: So when they were doing their lessons I was just very bored and I didn't want to participate. Then the assignments that they give us were lame. It was like write a page-long reflection. (4/22/19)

There is little data on how many health classes in NYC public schools are being taught by certified health teachers. Critical race theory argues that inequities in school funding are a result of institutional and structural racism (Ladson-Billings, 2009b). As a result of continued public debates in NYC school funding, New York State Governor Cuomo implemented a school funding transparency website that required school districts to submit school-level funding data starting in the 2018-2019 school year, in an effort for increased transparency with the public with regards to school funding (NYS DOB, 2019). There are indeed cases where a school's funding does not prioritize employment of a health or physical education teacher, and as a result, many students from lower-income families may be burdened with a substandard health curriculum (Azzarito, Macdonald et al., 2017; Williams, Hay, & Macdonald, 2011). It is unclear whether the students listed above experienced low levels of investment from health teachers due to disparities in school funding or due to schools' lack of investment in the discipline of health.

Fear and risk. Fitzpatrick and Tinning (2014b) write that ideologies of healthism are inextricably linked to the fields of health education and health promotion. Discourses of healthism encourage individuals to monitor and navigate the seemingly pervasive risks associated with modern life (Petersen & Lupton, 1996). Discourses of risk, as a result, continue to underline many policies and practices in health education, and are deeply embedded in health education classrooms (Kelly, 2014; Leahy, 2014). Leahy (2014) writes,

> In neoliberal and risky times, health education pedagogies are directed towards enticing and folding children and young people into a process of governmental self-formation, with the hope that they can voluntarily and prudently manage their risks in order to live healthy, happy and productive lives. (p. 178)

While the pursuit of a healthy, happy, and productive life for all students may seem entirely benevolent, Leahy's (2014) work suggests that teachers' risk discourses can

result in confusion for students and harm their sense of self. This section explores students' shared experiences of risk discourse in their health classes.

Leah shared one memory from health class that exhibited risk discourse with regard to nutrition:

> Any health class that I can recall ever in school was just ... if you don't stop eating this way, your arteries are going to get clogged up…. I feel like they taught us general things but they didn't really teach us things that really apply to us as individuals. Like yeah, we probably shouldn't be doing that. Like we should eat better. But, what should we eat? Can you tell me something that I can eat that I'm allowed to eat? Not just, "Don't eat McDonald's, please." (7/1/19)

Leahy (2009) refers to this and other worst-case scenario discourses as "disgusting pedagogies," or messages about health that contain the most severe, "stomach turning consequences" (Burrows & Sinkinson, 2014, p. 163). Welch, McMahon, and Wright (2012) argue that risk discourses around nutrition "limit what young people can feel by negating any pleasurable, alternative knowledges, or the social and cultural benefits of foods" (p. 725). Lupton (2014) asserts that strategies of risk exist because public health discourses assume that children will make the wrong choices if adults and social institutions are not paying close attention and providing consistent education. Leah's example is reflective of Leahy's (2014) research that teachers employ affective and cognitive strategies to encourage students to consider and take their health risks seriously, without further information what to do in the face of it (Fitzpatrick & Tinning, 2014b). This ignores the complex reasons that people make their health choices in the context of their social environments, especially in the context of food and nutrition, where nutritionists continue to disagree about which choices are actually the healthiest option (Fitzpatrick & Tinning, 2014b), and structural limitations limit healthy food access for many communities.

Further, Gilbert (2014) writes that "sex education must make room for a theory of adolescence without casting the adolescent in the risky role of not yet adult" (p. 27). Four

students shared the following examples of risk discourse in the health classroom focused on sexual health, which unfortunately suggest that their teachers and/or schools did not live up to this charge:

> Shoshanna: They really made it feel scary, like your life would be over if you don't use a condom and stuff like that. Like consequences, they used consequences to make, to let the lessons stick so that we'd learn ... they made us feel scared. If we learned about an STD or something, say, "Oh, if you don't use protection then you're going to get this and you might be in the hospital," and that and that and that. So we're young, we're going to think, "Oh oh. Now I really have to do this. I really have to use a condom before I do anything." It worked with me. It worked with the rest of my friends. I don't think it's the right way, but it worked. (5/3/19)

> Sharon: Then in high school, our school does sexual health through advisory. So ... first semester we'll have a unit on sex ed, sexual health and they'll do the HIV statistics, STI stuff. Talk about birth control, contraception. Oh we did a consent thing too, like different situations of consent, we talked about that. But I remember I'm like always the one to educate about it, or talk about it or add onto it, my advisor, oftentimes I'd educate my advisor too. And then a lot of my sex stuff came from you.... Like when you told me, oh I remember the sex lesson, we were talking about the STI's lesson, whatever and you compared some of them to having a cold and stuff like that. And I really didn't think about it that way, because people always talk about it like it's the plague. And I didn't realize that some of them are actually really easy to get rid of. I just thought they were all like, you have them forever and then we die and that's it and no one wants to have sex with you. (4/12/19)

> Zione: It was gross. They taught us about STDs, and the way that they taught us was scaring us. They didn’t talk to us about ... I don’t know. They just did it in a very ... trying to scare us from doing anything, type of way. They were all just like, "I was disgusted because I don’t want to see that." It wasn’t just under a microscope. They would show literal private parts with chlamydia and stuff like that. They would just put it on the screen. I’d be like, ‘what is that? Why are you showing me this?’ They’re like, "if you do this, you can get that, and so you have to wear a condom, and you have to do this." It was just so nasty, and I was like, "this is making me not want to touch anyone, ever"... for me, I think people our age, if people say, "don’t do something," they’re going to want to do it even more. (6/5/19)

> Maria: Or when she showed us all these pictures of all these STIs, it was disgusting. I'm sorry, but.… Oh my god, there was this person, he had a big bump on his penis or whatever, and it was so disgusting. It was pus and all of that, and she showed us all the photos. All. Yes. It taught me a lot. I'm like, 'Now I know what this look like, now I know when to say, 'No, I'm good,' and go home. (7/30/19)

All four of the students who identified risk discourses in sexuality education are females. This is relevant to Fine and McLelland's (2006) assertion that risk discourses, embedded in the examples that students shared above, restricts the sexual subjectivity of young women, especially those most likely to be labeled "at-risk." All four students shared stories of learning about sexual health through fear tactics and risk discourses. Fine and McLelland argue that in sexuality education, "an exclusive focus on risk not only alienates but also distorts the complexity of human relations of sexual desire" (p. 326). Consequently, they recognize that while it may be unreasonable to imagine a sexuality education that focuses only on pleasure, it is "perverse to imagine that teaching only about risk will transform human behavior" (p. 326). Garland-Levitt (2017) similarly argues that risk discourses, especially those that silence or even ignore the presence of pleasure in the lives of young people, lead to sexuality education that does not adequately meet their needs (p. 132). It is important to note that Shoshanna asserted that her teacher's fear-based tactics "worked," either meaning it scared her and her friends away from sexual activity, or that it encouraged regular condom use, and that Maria said her experience taught her when to walk away from a sexual encounter. While I don't intend to define what "worked" or what didn't, the students' feelings about their experiences do matter, while we also consider the long-term implications of messaging that associates sexual activity solely with fear and risk.

Further, Aissatou shared the harmful impact that repeated risk discourses had on her psyche:

> They're always talking about all these types of sickness and I get scared all these type of sickness, and sometimes I'll be doubting myself like do I have this sickness? but I'll sit back like I can't have this, I didn't do anything.

> It could just be genetics, you never know. My mom be like, "but I don't have it," that doesn't mean anything. Grandma could have it, you never know. My mom was like, "So you're telling me you're going to go to the hospital, waste your insurance for a test you know going to come back negative?" I was like, no no. I don't have it. What am I doing? I never knew you could die from asthma. I was like wait, you could die of asthma? So that kind of scared me because I have asthma and I could die. (7/26/19)

Aissatou demonstrates the fear of poor health that Fitzpatrick and Tinning (2014b) argue is an unintended consequence of risk discourses. Her anxiety about getting sick or diagnosed with a disease causes her to constantly monitor her body and is not an uncommon response among young people to health messages embedded with risky discourse (Burrows & Sinkinson, 2014). Aissatou's anxiety about her health begs the question: what role, if any, does her socialized identity as a young woman from a systematically marginalized community play in her health-related fears?

Finally, Abou asserted that these risk discourses about the worst-case scenarios of certain health behaviors are the cause of students' disinterest in health:

> I think I know why a lot of young people don't like to learn about health.... Because they always hear about the bad side of health. And this starts scaring them.... Because if you tell them the good side of health, always talking about that mostly, they ignore the bad stuff about it. (4/17/19)

Here, Abou lamented the common use of pathogenic approaches to health: pathogenic approaches involve "viewing health as the normal condition of human beings," consequently viewing disease and "risky" behaviors as things that deviate from idealized norms, or the standard on which health education is based (Quennerstedt & Öhman, 2014, p. 190). Pathogenic approaches in school-based health inevitably create risk discourses because students are encouraged to avoid risk factors for such diseases and choose lower risk behaviors (Quennerstedt & Öhman, 2014). Antonovsky (1987) argues that while preventing disease and poor health outcomes is important, it is not enough to understand health as a whole, and the exclusive concentration on risk factors stigmatizes people with diseased or at-risk labels, while ignoring the social, cultural, and societal aspects of health (Quennerstedt & Öhman, 2014). Abou added to this argument by

asserting that only learning about the negative consequences drives young people away from the study of health. Abou engaged in the dualistic notion of the "good" and "bad" sides of health while he challenged schools' focus on the "bad."

Shame. Leahy (2014) argues that, in addition to risk discourses, teachers typically use "affective intensities" like disgust and shame as pedagogical tools in the health classroom (p. 179):. She elaborates, "the risk of 'shame' is used to entice students to develop a raft of strategies to avoid the (shameful) consequences" (p. 176). Leah shared the following:

> I feel like health class for me was centered around sexual health. It was more than just like sex ed, I feel…. I remember my sex ed teacher like, "Oh my Gosh, you're having sex right now. You haven't had a test, and you're all disgusting." That stuck with me, I don't know why. She called us all disgusting for some odd reason.... I feel like our culture kind of shames. Our youth that are having sex and stuff like that, it kind of stops them from being honest about it.[2] (7/1/19)

While this is undoubtedly an extreme example, it reflects Leahy's (2014) findings that shame is used as a pedagogical tool in health education to ensure that students manage their health risks through moralistic assertions. Her teacher's use of the word "disgusting" is further problematized by her context: she teaches at a public school in a historically Black neighborhood that serves majority Black students. Would such behavior occur, seemingly without consequences, at a school with different demographics, with mostly White students, for example? Critical perspectives point to the differential treatment that is experienced by students at the intersections of race, class, and gender (Brah & Phoenix, 2009). Shame was a strategy employed by this particular teacher to uphold particular health behaviors; a common tool in neoliberal societies wherein "negative judgments are directed towards those who refuse to adopt active and healthy behaviors" (Rose, 2006, p. 25). This particular teacher's extreme strategy, when

[2]When asked if she would like to report this teacher, Leah stated that it wouldn't go anywhere: she had seen too much "corruption" over the years to believe that meaningful action would be taken.

viewed through critical race lenses, is exaggerated by racial inequities that are inevitably upheld by education policy (Ladson-Billings, 2009b).

Additionally, Ijeoma shared an experience from her middle school health class:

> I did health since eighth grade. I hated it. It was with Mr. J [pseudonym]. I love him, but I hated it so much. It was so awkward. It was so divided. It was the girls on the side and the guys over there. He was talking about sex and guys were making jokes, and then there was the girls were being laughed at when they talk about periods. And this is like, "I don't want to be there. I don't want to look at the picture of a vagina. I don't. I don't want to be there." (7/24/19)

The male students' targeting of the female students during discussions about menstruation created feelings of shame that made Ijeoma want to escape and avoid her body altogether. Indeed, there is evidence that teachers typically use dominant discourses that present menstruation as "a shameful, hygiene crisis that must be kept secret," and that positions girls as messy and dirty (Agnew & Gunn, 2019, p. 671). Maria also shared an unwelcome experience learning about the processes of the female body:

> Oh, when we had to watch loads of pregnancy videos where the baby is coming out, different positions, that was the worst. Because the baby could be popping out and the guys... I'm sorry, but that's life. People get like, "Oh my god. That's the circle of life." I did not feel that way. I feel like that was gross. That was not no harmony, all these angels coming around. No. That looks disgusting and everybody was like horrified, seeing all that. It was not beautiful. It wasn't. It taught me not to have babies right now because that was disgusting. (7/30/19)

In Ijeoma's case, she expressed shame as a result of being laughed at by the male students. In Maria's case, she expressed disgust as a result of the graphic nature of the childbirth videos she was exposed to in class. Fitzpatrick and Tinning (2014b) argue that neoliberal discourses of health, taken to extreme levels, can produce a "disembodying and dehumanizing" of the individual by either health providers or health educators, wherein the body is treated as entirely "separate from the self" (p. 8). Indeed, there is some evidence that women who report higher levels of shame about their bodies also demonstrate more negative attitudes towards their own reproductive functions (Johnston-

Robledo, Sheffield, Voigt, & Wilcox-Constantine, 2007). Maria's stated disgust with the process of childbirth is not uncommon among her age group, but her teacher's use of birth videos that produced "horrified" students—while it may be considered successful in mainstream discourse because it taught Maria "not to have babies"—points to broader questions about how health educators teach young people about their bodies, and the implications that these lessons have in young women's sense of themselves.

Finally, Bryant shared the shame that stems from being judged by peers for speaking out against the norm in a school-based health class:

> In school, it's not as welcoming, because some people come in there with their own expectations, and if you say something that differs from that, then they're going to start to judge you. Then you feel self-conscious, and that just goes back to impacting your social life. (7/1/19)

Bryant's experience with shame in disagreeing with the class norms points to the necessity of educators building relationships with and community among students, as Ladson-Billings (2009b) suggests especially in a health classroom, where topics are often sensitive and personal (Fitzpatrick, 2013, 2019).

What's missing? I would like to use this section to share specific students' opinions on what they felt was missing from their school-based health classes. Though I will elaborate on students' desires for future health education content in Chapter V, the following excerpts demonstrate significant gaps in students' experiences with school-based health:

> Bryant: It was garbage. What I learned in ninth grade, I learned again in twelfth grade. Then, I was just ... stuck, because I just felt like it was, everything was redundant. They weren't covering all the kind of aspects of health. They definitely skipped over mental health, and they described it as something like ... It was just like a side issue. Like physical health, sexual health was the big one, and there was always promoting abstinence. It wasn't ever telling you about your different options. They would tell you about birth control for females, but it would never specify anything. It would kind of just want you to go out there and figure it out for yourself. "Here's a contraceptive, a female condom." Have you ever used a

female condom? I haven't, because I don't know how it works. It's confusing to me. (7/1/19)

Jupiter: High school, it was more so about drugs and sex. We didn't really focus on mental education, like mental health. The majority of times it was about drugs and sex. We did one class with practicing CPR, but that was about it. And everybody didn't even practice on the doll. She just told us what to do in case this has happens. It's not like I'm going to forget that. But we had different books about types of drugs. I learned more about K2, acid, LSD then I did about depression, anxiety, bipolar disorders and other things we really do struggle with. I think it could be better. (8/1/19)

Mia: In that health class we talked about sex education, we talked about just like food and stuff like that. That's pretty much all I remember from health class. We didn't really talk about mental health at all. (5/14/19)

Kimberly: Actually, I recently, a couple of months ago, my last semester of senior year, I had to write a letter to a representative. And I forgot who I wrote to, but I actually wrote about health education in public schools and how it doesn't cover people with different sexual preferences other than being straight.... So I thought that was a big thing, because when you're learning about health, well when I ... at least when I learned about health in my school it only covered man to woman. I mean actually, I think it did cover if you were, if you were gay or lesbian, but I don't, it wasn't memorable. So it was, I don't think it was covered enough for me to remember it; or any other students to remember it. So I think that's what it lacked…. I [also] said the teachers that are being hired to teach help that because a lot of the times health teachers are gym teachers, and yeah, some gym teachers are qualified to teach health but a lot of them are not qualified. (4/15/19)

Zione: They don't tell about any type of same-sex relationships or anything like that. People who are in the LGBT community think that there's something wrong with them, or they don't talk about. I remember in high school, we talked about that once. I think somebody was like, "why don't they have girl and girl, or boy and boy, or whatever?" People in the class were like, "Ew, because they don't need to put that in there." I think if it was in the textbooks and things like that it would be more normalized, or if it was taught, it would be more normalized. (6/5/19)

Kimberly's and Zione's statements are significant: the exclusion of LGBTQ individuals and lifestyles in school curricula is not uncommon. Fitzpatrick (2013) asserts

that schools are charged with aiding the development of their students' sexualities. If that is the case, then the intentional or unintentional omission of LGBTQ identities in school curricula is a part of our cultural desire to "bring up our children with the expectation that they will be heterosexual and will feel at home in the bodies into which they are born" (Gilbert, 2014, p. 6). Gilbert has also suggested that the public discourse about bullying that targets LGBTQ students may be seen as an effect of the lack of positive discussions about being gay that students are allowed to have with adults in their schools. As seen in Kimberly's and Zione's excerpts, with Kimberly even going to the length to write a letter to her representative about it, students in this study indeed expressed disappointment about this missing discourse.

These five students all attended different public high schools, except for Makayla and Zione, who attended the same one. They all identified significant gaps in their experiences learning about mental health, and inclusivity around a variety of sexual orientations. Students' imaginings regarding health content for the future will be included in the next chapter.

This section focused on the ways that students in this study experience and navigate school-based health. The next section will address their navigation of health through the use of a variety of social supports in their environment.

Community

> That's the main thing: support, and lack of judgment, I guess. For you not to be controlled, so your parents always telling you, "Do this, don't do that. You should do this. You should be that." I think that being healthy is like being yourself, being able to be yourself in the community that you're in, nobody trying to force you to change. (Zione, 6/5/19)

This section further continues the exploration of students' navigation of health through their community, organized into the following categories: peers, parents and families, and environment.

Peers. Three ways that students in this study navigate their health through their peer community are by offering their peers support, building communities of care, and resisting "healthy" visibility.

Offering peer support. One of the ways students in this study navigate their health through their community is through their relationships with their peers. Critical scholars have observed that the commodification of education in general has prioritized the needs of students who fit Eurocentric norms, while pushing others to the margins (Azzarito, Macdonald et al., 2017). Some scholars have argued that the current iteration of neoliberalism is difficult for young women in particular (Gill, 2008; Leistyna, Woodrum, & Sherblom, 1996), while others have demonstrated the ways education has failed to integrate meaningful diversity and inclusion (Ladson-Billings, 2009b; Taylor et al., 2009). Dagkas (2014) argues that the neoliberal health discourses and policies of Western culture ultimately "[have] an othering effect for those outside the norm," for those individuals who do not engage, or appear not to engage, in health behaviors that are deemed acceptable to mainstream expectations (p. 76). We see some of these discourses play out in some students' descriptions of the way they support their friends in maintaining certain health habits. Shirley shares the following about her friends:

> I think they all take pretty good care of themselves. Yeah. They're really responsible human beings…. They care about themselves. They don't harm themselves in any other way physically or mentally. I mean, yeah, they can get a lot of pressure on themselves. They put a lot of pressure on themselves, but a little bit of pressure is good sometimes. They value their presence. I don't know. Let's say they take on advice that you give them. Like let's say one of my friends has depression and I tell them you should seek out help or, yeah, something like that and they actually listen. Not listen like, "Yeah, I'll do it," but they actually consider what you're saying and stuff, they don't just ignore it. (5/1/19)

Shirley identifies the pressure that her friends find themselves under, but labels it as "good" pressure, perhaps because of the way she states that they "value" themselves. This is significant in light of Lee and Soon-Mook's (2014) finding that global neoliberal

ideologies may be related to the rising incidences of poor mental health among young people, as they experience increased pressure to succeed in school in order to keep up with international academic rankings. Shirley mentions depression, but doesn't mention it in relation to the pressure her friends feel. She mentions it as a normal process of life, without stigma. Is this as a result of young people's increasing pressure to succeed, the burdens that are accompanied by her friends' racialized, classed, and gendered experiences, some combination of the two, or simply the universal pressure of growing up? It's unclear; what's clear, though, is the support that Shirley is willing and eager to provide when her friends endure ill-health, and the receptiveness with which she says her friends respond.

Ijeoma takes Shirley's ideas slightly further, calling herself the "police" among her friends:

> Some of my friends they don't really care about what they eat. I mean, eat whatever you want. Go crazy. But I think they have to be more aware of the things you put into your body. I feel like I'm always the police among my friends to like, "Oh, let's go to the gym. Let's go work out. Let's eat this. Don't eat that." You know what I mean? But it's like just some are more cautious of the things they do to their body than others. (7/24/19)

Her label of herself as the police of her friends reminds me of Foucault's (1980) assertion that "the 'police' of the social body must ensure [the health of populations]" as a "political objective" (p. 171). Ijeoma does not take any structural or environmental barriers into account when she describes her friends as not caring. She doesn't take their choices personally ("eat whatever you want"), but she does see herself as playing a role in their decision-making. Andrew does the same for his friends:

> I try to make my friends better. Make them eat better, stop going to McDonald's every time that it's close. Keep them out of the violence. So we play, initially, play video games with me in a house, so they won't be able to go outside and stuff. We talk about stuff. They're friendly and they communicate. (7/25/19)

The language of making his friends “better” is reflective of the “good” or “bad” categorizations that result from decision-making around health cited by Dagkas (2014) above. Sharon similarly expresses the way she supports her friends’ healthy lifestyles below:

> So when I would tell my friends about like, "Make sure you're using a condom during oral sex," they were like, they would laugh and be like, "Oh well, I'm not going to use a condom during oral sex". I was like, "B---, what the f---? Eww, that's gross that you're not going to use that." And they were like, "Oh, what about my boyfriend?" I know if you're monogamous and you have a boyfriend and you've been dating for a long long time, I mean I guess that's better than just meeting a stranger and not using a condom.
>
> But they were like, "Oh, it doesn't feel good. It doesn't feel the same." And I'm like, "I feel like it feels the same. How will it feel different?" Yeah it'll feel different, but I really don't feel it's such a big difference, I think it's just that people say it and then they're like, "Oh yeah, I feel the difference." … I don't know what it is. I remember hearing that I was like, yikes. Or they just don't know so many things and I didn't know it was that bad. Like I knew it was bad, but when you see it with your friends, they're like, "Oh my God, it's bad." Like oh my God, it just showed me that when I go to college I'm going to have to educate a lot of people. (4/12/19)

Sharon’s “yikes … it’s bad” demonstrates her anxiety over the lack of information her current and, potentially future, friends have about maintaining healthy sexual habits, and the role she feels she has to play in educating “a lot of people.”

There’s tension here: Fitzpatrick and Tinning (2014b) argue that neoliberal health discourses “employ moral imperatives to enable people to self-monitor,” encouraging the upholding of health behaviors that rely on an individual’s ability to manage themselves (p. 1). Dagkas (2014) has asserted that this expectation of the individual maintenance of health produces negative judgments toward those who do not adopt healthy behaviors, regardless of their reasons for it, and Azzarito, Macdonald, and colleagues (2017) suggest that the structural limitations imposed upon marginalized racial and ethnic groups “restrict the individual’s capability to make the ‘right’ choice” (p. 209), leading individuals to blame themselves and the people around them for their choices. In the

above excerpts, though, the students do not use language that communicates stress over their friends' choices; instead, they present themselves as the caring supporters of their friends, who, in Shirley's case, give them advice for their mental health; in Ijeoma's case, encourage them to work out and be aware of what they're eating; in Andrew's case, keep them out of violence; and in Sharon's case, educate them. In many ways, they're building the "communities of care" that adrienne maree brown (2019a) suggests can be understood as cultivating resilience and even part of a political struggle (p. 59).

At the same time, the potential for and regular exposure to violence are highly influenced by Andrew and his friends' classed and racialized, even gendered position: only two people in this study mentioned violence, and both were male. The need to stay in the house in order to avoid violence is not a need that students in suburban areas, or even wealthy neighborhoods elsewhere in New York City, experience. Therefore, his and his friends' choices are influenced by structural and environmental barriers that are a direct result of racism in governmentality, specifically in housing policies and zoning. His language, though, does not clearly demonstrate the "othering" effect that implicit cultural assumptions about making the "right choices" might have (Azzarito, Macdonald et al., 2017). Kimberly, on the other hand, explicitly recognizes the structural barriers she and her friends face:

> So I'd say some of my friends don't have the best eating habits. So yeah. Yeah, they eat poorly. Very poorly. Because there's a bunch of food from outside, like fast food. And just, I don't know. I mean, it makes sense. I mean, I go through this too because I try to save money. So you eat poorly to save money, you know. Because healthier food is more expensive. So I guess it's easier to make the decision, to go to McDonald's rather than, than to go to like Sweetgreen or something. (4/15/19)

Here, Kimberly does not explicitly blame her or her friends for their habits, as McRobbie (2007) suggests happens when the "right" choice cannot be achieved, but she acknowledges that it is just easier for her and her friends to "make the decision" to "eat poorly" when the healthier option feels out of reach. Azzarito, Macdonald, and

colleagues (2017) suggest that for students with a marginalized racial and classed status, prevailing notions of "appropriate" health behaviors, including food selection, are not a “choice” available to them at all (p. 208).

Communities of care. In the last section, I cited adrienne maree brown’s (2019a) conception of building communities of care, which can be understood as an act of resistance to oppression and of cultivating resilience (p. 59). She defines communities of care as a shift “from individual transactions for self-care to collective transformation,” a way to “be in family with each other—offer the love and care we can, receive the love and care we need” (p. 63). She states that the building of such communities is one way to overcome a “deeper socialization:” “one that tells us that most of us don’t matter—our health, our votes, our work, our safety, our families, our lives don’t matter—not as much as those of white men” (p. 59). Students’ responses in the previous section demonstrate small ways that they already contribute to the love and care of their friendships. Two students, Ijeoma and Patricia, build on these ideas further by citing their communities of chosen friends as sources of support in their experiences of health, and in life, in the excerpts below:

Ijeoma: It’s just people that make my community. It’s a very healthy community because I have people that I trust…. It’s just people that I can always vent to. And then they can vent to me as I will always be there for people that I have chosen and care for. They're always there to listen. When I need to do something they always want to do things with me. They help me up and I help them up. That's the vibe, very happy around each other. (7/24/19)

Patricia: I would say at school, that's my healthy community. Everything around me is good vibes besides the papers that I have to write. Everybody around me is good vibes although sometimes I stress, whatever is around me de-stresses me. I wouldn't say that I created it, but I can say I contributed to it. Everybody around me is just like me, is looking to be not stressed. I feel like we all come together, that's where it's created. So not just like one person by themself. Honestly I like that I have a good number of Black people around me so … I did go to PWI so it's not like me and like five other Black kids; there's like a handful, so it doesn't make me

> feel that I'm at PWI. So, I feel like it makes me feel comfortable. (7/29/19)

Both Ijeoma and Patricia cite the communities they have chosen and/or contributed to as sources of support in the alleviation of stress. Patricia specifically cites how supportive cultivating a community of Black friends in a PWI (predominantly White institution) has been—there is indeed evidence that a higher level of identification with one's racial or ethnic background, through seeking social support from one's same racial or ethnic group, for example, may protect against poor mental health (Mossakowski; 2003), especially in a predominantly White educational institution (Datnow & Cooper, 2009). Yosso (2005) defines "navigational capital" as the skills required to navigate social institutions –like higher educational institutions, for example—that were not created "with Communities of Color in mind" (p. 80); Patricia demonstrates this capital here by intentionally seeking out other Black peers who make her feel comfortable and help alleviate stress.

I agree with Macdonald and colleagues (2012) that marginalization takes place in our neoliberal society now more than ever, and I think it is similarly important to highlight these students' resilient responses to their experiences: their chosen communities lift them up, and that's what they choose to focus and lean on.

Resisting "healthy" visibility. Dagkas (2014), citing the work of Ansley (1997) and Gillborn (2005), writes that "whiteness is a political, economic, and cultural system in which one race (white) overwhelmingly controls power and material resources" (p. 81). One of the systems that Whiteness has control over, as we have seen, is the mainstream discourse of health, where White identities are normalized as healthy through repeated acts of "reinforcement and reiteration" (Azzarito, Macdonald et al., 2017, p. 211). Recent research (Cameron, Muldrow, Faylola, & Whitney, 2018), in addition to public discourse (for example, Aiken, 2018; Wu, 2015), suggests that for some members of non-White groups, this upholding of White bodies as the epitome of healthiness, while

simultaneously maintaining racialized and classed limits of accessibility to quality unbiased healthcare and health behaviors, has produced a (reasonable) resistance: dominant discourses of health and White norms are oppressive and unsupportive, and therefore some individuals are not interested in engaging. This is reminiscent of Foucault's assertion that individuals in part create their subjectivities in response to forms of domination and exploitation (Foucault, 2000, p. 331). Hokowhitu (2014) applies this concept to discourses of health, arguing that individuals who are objectified by White standards or expectations, create a sense of self partially through their resistance (Hokowhitu, 2014). There is evidence of this taking place in the academic sphere, wherein some Black students are labeled as "acting White" when they pursue normalized forms of academic achievement (e.g., Tyson, Darity, & Castellino, 2005), and the following excerpt from Samira lends the question as to how much this happens with regards to health:

> If I'm going to bring a big water bottle to school, I see people with the gallons and they drink that in a day. If I were to do that, I know there'd be a lot of, "Okay, water girl." There's this girl in my class, they call her water girl because ... I don't know, I feel like when you want to be healthy, you can never ... People always say something about you. So what if you live the way you want to live? Like if you wanted to eat plants the rest of your life, you might as well because people are going to say something. If you want to eat meat the rest of your life, people will say something…. And it's like, people don't value themselves. They like to put the shame on you for being ... For example if I were to go out get a salad they would look at me like, "Oh, who do you think you are," but no, I just want to be healthy. (4/10/19)

Samira attempts to navigate her desires to engage in behaviors she deems healthy while resisting the visibility that comes with it. She wants to engage in specific behaviors, but she doesn't want to be noticed, or worse, shamed for it. Her rejection to her classmates' potential judgment leads her to create her own judgment that those who place those labels on others don't "value themselves." Hokowhitu (2014) uses Foucault (2003) to assert that "insurrections of knowledge can be viewed as intelligence that propagates resistance through bodies to produce dissenting subjectivities" (p. 41). In other words, bodies that

have been systematically oppressed, through imperialism, colonization or enslavement, for example –deemed "hierarchically inferior" (Foucault, 2003, p. 7)—may resist mainstream discourses that are presented objectively as "knowledge" (Hokowhitu, 2014). Applying these ideas to this example, Samira's classmates might resist institutional expectations of drinking water and eating salad as a form of rebellion to being objectified as "risky," while not being given the same access to low-risk behaviors as others.

Steele (2009) writes the following about academic achievement:

> To sustain school success one must be identified with school achievement in the sense of its being a part of one's self-definition, a personal identity to which one is self-evaluatively accountable. This accountability—that good self-feelings depend in some part on good achievement—translates into sustained achievement motivation. For such an identification to form, this reasoning continues, one must perceive good prospects in the domain, that is, that one has the interests, skills, resources, and opportunities to prosper there. (p. 164)

Here, he explores the complicated relationship with school achievement that women and African American students appear to have, which is largely affected by the negative stereotypes that exist about these groups in academic institutions as a result of historical and contemporary forms of systemic exclusion. Samira's lamentation of the hyper-visibility that comes with engaging in health behaviors, coupled with the public resistance to White expectations and definitions of healthiness, points to the larger questions within this study: do similar tensions in the relationship to health occur for non-White, lower-income students as they occur for some in these groups with academic achievement? Are mainstream discourses of Whiteness as idealized versions of health detrimental to the public health goals that are proclaimed as priorities by White-led social institutions, when not accompanied by the conditions that promote good health as accessible for all people? These questions can't be answered by students' responses in this study, but Samira's story suggests that tension exists for some youth—tension that Hokowhitu (2014) asserts is a result of resistance to colonization and ongoing systemic

oppression, and that shows up in response to "the stranglehold healthism maintains over the body" (p. 40).

Parents and families. Another way that youth in this study navigate health is through their parents and families: health lessons at home, parental and familial role models, learning from their health issues, and navigating differing values. Yosso (2005) identifies "familial capital" as one aspect of the "cultural wealth" that Communities of Color have access to: this refers to the "cultural knowledges" fostered among family that extend beyond assumptions of the nuclear family and include a commitment to the welfare of one's entire community (p. 79). This section begins with the understanding that mainstream stereotypes of Black families stem from our historical and contemporary forms of colonization and slavery, wherein the humanity of members of the Black community's sense of self and family was and is repeatedly undermined in order to justify racist governmentality (e.g., Gardner, 1994; Roberts, 2012). This undermining of self and family has been applied to Immigrant Families of Color as well, and continues to pervade public discourse (Burns & Gimpel, 2013; Souto-Manning, 2007): "deficit thinking" regarding Communities of Color in education blames students and families for poor academic performance because it is assumed that parents do not care about or support their child's education (Yosso, 2005, p. 75). This section explores how this deficit thinking shows up with regard to students' health, and provides stories from students that are counter to such prejudicial discourses, instead representing their families as integral sources of support in defining and maintaining their health, as well as places where differences in values occur.

Health lessons at home. A number of students expressed receiving explicit health directives at home from their parents. While Lupton (2014) problematizes the pressures that neoliberal health discourses put on parents—especially moms—to attend to their children's health, many students used language that suggests they perceive their parents' health lessons as supportive. Zadie shared,

> Had it not been for my parents, my parents work out all the time. I don't know why I don't work out more. But had it not been for them, I wouldn't have worked out at all. Like I just recently stopped working out but before I would do it all the time and I used to ride and I used to, like, roller blades and like I used to ride my scooter to school. Like you saw me coming to [program] with my scooter. And that was because of my parents. (4/22/19)

Zadie questions her current exercise habits, but cites her parents' habits as the reason why she got any exercise to begin with. They used alternative transportation methods like riding scooters and roller blades to school to be active as a family.

Lupton (2014) writes that there has been an increased emphasis placed on mothers, specifically, to take responsibility for their children's health. Several students identified their moms, specifically, as where they got their health lessons from: Andrew, for example, shared the following, when asked who he learned the most about health from:

> Mom. My mom. She wanted me to go on a diet when I was a kid, but I was like, I didn't like, I used to throw up every time I ate salad. I can't do it. I still can't. So she was the only one that made other alternatives besides salad. So she cut my soda out, so I can't drink; I haven't drank soda since I was 8. So she cut the soda out and that made me lose a lot of weight too, and she also made me stop drinking juice, but she said I couldn't drink water all the time, so I went back to juice. So she helped me. (7/25/19)

Andrew is the same student who previously stated that he engages in healthy behaviors like exercise because he was "fat as a kid" (7/25/19) and he shared here that his mom was, and still is, committed to his health—she was the "only one" who took time to prepare alternatives to salad, and to help him cut down on soda and juice. He expressed this in a positive light—that she helped him, and that he was proud of the fact that he hadn't had soda "since [he] was 8" (7/25/19).

Leah also shared that her mom gave her health directives about her diet: "My mom was like … she used to tell me, 'You're going to die young because you don't eat your vegetables'" (7/1/19). Lupton (2014) provides evidence from mothers about the pressure that comes from "reproductive citizenship" (Salmon, 2011), wherein the ideal mother is one who puts her children's health above her own, and who closely attends to her children's bodies in order to keep them healthy (Lupton, 2014, p. 48). Discourses of

health risk and personal responsibility ultimately put mothers in a position where their child's poor health is reflected on their ability to mother, especially in the context of the "childhood obesity epidemic" (Lupton, 2014; Tanner, Maher, & Fraser, 2013). Garcia and Guerra (2004) write that deficit thinking about Communities of Color pervades public thought: There is indeed a wealth of research that implicates mothers in their child's health—weight, specifically—especially mothers in racially marginalized communities (e.g., Augustine, Prickett, & Kimbro, 2017; Phillips, Comeau, Pisa, Stein, & Norris, 2016). These data often find themselves in the public discourse (e.g., Fountain, 2017). Shining a light on these limited viewpoints with a critical race feminist lens directly challenges the mainstream assumptions that mothers in Communities of Color are to blame. It is unclear from these students' comments whether their mothers felt pressure to reach ideals of motherhood; paying attention to their child's diet can also be interpreted as care and support. Both Andrew and Leah expressed their mom's attention to their food intake as supportive; Leah described her mom's comments as helping her learn, because before then, "I didn't really internalize the fact that what you do when you're young matters" (7/1/19).

In a different context, Kimberly shared fond memories of her mom helping her understand her bodily autonomy:

> I know that when I was a child she used to shower me…. Yeah, my mom used to bathe me. And then growing up she wanted, she stopped so that I could do it myself, but I remember her always telling me, "Take care of your body." Every time she would shower me, she was like, she reminded me that my body was my own. That I always have to take care of it. It's actually really funny that that [memory] came up. But yeah, I just hear her in my head. She'd say, "This is your body, this is your temple. You have to take care of it and don't let people disrespect it." And she used to tell me that when I started showering, bathing myself, so that's when I was like six, seven, so I don't know, I was pretty young. (4/15/19)

Here, Kimberly's mom exhibits recently popularized methods to teach their children consent (e.g., Girl Scouts of the United States of America, 2019; Stevens, 2019) in an

attempt to teach children, especially young women, that they have the right to their own bodies. Hokowhitu (2014) describes parents' health edicts through a critical lens: individuals willingly adhering to the language of healthism in producing their and their children's healthy bodies. This may be true; the students, however, used language that demonstrated appreciation for their parents' lessons. Bryant even took some of his health lessons home, to his dad:

> I've learned how to take care of myself physically. Like, I'm always encouraging my dad to do some of the things that you've taught me. I'm still doing those things right now and living by a lot of those things. (7/1/19)

Mia similarly shared that she's learned the most about health from:

> My family, because I think that we're all learning together … being here, I learn different things about health, and that kind of gives me the opportunity to have conversations at home. It's kind of bringing two worlds together. (5/4/19)

Several of the students in this study shared their experiences learning about health at home, and sharing their own learning with their families, through lenses of support. These stories may be read through a critical lens, as Hokowhitu (2014) does, or they can be understood as stories that stand in direct contrast to mainstream deficit discourses that situate families as at fault for their children's poor health, especially among Communities of Color.

Parental and familial role models. Other students looked to their parents and families as models for understanding and defining their health. For example, when asked about the healthiest person she knows, Jupiter proudly identified her mom and proceeded to tell the following story:

> I've seen that she's gone through so much. And then now, she's more putting herself first, and doing what she wants, and doing things that'll make her happy. So she had a career recently that had her working with a boss that wasn't really good for her, mentally and physically. And then she changed her career and started working in Florida with the ex that she really loves, and now she's a lot happier, enjoying herself. She calls me. When she calls

> back, it sounds like she's a lot happier and our conversations are longer, about like what she's doing.
>
> I think [she got this way by] listening to people around her. So we see that her boss wasn't good for her. So we would say like, "Oh, you should put yourself forward and do things that would better yourself instead of staying around negative energy." It's also just being around family, we see it's not good. So she knows what's best to work with…. Her side of the family, there's just a lot of negative energy. To say it in the nicest way, we cut them off, because it's not worth the disrespect. So we just focus on people who have positive influences. (8/1/19)

Jupiter expresses nothing but happiness and support for her mom's improved well-being. The "we" that she refers to in supporting her mom's choices include her aunt and her dad, two other family members that she feels a close connection to. She shared stories about her mom with a big smile on her face, and happily identified her as a role model in taking care of herself, as someone who helps her "focus on people who have positive influences" despite the negativity that might exist elsewhere. To Jupiter, her mom's shift from a career that drained her to one that she loves exemplifies health. Jupiter later identified her aunt as someone who has taught her the most about health:

> I've seen how much my aunt has grown, and I think I have one of the closest relationships with her. So, she tells me everything. Like how she struggled with depression and anxiety and went through some really dark times. She started talking to a therapist, started being more open and being true to her true self instead of hiding and being what people expect her to be and being what like people want her to be. She started focusing on herself and moved away for a few years, came back a lot happier and started following a career that she really wanted. Started being around people that she liked more instead of just trying to live up to her mom's expectations. (8/1/19)

Jupiter's aunt is yet another source of support for her, as a role model who experienced hardship and pursued her mental and occupational well-being in response to it. While Jupiter uses language of personal responsibility in both descriptions of her mom's and aunt's response to health challenges, her admiration of them and closeness to them suggest that their family's closeness is a protective factor from individualistic discourses

for all of them. Makayla similarly learned to define health for herself through lessons from her mom, aunts, and grandpa:

> I think [we learn from] everyone in life, because everyone has different points and perspectives. Because for example my aunt, she sees it as, being healthy like that, media shows certain things you got to be healthy with. And then you got school, is talking to you about health stuff. And then also my mom too and family, other family members. Because I saw one of my other aunts who lives in New Jersey, she's losing weight but she's still eating what she wants, but she's eating in a proportion size to the point where she still eats it, but it's like in a proportional size. So that's how she's losing weight. So, obviously you'd still eat what you want. You just got to make sure certain things have to be on your plate and portion it right.
>
> And my mom always says also too like, sometimes it's not even about like how you eat stuff and like what you want to eat. Sometimes it's just like you just want to live your life the way you want to. So, it's like you just eat it that way. And sometimes healthy people can pass away young too. So, it's like sometimes I just want to eat right to the fullest. Because I mean my grandfather, he doesn't eat the best, but he's 90 still walking and he's survived three strokes. So, it's like he's still doing what he's doing. So, I think it's more like, making sure that you have the life you deserve, but also make sure those healthy relationships with other people. Because I feel like love also helps you prosper, and environment too. (6/12/19)

Makayla identifies the combination of complex health messages at play in the public pedagogy (Giroux, 1998), in school, and with her family, and how she navigates those to make health decisions for herself. Rich (2012) warns about the potential unintended consequences of health surveillance that extend beyond school to the family as another site of learning, but Makayla looks to the balanced messages of her mom and aunts in order to “have the life [she] deserve[s].” She also looks to “love” and “environment” to help her “prosper,” which is echoed by brown’s (2019a) ideas cited earlier, wherein love and care for self and others can foster resilience (p. 59).

In another light, Viv also looked to her mom as a source of support, and as the reason she maintains health behaviors:

> I feel like I'm a good girl. I love my mom, she expects so much from me. Mostly coming from... She's an immigrant, so I feel like I just can't let her down, that's just so dirty. Why would she travel, having such a hard

> experience for me to just come, go to the school and smoke. It just doesn't add up, and I feel like I just don't know why someone would do it. But yeah, I just don't support it. (5/22/19)

Viv's use of the term "good girl" and intentional distancing from being "dirty" are reminiscent of Quarmby and Dagkas's (2013) assertion that neoliberal health discourses create categories of "good" and "bad." It also exemplifies the pressure that being the child of an immigrant can create among some youth, especially as it relates to the gendered identities of young women (Hartmann, Rivadeneyra, & Toro-Morn, 2016; Toro-Morn, 2007). In Viv's case, the expectations of her mom, her love for her mom, and her knowledge of her mom's hardships are supportive to her in this moment—are what keep her from smoking, for example.

Fernando identified the emotional support of his mother as the context in which he learned to take care of himself. He shared:

> My mother… Well, she wasn't always like super open…. But then later on, when I started getting older, we would always talk. So if I ever need to talk to somebody about how I'm feeling, I just talk to her. Or, she would always talk to us about how we feel, how we should talk to her, and like talk to us about like physical health and staying safe in certain situations. Everything, you know. You know, the first person you meet is your parents. They already know so much more than you do. Most of the time. Sometimes they're not going to say that as a general statement, because there's certain situations.
>
> But in my situation, she's been through stuff. Health issues and stuff. I've seen her taking care of herself physically. And then I've also seen her take care of herself mentally. Like when she was becoming, like, who she is now, because before she was like so much more different. And now she's open. I don't know. So, I feel like I've always just seen it, taking care of yourself…. So, whenever. If I'm feeling a lot of things, I do talk to her. And then I'll always feel better because then I'll also probably cry about it. Because I just so comfortable in front of her, you know? (7/26/19)

Fernando's relationship with his mom allows him to openly express himself, even deconstructing gendered norms by sharing that crying with his mom "always" makes him feel better. His experiences watching her "go through stuff" also point to another

discourse that arose in several interviews, wherein several students expressed learning from their parents' or families' health issues.

Learning from health issues. Many students in this study cited learning from their parents about health, specifically due to their parents' health issues. For example, when asked from whom she's learned the most about health from, Destiny shared the following:

> I would say my parents. 'cause I feel like they've been through more with their health than I've ever been. I've never been in the hospital, I've never had to go to the hospital for just a day or a checkup or anything. So I would feel like they've showed me more, 'cause they taught me how to keep myself healthy, how to maintain my health the way I am now. Especially my dad… He used to have a bunch of junk food, like cookies, Oreos, all that stuff. So, I think the kidney stones kind of scared him a little bit to stop eating all that stuff, but I think that's what it was. It was the stones. 'cause he would drink soda at least five times a week. So that's, imagine what happened. I don't know. I'm actually glad that he got scared like that because he had been trying to cut it down like that for a while now but, I think he's starting to learn from that now. (7/25/19)

Samira shared,

> My dad, he has diabetes so I help him. When I see him eating something I'm like, "Dad, remember your diet?" Because he's on this imaginary diet. And it also reminds him to eat better. He doesn't eat bad, but when he's having too much rice I tell him to stop, so I can stop too. I stop myself, I don't really eat rice. (4/10/19)

Andrew shared that he learned from his mom in the excerpt above, as well as his from own health concerns, and those of his father:

> When the doctor, she said that if I keep eating like this, I will be, have diabetes or overweight. Yeah, so I push myself to be better and try to be fit because diabetes runs on both sides of my family. Yeah, so I wasn't trying to catch it. Got my father, he knows. Yeah, because my whole life all he's been doing is drinking a liter of Coca Cola every day. One liter. If he's not, then a 16 ounce. That was bad. I watched that since… He just got it now. So I watched that since I was, like, six and he just got it. And I was a little, just a little late, but, like, all right. We told him to stop. He doesn't listen. Now he can't drink it no more. (7/25/19)

Finally, Maria shared that she learned the most from her sister's challenges with mental health:

> I want to say my sister, my older sister. Because she's depressed and everything, but when I see her she has her moments. She has her ups and downs where she just wants to be in bed and everything. She don't feel like she could conquer the world, where I always saw her as, "she could conquer the world and she's amazing. Look at all of the things she done." I feel like she's healthy. Even though her mind is out of whack, I think that she takes care of herself. I think she tries. even though my mom.... Before she didn't understand it and she thought she was being lazy. I see how hard she's trying to get up out of bed every morning, or when she deals with a problem, I could see the hurt she's in. I remember where she felt really low and she lost her apartment and she lost her job, and she felt worthless because she was in her prime and she was like, "Now I'm back in the projects," living with her mom and she's old. And she's like, "Wow." She had everything, now she's back to her old state.… And I see her, she's trying to be more like herself again. She's trying to be in her prime, but her downfall, she's still trying every day to wake up and be happy. (7/30/19)

Maria recognizes the impact that social class has on her sister's subjectivity (O'Flynn, 2010): she feels "worthless" for being "back in the projects," with her mom now that she's "old." Maria refers to her sister's "prime" as being out of the projects, with her own apartment, and her own job. Her language implies that her worthiness and sense of self is heavily related to her independence and her ability to make it on her own—this is reflective of neoliberal discourses that urge personal responsibility and the self as a constant project. Still, Maria acknowledges the real challenges her sister faces while admiring her willingness to keep trying to be "herself" and to "wake up and be happy."

These stories of students seeing family members who are important to them experience health concerns provide counter-narratives to recent literature targeting the familial beliefs and habits of "at-risk" communities in order to inform health promotion activities (e.g., Phillips et al., 2016), and allow students to share stories of how their family's health scares have supported their understanding of health.

Differing values. Of course, I do not intend to idealize or romanticize students' experiences. Like many adolescents, Ijeoma, Samira, and Abou expressed some similar

and some differing values from their parents with regards to their health, which influenced what they felt able to talk about at home. First, Ijeoma shared that while she's grateful for her family's values with regards to nutrition, she disagrees with them when it comes to mental health:

> In my family, I'm the only one who really takes care of my mental health. Because in the African culture that's not really a thing. I don't know how to explain it but it's ... I don't know. But mental health is not a thing in African culture. It's just not. I don't know. Personally, my mom and my dad usually just keep everything on the low and just deal with it whenever they're ready. Or they'll just be like, "Oh, it's God's plan." Any problem is God's plan. I feel like I've been—on that part—Americanized. That's the word. Because I really didn't really look at it as an issue if I wasn't in the space that exposed me to mental health issues, and I'm talking about [this program] specifically.
>
> So now I know when I need to check in with myself, a thing I never seen my mom do that because she's like, "I'm that strong. I can do it," whatever. Yeah. Verses me I'm like I need to break it down before I just lose it. My mom is just like, "Nope, just keep it to myself crying the entire...." My mom cries … I think it's a lot. And I could tell.... And then my dad also like.... It's so easy to tell when someone is just not mentally healthy, but it just makes you smile off, like break yourself. But then me, I just check in with myself, and I've learned how to do that. (7/24/19)

Ijeoma stated that she's been "Americanized" because of her beliefs about mental health and her self-awareness around checking in with herself. While she expressed gratitude for so many aspects of her family's connection to her home country, this is one area where she feels she differs from her parents, and where she feels she benefited from other resources. There appears to be a magnifying glass in the research on African American families and their use of mental health services, most of which employ "at-risk" discourse—which I do not intend to add to—and little academic research on the differing opinions of African parents and their children on mental health, as Ijeoma explicitly pointed to. Samira also pointed to cultural differences as playing a role in her relationship with her family about health:

> Oh at home, I feel like depending on the parent, you don't always get to talk about health. I honestly don't want to talk to my parents about health…. I mean I don't feel comfortable, because it's truly awkward. I wish I could not feel awkward talking about health, but to me it's really awkward. Even at the doctor's office when they tell us, ask us questions, my mom's like, "Oh, what did they say?" So at home it … I mean it doesn't really get brought up unless it has to. Just thinking about, I don't know why it's so awkward. It's just the culture.... I know a lot of parents, my friends' parents, their parents come and talk about, "You're going to learn this and that from me." And I was actually reading something where, they were talking about it on a talk show where parents pay different people like hundreds of dollars to come and talk to their kids about the birds and bees stuff, and it was so funny. But there was a big, whether that should be allowed, I mean whether that's a good thing or not. And I thought about my parents and how I would love for someone else to come talk to me about that.
>
> But my parents, whenever they want to talk about it, I tell them, "You don't have to because we learned about it at school." I can use that as a way to not get them to talk about it. I don't want to talk about it with them. I'd rather talk about it amongst friends and teachers, because it's really uncomfortable. I guess it has a lot to do with whether you're comfortable with your parents or not. I'm comfortable with my parents, I love them, but I can't talk to them about it. (4/10/19)

Samira seems to be referring to the "birds and the bees" when discussing whether she can talk to her parents about health, and isn't comfortable with that because "it's the culture"—her parents are not from the U.S. This may be the topic where her values differ from theirs, though she expresses feeling "awkward" talking to them about health in general.

Finally, Abou shared that he learned a lot about health from his mom—"I used to go to sleep with pimples, and then [she] blessed me with that soap"—but has conflicts with his extended family about his long hair: "They'll say, 'This is the devil's haircut,' I guess. Then they'll try to make me just bald (4/17/19)"

I present a deeper analysis on students' perceptions of the impact of American culture on their navigation of health in a later section. This section presented a variety of ways that students navigate their health through the support of their parents and families.

Environment. Yosso (2005) identifies social capital as one of six forms of capital that Communities of Color have access to that nurture their “cultural wealth” (p. 76). Social capital can be defined as “networks of people and community resources,” wherein students and families use these networks and resources to support them in navigating larger institutions like education and health care (p. 79). In this section, I examine students’ use of social capital through their navigation of the following networks and resources in their environment: their after-school program, neighborhood support, and their perceptions of American culture’s impact on their health.

After-school program. As previously stated, all students in this study were current or previous participants in an athletic-based after-school program that also provides academic support, college and career preparation, social work groups, and health workshops. The students who regularly attend this program tend to view it as a resource to support them in navigating larger social institutions, though not without its faults. Students have mentioned their positive experiences with the program and what they have gained from it with regard to health in previous excerpts. The following excerpts show the way students have navigated their health through their use of the program:

Tim: From a young age they [the program staff] start trying to get you into healthy habits. Since you are there with friends too ... I wouldn't want to say peer pressure, but it's kinda like if you're at a young age if other people do it you might as well do it too. Kinda like a good peer pressure. (4/18/19)

Sade: I think here is when I actually started seeing sex as not a taboo thing, and not something as a curse word, and stuff like that. Not a bad thing because the first time, when it comes to sex and health, you guys didn't split us up, didn't split us into girls and guys. I think it was in 8th or 9th grade, they put us together in the sex ed class all together. At first, it was uncomfortable, but then by the end, it was a normal thing, talking about sex isn't a bad thing. You can talk about it with guys and girls could talk about it with girls, it doesn't matter 'cause it's a normal thing, and it's things that people go through. This goes back to what I was saying with you guys with the lessons with the condom, and stuff like that. I feel like... Oh, when we went to the, I think it was the health center right

around the corner, and they actually gave us supplies of condoms, and stuff like that. They don't do that in school. They'll tell us, "Well, practice not having sex and make sure not to have sex. But if you do have sex have a condom, but you can't have any condoms from us." It's that type of thing, but it was weird. But you guys actually provided us the stuff and then taught us a lesson still. (7/1/19)

Bryant: Here, [at program], those workshops, as tedious as I might've thought them to be sometimes, I did listen. I did raise my eyebrows sometimes when I heard things. I was like, "Really? I didn't know that."… In school, it's not as welcoming ... this place, it was very clear … it's a much more safe place to ask questions that you can't always ask anywhere else. (7/1/19)

Zadie: I feel like Hanna[3] [program staff] does a great job at getting deeper into things and talking about like consent and what we would do in certain situations. Because while I was already thinking about those things before and I have my opinions not a lot of kids think about those situations and it really like opens my eyes to see what my peers think, right? Because there's a lot of kids that, like me, before thought that like, "They must know the same thing. They're my age." Right? And you get put in those situations with those kids and then you see like no, this is ... they think differently. They'll do things differently. Then that peer pressure like starts, you know? (4/22/19)

The above excerpts reflect students' feelings about their direct health programming. Below, Maria grapples with her sense of self as a result of larger cultural discourses of class, health, and happiness. She ultimately decides that she and other students like her are healthy "because we still have fun with our family."

> People in [this program,] some people go to public school and don't have enough money, but you see them families playing [sports] and they're happy. Money don't determine worth, but it's just like your happiness. Yeah, money don't determine your happiness, but when you see these people having fun it shows that our mental health is not that messed up. It seems healthy because we still have fun with our family, we still get to go to the park, we do family.... Well, I do family things but I also see people [in the program] hanging out for those family nights. They do family things. I mean, people go to parent-teacher conference. That's healthy. I feel like that's healthy. (7/30/19)

[3]Pseudonym

Azzarito, Macdonald, and colleagues (2017) problematize the influx of external programs that teach health, outside of public schools: they assert that the “neoliberal market economy” creates a competitive market for health and physical education programming, and that “schools are required to compete in the marketplace,” through their partnerships with outside programs and resources that are marketed to improve their performance and the performance of their students (p. 208). Schools often list their partnerships on their website in order to compete with other schools, to demonstrate the ways that their school will make their students competitive for college (McCall, 2014)—including health and physical education programming within these partnerships is one way to enhance that competitiveness (Azzarito, Macdonald et al., 2017). McCall (2014) argues that though after-school programs may have benevolent intentions, the assumptions around students’ “needs” for additional resources outside of the school day ultimately suggest that students are not enough as is, that they need “to be transformed from potentially at-risk or diasporic to [students] who can save [themselves] by going to college with the knowledge gained from success in high school” (p. 148).

Programs like the one referred to in this study, which include both athletic and academic components, often position students at the center of the discourse but are confined to the demands of the marketplace (Azzarito, Macdonald et al., 2017). While students expressed gratitude for their experiences in the excerpts above, and after-school activities in general can allow students opportunities to learn in new and varied contexts (McCall, 2014), Azzarito, Macdonald, and colleagues (2017) argue that the outsourcing of knowledge to external programs can contribute to public disinvestment in school-day funding. O’Flynn (2010) further argues that the positioning of programming for a specific group of youth—often those labeled as “disadvantaged”—tends to present health and physical activity as a means for "saving" children in the minds of the educators involved. The students’ expressions of gratitude for the program and the activities in it conceal the program’s discourse of "bettering" students’ lives (O’Flynn, 2010, p. 441) without

acknowledging the intricacies of the internal conflicts that it has produced in students (McCall, 2014), as expressed by students and alumni in the past, outside the confines of the study. Applying these concepts to Maria's story above, it begs the question: in what ways was Maria exposed to the program's discourses around health, happiness, and money, and what impact have these discourses had on her constitution of self? Extending these questions further: which institutional discourses produced this particular understanding of herself—the public discourse? The discourse of the after-school program? Of her school? Or all three? Her responses in this study do not lead to a definitive answer but promote further exploration.

As a result of the neoliberal marketplace, Azzarito, Macdonald, and colleagues (2017), as supported by the work of Evans and Davies (2014), state that policymakers and program developers should be interrogating "the values underpinning the products and services, the beneficiaries of the products and services, their fit with students' needs and interests, and the extent to which teachers can tailor them to create contextually appropriate learning experiences" (p. 208). Evans-Winters (2011) similarly asserts an "urgent need to reevaluate programs that spend large amounts of money on mentoring programs that tend to focus on outsiders as role models" (p. 142)—she specifically attends to young, lower-income African-American girls, and I extend this to Students of Color who are subject to the "disadvantaged," or "at-risk," labels in education. Instead, she calls for policymakers and program developers to consider providing resources to existing programs that target natural—"family or community"—mentors, or even to assist families in spending more time with their children at school or in their after-school programs (p. 142). She argues this due to the findings of her ethnography that suggested the most resilient students "sought out natural mentors inside and outside of the school building who were of the same gender and cultural (economic and social) background as themselves and family" (p. 143). For programs like the one students refer to here that

already exist, that would look like prioritizing the wants and needs of students, families, schools, and neighbors over the competition of the market.

Neighborhood support. Evans-Winters (2011) suggests that educational researchers and policymakers broaden their understanding of how they define family in order to remove boundaries that are typically placed between schools and communities. In response to mainstream risk discourses that urgently identify the deficiencies in Communities of Color as a justification to intervene, this section provides examples of the often unacknowledged ways students navigate their health through the support of their neighbors and neighborhood, another aspect of what Yosso (2005) calls “familial capital” (p. 79).

First, Destiny reflected on the ways her neighbors support each other:

> I guess they [my neighbors] all come together, they put effort to keep the community clean. That everybody has their own way of keeping themselves healthy. They really pitch in to help the community. Cleaning the parks, helping out in the soup kitchens. [The best thing about it is] the way a lot of people try to help out, even though they might have other things to do. I know some kids, they stay on the block sometimes because there's a school right across the street from my building, so they would stay on the block sometimes and help the kids get back to the house, 'cause there's a few kids right there. So they'll walk them back to the house, into their parents. I actually think the kids help more than the adults. (7/25/19)

Viv also identified her neighbor as a source of support:

> So my mom, she has... We live in front of a park, a garden. And each person can own a little garden thing. And my mom she just doesn't.... Her plants are not growing. And we have this neighbor who has a lot of experience and grows cilantro, and she usually gives my mom something. So I feel like being supportive is healthy. (5/22/19)

Finally, Maria shared her gratitude for the love she feels for her neighborhood:

> I see now in my community and everything there's a lot of love, especially in my building. Everybody knows we're poor. Everybody in that building, they're broke, whatever. But they are still families and they show their families with love, and I see the happiness even though it's a bad neighborhood. It's not really a bad neighborhood, it's just Harlem is getting gentrified. It just still seems like a lot of love. (7/30/19)

Critical scholars have highlighted the ways working-class and lower-income families are positioned as "other," or deviating from the "norm" of middle-class identities (e.g., Dagkas, 2014; O'Flynn, 2010). We see in this short response the way Maria's subjectivity is affected by classed power relations in the larger culture (O'Flynn, 2010): she identifies her family as "poor" and subsequently calls her neighborhood "bad," and then takes it back right away. She ultimately focuses on the love and happiness that the families in her building share with each other. Maria later elaborates on her neighborhood, beginning with memories of her childhood and quickly shifting to her resistance to gentrification:

> Okay, well, I see kids healthy. When I was a kid I saw little girls jumping around, playing double dutch and everything, and then now it's just like all these people coming in and they're making all these big stores, taking away places. I remember my teacher told me about James Baldwin and how he was talking about the buildings where he was seeing at his area, and then the next couple years it wasn't the same. It was all gone. That's how I feel, like they're taking away all the good stuff. They take a mural down. Not a mural, a painting, like it's graphic design of this guy, or like jazz. If they take that down it ruins the art because they trying to make it for money. They trying to do that and I feel like that's not healthy no more because they're just ruining what we built and I'm like, "Wow. That hurts."
>
> Because I want to still see that playground the same. I don't want it more advanced, I don't want to have new swings and everything. Even though it's nice to have it's just like it was like the memories I built, it's just like it's not going to be the same for these little kids growing up…. I accept people and everything. You could come in, just don't change it up. (7/30/19)

As previously cited, Kinloch (2010) has extensive work on the tension young people experience in response to gentrification and their neighborhoods changing. James (2010) asserts that racist institutional and societal practices like gentrification are real instances of discrimination on the individuals affected, and are experienced in the psyche as trauma. Here, and throughout her excerpts elsewhere, Maria is very aware of the influence of the dominant culture on her ability to gain resources, specifically with regards housing opportunities (Graham et al., 2011) and the diminishment of access to

activities that feel like home to her. Graham and colleagues (2011) suggest a relationship between an individual's perceptions of the dominant culture's impact on their mobility and their psychosocial outcomes. In this excerpt, Maria shares that her neighborhood already had plenty of opportunities to play outside, and perceives the dominant culture to be "ruining what we built," specifically her memories, and art, for money. Looking through a critical race lens, these students shared examples of the way their communities "nurture and empower" them and their families (Yosso, 2005, p. 76), and in Maria's case, the way the larger social structures impede that.

American culture and health behaviors. Graham and colleagues (2011) argue that in the U.S., "dominant cultural customs are frequently presented as universal" and are used to label individuals and communities with different cultural orientations as "not suitable to succeed in institutions" (p. 85). This results in the undervaluing of cultures that fall outside of the supposed White norm, and leads "ethnic minorities' cultural heritages to act as liabilities and sources of eradicable shame" (Graham et al., 2011, p. 85). In response to this, Yosso (2005) uses critical race theory to understand the "empowering potential of the cultures of Communities of Color" (p. 76) in order to expose the racism underlying the comparison and hierarchy of cultural norms. In direct contrast to dominant cultural assumptions, several students in this study identified cultures outside of the U.S. as supportive of health habits, and American culture as a barrier to their ability to navigate their health. They shared stories and experiences that challenge the contradictory neoliberal discourses that personal responsibility and hard work lead to success, and that other cultural norms carry less value.

First, students cited growing up outside of the U.S. as being supportive of eating and exercise habits that they define as healthy. Leah identified the healthiest person she knows as her dad, because "he was born and raised in [the Caribbean[4]]. So it's kind of

[4] Specific name of country redacted for anonymity.

just like they eat their own food. They're not really into eating a lot of fast food" (7/1/19). Ijeoma stated that the reason she's healthy is "traditional foods. Traditional foods are just naturally healthy. It has a combination of everything you need: veggies, carbs … that's my mom's culture. I cook for myself…. I rarely go out to eat" (7/24/19). The traditional foods she's referring to are those from the country in Africa where she was born and lived until middle school, and where her family is from. She also shared that the reason she takes her exercise so seriously as a young adult is because in her home country, "I was on the junior track team for the Olympics. Did you know that?" (I didn't.) For Ijeoma, it's her connection to her home country that acts as a protective factor and supports her in maintaining behaviors she defines as healthy. Samira also identified the eating habits of her mom before she moved to the U.S.: "My mom will tell me about all the things that she wasn't allowed to eat as a kid and it all makes sense. My mom grew up eating very well, and then she came here to America." We remember Samira's stories about her grandmother from the beginning of this chapter.

Similarly, Shoshanna cited moving to the U.S. as one of the key experiences that helped her define her health:

> When I left Africa, I was really skinny, like I was really skinny. And I came here and I got really fat. I gained a lot of weight just because I got exposed to donuts and Skittles and stuff like that and I couldn't stop asking for it. My mom felt bad because I didn't eat stuff like this at home because she was like, 'Oh why don't you try something new?' And I just kept on going and going and going and the weight added up and then I lost it through sports and stuff at school. Now it's like I don't really think about it. I just eat.
>
> Yeah because I wasn't ... choosing when I was eating if that makes sense. I would have meals. And at school too, the food was just different. I don't really remember, but all I remember is at school, people would actually stand there and make the food instead of it just being made and frozen and then reheated. You would actually see it being made in front of you, even if it was for Kindergarten, there would still be chefs making food. (5/3/19)

Shoshanna equates "skinny" to healthy and "fat" to unhealthy, and later explained exposure to unhealthy foods when she first moved here as the reason why "the weight

added up.” Samira also shared the way the eating habits of her cousins in Europe differed from hers, as well as their perceptions of American habits:

> I don't know, nobody here cares about health. We have McDonald's, I think McDonald's is a big thing here. Like fast food, but over here it's like times 10. When I went to Europe [to visit my cousins,] when I went to Europe*, my aunt was making fun of us, like Americans, like we drove past a McDonald's. I was shocked that there was a McDonald's in Europe. I was like, "Oh wait, McDonald's is everywhere." And she was like, "Yeah, I don't take my kids there." She was like, "Well, I feel like in America, like you guys eat so bad, poorly." So I think here no one puts their health first. (4/10/19)

The aim of neoliberal messaging in health curricula throughout the U.S. may be to produce fit bodies that can effectively contribute to a capitalist society, as Azzarito (2009) suggests, but the easy, cheap access to sugary foods and the “frozen and then reheated” school lunches—compared to chefs who make school lunch in front of students from kindergarten forward, in Shoshanna’s case—make these values inaccessible to students and families who live in the margins. It’s not the language of health messaging that impedes students’ health behaviors, it’s the easy access to unhealthy foods compared to the availability of freshly cooked, healthy meals in their countries of origin.

Shoshanna also shared some interesting insights about the differences in her conception of community in her country of origin compared to the U.S., and the impact that had on her understanding of health and ability to take care of herself:

> Ever since I left Africa I’ve never talked to a neighbor or got close to them…. I would understand community and neighbors if I was still back home, but not here. Back home, your neighborhood was your family so you’d know everyone in your neighborhood. That was really your community. I would call every kid on my block back home my cousin because I’d always be at their houses and we would always talk and have fun and stuff but here it’s just like, that’s a stranger, don’t talk to them. Back home, it’s like that’s your family. Here, there’s always tension somewhere. People think no one is really there for them. People are just selfish, you know? Just want to benefit themselves instead of helping others. (5/3/19)

* Name of country concealed for anonymity.

Shoshanna’s use of the word “home” is interesting: Mohanty (2003) writes that “notions of home and community [can be] located within a deeply political space where racialization and gender and class relations and history” meet (p. 129), and I don’t intend to make assumptions about Shoshanna’s interpretation of home here. Her insights about community are quite different from those of the students in the previous section who shared their experiences with community support. In many ways, she looks to her neighborhood in her home country as the “cultural norm,” and to her idea of American culture as the norm that can’t measure up, that’s inherently inferior, because of the “tension” and the “selfish” nature of the people.

Samira also had some interesting ideas about why American culture is not conducive to good health: “Everyone wants to chase the American dream and I don’t think that’s living a healthy life.” She continued,

> It's not, it's so not healthy. It's so toxic and misleading. Your emotional health and mental health suffer because people go to extreme measures to reach success, whereas success is sort of a journey. People see it as a step by step process which is unhealthy to me, because you have to live your life, and if you're not living your life, you're not being healthy. And people are just living with a constant end goal, and I think that's toxic. It's not good for you, it's not good for your health, but for some people it works. I think it works for people, but I feel like the more successful people that I've seen, have struggled with ... You know we're human. We're emotional, but some of the people, the doctors and stuff that I know are people who are successful and rich—they suffer, they suffered in the past. Yeah they work hard, everyone really likes to ... I feel like part of the American dream is to work hard, like work hard.
>
> People work hard for what they've got. People love to brag that they work hard, but they suffered in one department which may look differently for each person. So like in medical school for example, half the students in medical school suffer from depression because living a healthy lifestyle does not come before success. So once they become a doctor, once they have a certain salary, that's when they start caring about living healthy because they had to chase this American dream or whatever…. Even in school we're not taught to live a healthy lifestyle. We're taught to get good grades, but no one ever talks about being healthy. (4/10/19)

Azzarito, Macdonald and colleagues (2017) argue that "Whiteness, classism, and 'popular postfeminism' … play a crucial role in constraining many young people's access to holistic, meaningful, and empowering learning experiences" (p. 205). Shoshanna's and Samira's stories suggest that these neoliberal educational and professional practices also constrain young people's well-being: Samira stated that the culture around "hard work" and the "American dream" cause the emotional and mental health of individuals and communities to "suffer," rather than learn how to enjoy their journeys to success and cultivate their well-being along the way.

These storylines depicted American culture—specifically the cost of food, the access to fast and sugary foods, the loss of community, and the hustle—as a barrier to achieving health behaviors that the students defined as important to their well-being. Azzarito, Macdonald, and colleagues (2017) state that "othering means treating difference between people hierarchically, for example, in terms of superiority and inferiority, thereby dismissing the needs of others as invisible or unimportant" (p. 210). How would these stories look different if we valued the cultures of the countries where students came from in our classrooms, if Whiteness wasn't the norm we used to measure all "other" cultures against? In what ways do we gain from learning from students' experiences with community, food, exercise, and happiness in the variety of countries they came from, and applying those to our health and educational practices? Their stories and expressed frustration with American culture for constraining their access to their well-being provide support for Yosso's (2005) assertion for the "need to restructure U.S. social institutions around [the] knowledges, skills, abilities, and networks—the community cultural wealth—possessed and utilized by People of Color" (p. 82).

Summary

This chapter presented my analysis and interpretation of student-participants' answers to the first two research questions: (1) What are participants' thoughts and feelings about health? and (2) What are the ways youth navigate health? I identified discourses of health, of risk, shame, and fear, and I placed these discourses in the context of power relations in U.S. culture, especially the intersections of race, class, and gender. I also identified students' stories about what constitutes a healthy person, and how students have experienced health, health class, and health messaging throughout their upbringing. I applied the lenses of critical race and critical race feminist theory to challenge the deficit thinking typically presented in research about Communities of Color and presented their stories about their feelings around and navigation of health in an attempt to identify the "empowering potential" of their cultures (Yosso, 2005, p. 76). I organized students' answers for their thoughts and feelings about health into the following categories: health as an external process or performance, and mental health. I organized their answers' to questions about their navigation of health into the categories of school-based health, community, and environment.

Chapter V

FINDINGS II

> I was telling my mom if I was born into money maybe a lot of stuff... Maybe the situations would be happier. We wouldn't have to struggle like where are we going to pay for rent. There was situations where you got to think about rent, where you got to think about what you're going to eat, how to pay electricity, how to make your kids happy, and buying them things like the other kids. So I felt like no matter what it's just like I got to try 10 times harder to push myself and that creates a lot of stress for a 17-year-old … when I was 16 I created so much stress knowing that I was poor and other kids had their stuff. They had everything and I had to ask my mom, and I have a lot of siblings so I have to ask my mom even though she feels bad that she can't make me happy it's just like … she tried. (Maria, 7/30/19)

Maria is a 12th grade student who has felt stress over her classed status throughout her upbringing. Throughout the interview and many of our conversations prior, Maria demonstrated the tension she feels in learning to love herself while also being very aware that the experiences she's had access to, including those at school and in her neighborhood, have been determined by her family's access to money. She explained that she knows a lot of kids her age who feel the same way as she does, and that they don't like talking about their feelings "because they just like, 'Oh, what is that going to help with? I'm still going to live in this situation. Nothing else would happen.'" She said, "And that's kind of scary because if we keep putting ourself in a deep hole like you might do self-harm or other worse things like that. And, yeah, it's kind of scary because a lot of people in my community, they will often feel sad." Maria felt conflicted between the instances where she's seen a lot of happiness and joy from her neighbors and her classmates, and other moments when she felt their circumstances determined their well-

being: “I see a lot of families where they do stuff, where they go outside in the halls just doing nothing and it's kind of sad where they think that's their life. They can't get out of public housing, they can't get out the projects, and that's really sad.” Maria’s thoughts on her own health and well-being, and that of her neighbors and classmates, are complicated by her classed subjectivity (O’Flynn, 2010): she sees her living situation as limiting, as something she needs to get out of in order to be “happier,” but she has to try “ten times harder” to get there. She worries about the potential for “self-harm” for other “kids” in similar classed situations as she is, and she sees it as impacting their willingness to seek support.

Maria’s conflicting feelings extend beyond her understanding of herself: her concerns are not just for herself, but for her peers, and for her neighbors, who have experiences similar circumstances to her. Her perception of her own potential for happiness is determined by money and housing, by where money for rent, food, and electricity is coming from. The “stress” she has felt about being “poor” compared to other kids who had “their stuff” was about the “subject-positions” her schooling and housing experiences invited her to take up (O’Flynn, 2010, p. 432). Her feelings of stress were transient throughout the interview; they showed up in stories about her school experience in general, as it relates to her access to resources as a result of her school, and disappeared when she shared stories about her health teacher. They were sometimes contradicted by her imagination of health for other students like her.

Maria shared a lot of her ideas for what she enjoyed about her experiences in health class and what she feels that students like her need and deserve:

> Just a counselor that you just talk about feelings with, that cool counselor…. There was this teacher in middle school where everybody kept going to him at lunch and he picked kids up for groups, played UNO. That was in middle school. That was so fun. They should have that in high school, but nope. They want to be cheap with budgeting.

She felt that the actions of her teachers and counselors at school were determined by their salary: “If they paid the teachers well they would care about listening to kids' feelings. They just care about, like, ‘I didn't get paid enough for this. This girl's crazy. I need to call her mom. That's not my job, that's ACS's job.’” She wondered if they would care more if they had higher salaries. She also imagined what it would be like for her classmates—if they would feel more comfortable talking to someone—if it was less “embarrassing’ than being pulled out of class, and more integrated into the school culture: “They should have a safe space with these counselors playing UNO with kids, deep conversations, talking about feelings, making it more accepting.”

Though Maria expressed plenty of disappointment in her schooling experience, she felt uniquely supported by her health teacher, Ms. G. “She was a strong Black woman who.... She always talked about she used to be us, she used to be one of the kids, she used to do a lot of stuff that was dumb.” Maria self-identified as Hispanic,[1] and connected to the stories Ms. G. told about “her family being [Caribbean[2]] and whatnot,” and felt her classmates did too, because they frequently shared stories about, “‘Oh this happened when I was in a different country.’” She said Ms. G. shared personal stories with them about sensitive topics, like her friends transitioning from the gender binary, or coming out as gay, “and then she made it feel relatable, like this is okay to happen. Because she was one of us.” This stands in direct contrast to Gilbert’s (2014) assertion that adults in schools typically regard LGBTQ identities as “at best, an unfortunate accident of genetics or environment” (p. 6). Ms. G’s ability to teach students about sensitive issues like orientation and identity was enhanced by their perception that she used to be in their shoes—making a “cultural connection,” as Evans-Winters (2011, p. 148) names it. Maria

[1]Maria included a more specific description in addition to “Hispanic,” but I do not include it here for the sake of anonymity.

[2]Specificity redacted for anonymity.

also appreciated Ms. G.'s longevity: "Let's say there was a group of kids disrespecting a teacher and she was like, 'Oh, I've known you since freshman year. I've known you since freshman year and you're doing that?'" and her honesty about the realities of their experience: "She was saying how we, us as the people, we have to work 10 times harder in life. And for you to disrespect a teacher, that is disrespectful." She benefited from, as Ladson-Billings (2009a) puts it, her teacher's culturally relevant teaching strategy of helping students "understand the world as it is and equip them to change it for the better" (p. 152).

Maria's anxieties about her self-identified classed position were somewhat alleviated by her support from her teacher. Her teacher's commitment to her students, her honesty about the realities of the world for Students of Color, her personal stories, and her identity as a "strong Black woman" who "used to be us" facilitated Maria's ability to imagine something better for her and students like her in the future. When asked about how she would teach a health class, Maria spent a lot of time discussing how she would make sure to empower her students. She shared, "I want them to feel like a comrade … they got to be like, 'That's the teacher that educated me.'" More than that, she would want to make sure her students feel known as individuals: "I want to know every single person's name…. I would be that as a teacher, know everybody's stories." This echoes Ladson-Billings's (2009a) assertion that effective teaching involves individualized knowledge of the students (p. 136), and Fitzpatrick and Russell's (2015) suggestion for health teachers to prioritize building relationships with students in order to facilitate closeness in the classroom. Maria continued in detail about the ways she would make sure her students feel valued, and that they know how to value each other:

> I'm going to be like, "Everybody in that class is equal, the same, no matter what, no matter where you came from, no matter what shoes you wear, you are all the same and you all mean something. You're not worthless." Whoever told them that they're worthless, they're not. They have value and they're successful. You might not see it, but you're going to be successful and you are. And it takes time to know greatness. I'll give them a

> speech about how amazing they are. And I'm like, "But if you ever judge or call someone ugly, say anything and make someone feel bad, you are not your greatest self and you will not be your greatest self if you're constantly judging the other person on what they have." (7/30/19)

She prioritizes an introduction that ensures students see their "value" and their "greatness," while expecting them to act like their "greatest self" by withholding judgments. She even had specific ideas for content on that first day:

> I would show some videos about motivational speakers, about ... I forgot the writer's name, you know her. She's a Nigerian writer and she wrote a single story.[3] And I would show them that video because she was talking about the poor kid. They always talk about the poor kid, but they never talked about the poor kid's talent that they have where they always sew, where they make beautiful purses. They don't talk about that story. (7/30/19)

She specifically identifies class here, and describes the specific ways that she wants to subvert the stories, so that the "poor kid" sees their "talent." Maria would use her anxieties, stresses, and concerns about growing up poor to empower students who feel those same stresses. She continues, "Or I would tell them kids, like, 'You could be poor. They going to call you poor, but they don't know your story of what thing makes you, you.'" Maria wants students who grow up in the same social positioning as she did to be able to see their value, to tell their own stories instead of absorbing the stories that society tells them about their classed position. She finishes, "I will make them feel so amazing at the end. I'll make them feel so amazing. That's my goal."

Maria uses her positive experiences with her health teacher to imagine the classroom environment that she would create, to support students whose lived experiences make them forget their value, their greatness, and their self-defined stories. The support, love, and care that her health teacher provided her acted as a protective factor to her subjectivity as a "poor kid." It allowed her to imagine, to maintain what Yosso (2005) calls her "aspirational capital," or "the ability to maintain hopes and dreams for the future, even in the face of real and perceived barriers" (p. 77).

[3]Chimamanda Ngozi Adichie.

Purpose

In this chapter, I present some of the imaginings that the students in this study shared through an examination of the last two research questions: (3) What messages do participants recommend as being most important to communicate to youth? and (4) How do youth imagine a healthy life, and what do they want or need to get there? Directed by Greene's (1995) ideas of seeing people "big," wherein we "resist viewing other human beings as mere objects or chess pieces" and instead "view them in their integrity and particularity" in order to "be privy to the plans people make, the initiatives they take, the uncertainties they face" (p. 10), I aim to share students' imaginations for the future of health in the context of their lived experiences. Greene describes the desire to see things both close up and big as a doorway to one's imagination, wherein we "cultivate multiple ways of seeing and multiple dialogues in a world where nothing stays the same" (p. 16). This chapter examines students' imagination for what young people should be taught with regard to their health and well-being, and the structural changes required to reach their idea of a healthy life.

The students in this study shared ideas about the specific content they believe is important in a health classroom, but as I have argued in previous chapters, the content of a health class should be context-specific. Though these ideas for the content will be shared with the staff at the after-school program that the students are and have been a part of, it is more important for this section of the paper to focus on the larger picture of health education: What additional supports do students want and need at school and in their neighborhoods to access or maintain their sense of well-being? What do they want in terms of representation and support from their teachers? What values do they believe youth should learn to embody? This chapter uses critical race feminist and critical health lenses in an attempt to build on students' sources of restlessness and frustration with what

is, presented in the previous chapter, and open up their imagination, to move toward what might be (Greene, 1995).

Important Messages to Communicate to Youth: Reach Out, but Know Yourself First

Critical health scholars (e.g., Azzarito, Macdonald et al., 2017; Evans et al., 2011; Fitzpatrick & Tinning, 2014a; Fitzpatrick et al., 2019; O'Flynn, 2010) have demonstrated the individualistic and moralistic discourses of health that pervade schools and public discourses. O'Flynn (2010) to examine the effects of the dominant meanings of health on shaping the way students come to understand themselves and their futures. In this study, it is my position that social class cannot be understood without acknowledging the racism that is embedded within our society (Taylor, Gillborn, & Ladson-Billings, 2009), and that gender plays an inextricable role on young people's subjectivities (Evans-Winters, 2011), specifically in the context of health messaging (Azzarito, 2010).

One aim of this study was to take a culture-centered approach in order to present students as experts of their own experiences and locate them as agents of change (Dutta, 2007, 2010). Therefore, their opinions about the messages that are important to communicate with youth help us understand the way they have experienced their health and well-being so far, and the ways we can use their experiences to shape future health messaging and structural changes. While students' specific suggestions for health class content and pedagogy will be included in the next section, this section is organized into the following, seemingly conflicting categories: lean on your community, put yourself first, enjoy it, and "it's a never ending process."

Lean on Your Community

Many students expressed similar sentiments about hoping the young people in their lives will learn how important it is to reach out and receive support from the communities

of people who care about them. In many ways, their advice echoes what Yosso (2005) refers to as “social capital”: one aspect of cultural wealth that Communities of Color have, defined as the systems of people and resources that provide “instrumental and emotional support to navigate through society’s institutions” (p. 79). She provides examples to assert that historically, individuals and Communities of Color from a variety of ethnic backgrounds have shared the new knowledge and resources they obtained elsewhere back with their communities. Several students in this study wanted to share their messages about the benefits of leaning on their community with the young people who come after them, as demonstrated in the excerpts below:

> Abou: Be kind to people, don't judge. Everybody judge, but keep that information in your head until you know the person. Don't just assume that. Then after that, you look stupid, because ... Then you wish you never done that. (4/17/19)

> Shoshanna: If you ever feel overwhelmed, don't be afraid to step out of your comfort zone and ask someone to help you.... Because I see it in a lot of people, in myself. When you're dealing with something, trying to take care of yourself, you don't know what to do. It's like you just push that to the side and think about something else or don't think about it at all instead of trying to figure it out, trying to see how you can be comfortable with yourself and take care of yourself. So they just eat it up and don't say anything. (5/3/19)

> Samira: Always ask for help … there’s nothing embarrassing about it. (4/10/19)

> Jupiter: Don't be afraid to talk to people. I say be yourself, if it works for you it could be, but don't always just push people out of your life who are trying to help. You don't have to share everything, just make sure you have people around that possibly you can talk to. Sometimes you do need to talk to people. (8/1/19)

Here, Abou wanted to encourage young people to do their best to withhold judgments and practice kindness to others. Shoshanna, Samira, and Jupiter shared that they want young people to know about how valuable it is to seek out and receive support—that they should never be “afraid” or allow asking for help to feel “embarrassing.” Sade built on

this message by adding her experiences with support, and how mentors and friends have helped her maintain her health habits and feel less alone:

> When it comes to physical stuff, I think it's always good to have someone like a friend or someone who could support you to push you to be physical. And I have Nancy,[4] she's a mentor. I work out with her and we're working on that, and the whole thing I can use what I know now to take that with me when I go to college to use the gym there. When it comes to mental health, also just support, too. Always having a person, someone there you can talk to and vent to, not always feeling alone is a good feeling. (7/1/19)

Gloria similarly wanted to encourage young people to reach out, while acknowledging that using their community resources like libraries are important to understanding their health as well:

> Reach out—[that's] one message—and use your sources is another. Sources being like, I know a lot of the time students, really younger people don't actually go to libraries as often as people used to. The internet itself has become very wide range, and it's very much a source for anything possible. I would still advise them to be careful, because there's a lot of things on the internet that aren't exactly true and can lead to misconceptions. (7/31/19)

Finally, Fernando directed his message to his younger sisters, stating that he wants to make sure they know "that if they need anything, that I'm there. If they have any questions, they can always talk to me if they don't want to talk to anybody else" (7/26/19).

The students in this study are individuals who have successfully navigated multiple educational contexts by way of their own characteristics (Evans-Winters, 2011), one of which is their willingness to seek out and receive support from the people around them—their peers, their families, their neighbors, and their mentors—in addition to their neighborhood resources. As students who are all either already in college or about to begin college, they have undoubtedly been subject to the growing pressures resulting from educational practices that focus on students' performance for the sake of national

[4]Pseudonym

rankings (Lee & Soon-Mook, 2014), in addition to the added pressure of navigating social institutions that were not developed with them in mind and that may hold biases against their socialized identities (Yosso, 2005). It is unclear whether students learned how to reach out and ask for help after trying and failing to do it by themselves, or if they were taught early to utilize the networks around them. Regardless, the excerpts here demonstrate these students' belief that reaching out for and accepting support when needed plays a key role in accessing and maintaining health.

Put Yourself First

On the other hand, there were several students who wanted to share individualist sentiments for the youth in their lives.

> Ijeoma: Focus on you and your needs. (7/24/19)
>
> Tim: The only person you can really take care of is you. You can't really depend on everybody … not everybody has the best interest for you besides you most of the time. (4/18/19)
>
> Kevin: I don't know, just care about yourself. The people in my life generally do, so. Can't really tell them what to do. (7/26/19)
>
> Andrew: Do what you want to do in order to be happy. Just to figure out what makes you happy. Do what you, do what you want to do in order to be healthy. If that means doing salad, do salad, but then you got to do alternative things besides that and go for a nice run in the morning. (7/25/19)
>
> Chris: Your health comes first and it's more important to make sure that you're doing well before somebody else, so you would never put somebody else over you. You put yourself first. (7/29/19)

It is possible that the students quoted above have inevitably absorbed the larger neoliberal priorities of competition and self-management for individuals, especially with regards to producing a healthybody (Azzarito, Macdonald et al., 2017): "go for a nice run in the morning," "your health comes first," and "focus on you," for example. Their advice may also point to personal negative experiences that students have had with others, which

lead them to want to protect young people from learning the same difficult lessons: Tim's comment in particular suggests that he may have learned from experience that people aren't dependable.

Aissatou also shared an individualist idea, while recognizing that sometimes trying to take care of yourself can be an additional burden. She shared, "Just be you. Don't go all day killing yourself trying to take care of yourself or what. Do what you want to do, and just look after yourself" (7/26/19). Her message that taking care of yourself can feel like "killing yourself" reflects Burrows and Sinkinson's (2014) findings that school-based and societal expectations of personal responsibility for one's health put additional pressure on young people that creates anxieties, especially young people for whom many health habits are out of reach due to classed or racialized status.

Do young people deserve to feel like they have to navigate their health and their well-being alone? What are the potential harms and benefits of this mindset? For Burrows and Sinkinson (2014), the dominant discourses of health create an unrealistic pressure that is linked to poor mental health outcomes for many youth. For some of these students though—Ijeoma, Andrew, and Kevin, for example—it's simply the idea that establishing your needs and knowing what makes you happy that is important to your health.

Finally, a few students explicitly stated that young people need to know who they are as an individual in order to have a happier, healthier life in collaboration with the people around them:

> Makayla: A message I would give to them is basically … now go listen, but make sure you take care of you, make sure you're not swayed by the social standards and make sure you're not following that crowd. Even though you may think that you're not because a lot of people feel like they're not. But make sure, like, those decisions are based on what you want to do, and do only what you want to do. That decision that's up to you can't stop you. But do it because you want to and not because of anybody else. You are not constrained by relationships.

> And make sure not to do it out of ... Do certain things out of love because sometimes we fall in love with people and love makes us dumb, deaf, blind and stupid and you want to do anything for that person. And I've seen this multiple times before where they do stuff because they're in love. Make sure you don't do stuff because you're in love. Just make sure you go to self—public seminars, or look for positive things, because those really help. And make sure you date yourself because dating yourself really helps and a lot of people think it's devious and sounds lonely. But it's actually really fun to do. That's a good way to know yourself because you surprise yourself with your time about stuff you didn't know. (6/12/19)
>
> Sharon: Make sure you know your morals and your values. Make sure you try as much as possible to surround yourself with people who make you feel good, people who don't make it seem like it's hard to love yourself. (4/12/19)
>
> Leah: Just keep yourself in mind throughout all of your interactions, whether it's like you interact with other people, or you with your school, or just ask yourself, "Am I okay right now? Do I need to take a break?" Don't overwhelm yourself with work because that's so easy to do. And just remember that you are, before anything, you're a person before you're a student, or you're an athlete. You're a person first. So, treat yourself so. (7/1/19)

Shirley had a particular commitment to the messages she wanted to share with youth, because she sees herself as playing an integral role in the development of her little sisters. She stated,

> Be who you are honestly. Just don't judge yourself too harshly, don't let others judge you. Yeah. Honestly just be who you are. I was reading a book to them yesterday about that. (5/1/19)

Shirley referred to her sisters several times throughout the interview, and said she felt like "their mom, but I'm not." She elaborated that she wants them to be able to "express themselves freely," for them not to "care about what other people think … hopefully they're not like that because then I feel like I will … like I failed them or something. I don't want them to have that. I want them to be happy."

In many ways, Makayla, Sharon, Leah, and Shirley want to communicate messages of resistance to youth: you are not who other people tell you you are: "You're a person

first." They want people to know that they can resist societal judgments and expectations, by which Azzarito (2010) has argued are especially constraining for young women. Makayla suggests creative ways to do this: "dating yourself," and going to "public seminars," for example, to make sure they really know who they are before they get in relationship with others. Their messages recognize that they will always be surrounded by other people, but they still have the right to learn who they are first.

Students' messages here remind me of Janine De Novais's assertion in brown (2019a) that kids deserve "a map and a vocabulary and a practice" of loving themselves (p. 395). They want young people to know and understand oneself in order to thrive, and they suggest resistance to socially constructed ideologies of who other people say they are—through not judging, not letting others judge them, resisting constraints of relationships that aren't good for them, and defining their morals and values for themselves.

Enjoy It

Ijeoma and Jupiter wanted to communicate messages about laughter and happiness to young people:

> Ijeoma: Just laughter. Life is not that serious, man. I mean, it's serious because it's like, go crazy. Just have fun. I feel like that's what my circle has taught me. You don't have to sit there and have a long deep conversation to just have a connection with somebody. If you have a laugh with me, have a connection with me. I just realize you know, keeping you laughing makes me happy. So we could laugh. We could be happy for me. (7/24/19)

> Jupiter: She always just told me, my great grandmother on my mom's side. She was like, she was always saying, like oh like live your life to the fullest. It's like a basic scene but it's honest, though. Because you never know what could happen at any time. Just try to work towards your happiness. Your health is everything. Not just physical, because you could break your leg, but are you happy? (8/1/19)

adrienne maree brown (2019a) writes that for all of us, but especially for those of us who have to overcome being socialized to believe that your life matters less than others, “prioritizing ourselves in love is political strategy, is survival” (p. 59). In that same manner, Ijeoma and Jupiter want young people to know that to be healthy, they have to learn how to enjoy themselves, to laugh, and to connect with others. In many ways, these messages are in opposition to the arguments of critical health scholars who suggest that dominant health messages are othering and harmful in the way they encourage individuals to produce a healthy body (e.g., Azzarito, Macdonald et al., 2017; Hokowhitu, 2014)—Ijeoma and Jupiter may be categorized as people who would be “harmed” by dominant health messages, but their focus on laughter and joy, as opposed to pathology, suggests otherwise.

“It’s a Never-ending Process”

Finally, Sade wanted to send a message to young people that included some discourses of critical health education:

> I think I would tell them there's no such thing as like, “The healthiest person alive.” And just because someone is good or seems healthy, looks healthy, that doesn't mean that they're healthy mentally, spiritually, sexually, it doesn't take away from any of those things. You can always work to become a healthier person. And also, it's a never ending process, you don't just be like, “Oh, I'm healthy now, I'm just gonna eat everything. And I'm gonna have sex without condoms.” You don't do that, it's a never-ending process. If you make a mistake, it's fine, because you're human. (7/1/19)

Here, Sade wants young people to challenge the idea that health is something you can see—a notion that critical health scholars (e.g., Fitzpatrick & Tinning, 2014b) argue is central to the dominant discourses of health, at school and in the public pedagogy. She engages with the neoliberal concept that the “self” is something to be constantly regulated and managed (O’Flynn, 2010), but her language does not indicate anxiety around that concept: mistakes, indeed, are “human.” Her suggestion is reflective of a “salutogenic” approach to health, where health is a “continuum”; it’s not “something you

have or do not have," and the question becomes about what develops health in a person, not whether a person is healthy or unhealthy (Quennerstedt & Öhman, 2014, p. 193).

Imagining a Healthy Life

Greene (1995) uses imagination to "search for openings, without which, our lives narrow and our pathways become cul-de-sacs" (p. 17). When we explore such openings, we are able to see through new lenses, and "open new perspectives … identify alternatives" (p. 18). Greene uses the arts to facilitate imagination, and educational researchers have applied Greene's idea of imagination to a variety of fields, including instructional technology (Linaberger, 2007), literacy (Barrie, 1997), and inclusive pedadogy (Harwood, 2010). In this section, I attempt to apply Greene's concept of imagination to the field of health in general and health education specifically. I present students' imaginings for a healthy life, organized into the following categories: individual changes, structural changes, and suggestions for health class.

Individual Changes

Several students in this study imagined a healthy life through the bio-medical discourse (Primdahl, Reid, & Simovska, 2018), conveyed as individual changes that only they themselves can make. In general, bio-medical discourses focus on students' "knowledge, attitudes, skills, and behaviour [sic] concerning individual lifestyles and health risks" (p. 735). Students focused on a variety of health concepts as they shared what they needed to get there.

First, though Samira noted plenty of structural limits of her lived experience throughout the interview, especially those related to the constraints of American culture on her well-being, when asked what she needs for her definition of a healthy life, she responded:

> Discipline, like knowing that you have to sacrifice some things to be healthy and what else … you just have to put a lot of work into being healthy, and a routine, and what else … and obviously being educated because if you're not educated on health stuff then you can't be healthy. (4/10/19)

Samira insists that being healthy requires “a lot of work,” and “being educated.” I wonder, where does this privilege of education come from? Shoshanna also previously noted the limits of American culture, yet focused on the individual changes that she needs to make in her imagination of a healthy life:

> I need a plan. Well, there's different types of health. Physical health I need a plan because I need a set diet, stuff like that. Mental health I feel like to get to what I want to be I have to write more because I used to do that when I was younger and I felt better, but I stopped. Spiritual health, I feel like that one is like conflicting for me. I don't know why though. (5/3/19)

When I asked her why she needed a “set diet,” she responded,

> So I can get the food I need. Right? I mean that's how people stay healthy. I don't know. I don't know how to stay healthy without a diet. Like you have to keep track of what you're eating. (5/3/19)

Destiny also responded with a focus on food:

> I would say I would just take the junk food out of my diet in general. I mean, not completely out, at least once in a while. I need to definitely cut that back because I know that sometimes when I eat too much sugar, sometimes the back of my teeth could hurt. I don't know if that's a dental problem or just the way I eat, but I've noticed that sometimes could have an impact and if I keep doing that it'll have a bigger impact and I could have a cavity, and I've never had a cavity in my life. (7/25/19)

Destiny described herself as healthy previously in the interview, and she’s aware of the changes she “would” make if she wanted to get to a healthier place, and what would happen if she keeps eating “too much sugar.” These are not necessarily changes that she feels she needs to make just yet.

Furthermore, some students touched on changes they can make to support their mental and emotional needs. Kevin, for example, commented on needing direction:

> I usually, I just see when people are put together, like they have their friends and they have their hobby and they have their career and they have

> their girl and they have everything put together. I see people who don't have one of those things and I know that they are doing things to make themselves [sic] feel better. I think that's just life. When you have a direction, you don't feel aimless, and when you think you have a direction and your direction goes away, you feel worse than if you're just aimless. (7/23/19)

Kevin's idea of a "put together" life includes friends, a hobby, a career, and a girl. When missing one of those things, you "make [your]self feel better." In a similar vein, Chris identified a need for a mental break and some support:

> I would say just like a mental break I guess, because it feels like everything is going fast, and then I guess I would say just somebody there to push me along that you need to just keep on going to you know stay dedicated and everything motivated to keep on pushing through. (7/29/19)

While Chris said he'd benefit from support to keep him "motivated," the following excerpts show students who said they wanted alone time:

> Leah: I feel like being by yourself a little bit, in your own space, is essential for that, because, I think dealing with people consistently can take a toll on your mental health. Sometimes you need to just take a break. Or, well it's really kind of just like subjective to the individual. That's kind of what I find, as a place in which I can wind down and just recharge. But, other people may find it uncomfortable to be around other people for that. (7/1/19)

> Sharon: I have a list, so my planner is my best friend in terms of responsibilities. What do I want or need? Alone time. Because I notice if I'm always having fun with friends, riding the wave, going with the flow and trying to get as much as you can, oh my God I need it all right now, then I'm not going to have the time to sit down and take care of myself. It's so much easier to just go out and have fun all day, 24/7 and then you end up forgetting about everything else. So, always reminding myself alone time can be fun, but it also means business, but also means this and that and this. So it's like, but now I love it. (4/12/19)

> Zadie: I feel like I kind of just need space and time from certain people and certain things. And I feel like the rest will work itself out. Mostly because the reason that I haven't made that leap to where I would like to be right now is because of the limitations, like fitted toward me, not just because I'm a Hispanic lady of my age. Not because of that. I feel like it's the things that have been tailored to me. (4/22/19)

Interestingly, Zadie points out her identity as a "Hispanic lady of [her] age," but does not name it as the cause of her limitations, the reason she hasn't taken the "leap" toward more "space and time."

Patricia also named time as a need: "I think I need more time in my schedule. I don't think I have the best schedule to be exercising every day (7/29/19)." Ijeoma also shared the following:

> I don't know. I don't know. I deal with my emotion myself, and I don't think that would change. But it's more of like dealing with in a healthier way instead of avoiding my emotions … more of like process, if that makes sense. Yeah … and time. Nobody can give me time but myself. (7/24/19)

She takes full responsibility for the things she needs to reach her notion of a healthy life. Makayla, similarly, identified the "push" she needs for "positivity":

> I guess push more for positivity in myself because you always have those days where it's like, "I just feel so crummy and I just feel ugh." Or I think tried to push to do more positive things with myself or for myself. And just like treat myself right? If I do something for myself, just treat myself and then maybe I'll push to do more. (6/12/19)

It is possible that students' expressed need for time, and support for motivation in Chris's case, is in response to the increased pressure that many young people feel as a result of a global focus on academic achievement and competition (Lee & Soon-Mook, 2014), and the focus in the educational sphere on meeting "world-class standards" (Greene, 1995, p. 32), but this pressure was not named explicitly, and these students identify themselves as the person responsible for reaching what they define as a healthy life. Is this view of themselves ultimately empowering, because they position themselves as agents of change, or damaging in the face of their socialized limitations? How much does assuming such limitations reify the categories I have previously problematized? Was there something about the way I asked the interview questions that encouraged individualistic responses? The answers to these questions cannot be found through this study, but arose throughout my excavation of the data.

Interestingly, two students (Sharon and Kimberly) said they would like to read more to reach their imagination of a healthy life, among other things.

Finally, Viv and Bryant named changes that can be viewed as both individualistic and structural. Viv shared she needed to “have an actual calendar to see when I eat and track myself. I said I was going to do that at the beginning of the year. I started for the week, but I stopped. And take actual snacks to school, because the school lunch is bad. Have you seen it? Have you ate it?” (5/22/19). She’s focused on gaining weight, since her doctor told her she was losing weight, so while on the one hand, she sees individual changes to be made, on the other hand, the school lunch she has access to is unappealing. She continued,

> But then I feel like it’s just more my mindset … accepting yourself. I feel like I just can't get fat, and my weight is the only thing that I would say bothers me. But then I can gain weight, but I have to really dedicate time, and I don't have time for that right now. So maybe I'll fix that in the future, but I have to accept myself now, think it's going to change. (5/22/19)

Bryant also identified his needs for groceries, which has been challenging because he’s supporting himself:

> I need groceries man. I need it. I need to start cooking again. I really do. [It’s easier to do] at home, but at the moment, it's such a very expensive trip, and I kind of support myself a lot more now. So, yeah. But as soon as my checks come in, I'm going to be back on my grind. (7/1/19)

Here, he takes responsibility for his shopping and cooking habits, and in later excerpts, he elaborates on unequal access to affordable food.

Structural Changes

Samira imagines a healthy community as “a community that basically makes everyone feel comfortable enough to be themselves and there’s no barrier, and everyone has access to everything. Healthy, as in healthcare, actual healthcare.” Hokowhitu (2014) writes that at the heart of healthism its discourse is privilege and power, as the “healthy body and lifestyle have come to symbolize privilege” (p. 38). He continues,

> Healthism is sustained by the fact that being healthy signifies power as "ableness"; being able to afford the right foods; being able to afford the time to exercise; being able to afford the right education; being able to afford the time, land and resources to grow an organic garden; being able. These statements of power help enunciate the dialectic between healthy and unhealthy, able and disabled. (p. 38)

Some students in this study imagine a healthy life through structural changes in the form of accessibility to healthy food options and mental health resources, and additional supports in school.

Accessibility. In the excerpt above, Hokowhitu (2014) uses the language of ability to describe the privileges that healthism requires. In the below excerpts, students specifically named "access" as key to their imagination.

> Kimberly: If you tell me healthy community I envision, I don't know- I don't know what that would look like. I mean I think of yeah, where healthy foods, options around the neighborhood. So then that would, in my mind, that's what it looks like. It's like downtown New York and where all the people.... I don't know, that's what I see.
>
> I'd say money and access. Yeah, because I know [my sister,] she also tries to eat better, but I remember she was like, "Oh I'm craving Sweetgreen or something." And we had to go all the way to [street[5]] to go to Sweetgreen. 50 blocks from my house. And so I guess, nearby. And then, whenever my mom's like, "Oh do you want to order something?" The only options we think of are Mexican, Chinese and Dominican. So it's ... I mean, we have more options but it's Domino's and Kentucky Fried Chicken, things like that. Little Caesar's so, we don't, yeah, access is a big thing. Especially in our neighborhood. (4/15/19)
>
> Bryant: Just access to healthy foods. You know, just convenience, location sometimes, because in the Bronx you don't have as many healthy vegan places, juice places, salad places. In the Bronx, you have more like, a McDonald's is down the block from my house, or a Popeye's, or a Kentucky Fried Chicken. That's what's located near us, so that's why, it goes back to what I was saying, environment really does affect you….

[5]Street name redacted for anonymity.

> Since you're aware of like, the access is unequal, you're going to want to think about how these communities that don't have the same access to all these kind of healthy options, and people that don't get promoted, don't have health promoted to them as much, you're going to want to think about how they're already living, because it's hard for a person to just change their ways. It's really hard. Some people don't want to do it because they think they don't believe you. Some people don't want to do it because they just feel like it's too much work or it won't work. (7/1/19)

> Sade: Food wise, I would like there to be more supermarkets and food available, organic wise, and just more healthier options, more available to everyone, not just a certain class or rich people or stuff like that. Even if you go downtown, you'll see there's a lot of Whole Foods, and Trader Joe's, and Fairway, and stuff like that. But you head uptown towards the Bronx, it's Popeye's, KFC, MacDonald's, and stuff like that. I think that as a community there needs to be a balance of both, and there needs to be access that everyone in the community has access to healthy foods. (7/1/19)

Kimberly, Bryant, and Sade imagine healthy food options that are convenient to their neighborhoods—not just available "downtown," but everywhere. Bryant even states that the people who live in neighborhoods without healthy options accessible to them are the same people who don't have "health promoted to them as much" (7/1/19). Below, students did not name access, but did name money and jobs:

> Abou: I know what the problem is. I don't have the power, because I don't have money. My parents have money, but they're working hard. But I don't ask them for money. Yeah … I go home, there's barely food. I ask my parents, money don't come in like that. Life is hard, you know? (4/17/19)

> Tim: I feel like the way my diet is, I probably just want more vegetables. I feel like I get most of everything except fruit sometimes, but I can't really control that, cause I can't really buy stuff. (4/18/19)

Abou equates his lack of power with his lack of money and, along with Tim, is constrained by his status as a student.

Finally, in the following excerpts, Bryant and Mia imagine additional community resources for more people:

Bryant: There are MetroHealth health fairs on the blocks all the time, and that gets people to sign up for healthcare. That makes people realize that they need to go in for another appointment. 'Oh, that I'm not as healthy as I used to be.' You can set up these activities. Maybe this person doesn't do as well as they thought they would. Maybe they feel like they need to eat better. Maybe they feel like they need to be healthy. It's those things, like small things like that. (7/1/19)

Mia: I feel like we should start having more conversations like this. I don't think that this conversation happens a lot within communities like this. I think that if we were then a lot of, I don't know how to say it ... but I feel like things wouldn't be the way that they are. (5/4/19)

At first, it's unclear what Mia means when she says "I feel like things wouldn't be the way that they are" (5/4/19). When I asked what she meant, she said, "people would probably start thinking more about their health and stuff. People do that here, because they don't really have that education piece." When asked how we get there, she said by "legislation, maybe … introducing programs that do have access to resources, especially mental health resources, just different resources."

In contrast, Samira wonders if there are times when too much access is the problem. She ponders,

> We have access to the best research facilities, we have access to the best cancer treatments, we have access to everything, so who cares about health? And I think that's really bad because what if we could prevent that? What if we could get to a place where we didn't have to rely on so much to be healthy, to be living? I feel like it's possible, but it's not a priority. Even healthcare is a big industry. People would rather profit than teach one person how to know how to be healthy. If everyone was healthy, you know all these companies would never be making this amount of money, but I don't know.
>
> I think we have to be reminded that being healthy is important because we worry about a lot of things just as human beings, about a lot of different things. But I feel it has a lot to do with where you are in life and the way you live. Like my example of living in Africa and living in America. My goal here would probably be to successfully graduate college. Whereas an 18-year-old in a different country ... I don't know, I just feel like it's different things, scenarios. It just looks different for people. So I like to really take care of myself because of all of these, not distractions, but all the things that come with being an American. I let the culture define me, it's like if no one

> else does it then why should I. So you really got to be in touch with who you are kind of and know that being healthy is important in the long run. (4/10/19)

For Samira, taking care of herself keeps her from "all the things that come with being an American," from relying "on so much to be healthy, to be living." She views the healthcare industry as an entity that prefers "profit" over educating the public. The personal responsibility she takes for her health is indeed in resistance to these larger social structures.

Additional supports in school. In addition to structural changes in their neighborhoods, the excerpts below demonstrate students' suggestions for new or different structures in school that would support students' health.

> Kimberly: Apparently in some schools, their school counselors and guidance counselors are the same people or something. Someone who works school counseling like, "Oh, you're on track to graduate," is supposed to also cover like, "Oh how are you feeling today?" And in my school, it wasn't like that. So again, I'm lucky that those two people are separate. Because again, some people aren't qualified to do both. So yeah, I saw that post and I was like, "It's not supposed to be like that." And I guess students were aggravated that some schools have that, but she [my counselor] did mention that we had two separate counselors for just mental health and if you ever just wanted to stop by an office and be like, "Oh hey, I'm not feeling well," or something like that. (4/15/19)

> Bryant: I feel as if health is a big issue. So, the same way this place is different, a separate space from how the school would be, I feel like there should be those kinds of spaces in the schools themselves, create that space. My school had a space upstairs on the very top floor where there was a small room, and it was kind of like this. You could just go there, and you could talk about your issues with a counselor. Create those comfortable settings, and make sure that expectations are set for the students coming in, for everybody, and make sure you keep those expectations. You can't just bring kids in there, and then not tell them how they should act. They should know beforehand that this is a safe space, no question is dumb, everybody should be respected. You emphasize those rules a lot. Of course, they have those rules in high school, but it wasn't as important or appreciated as it is here. So I think an appreciation should be built the same way as it was here overtime.

> It definitely takes a lot of time, but overtime, that implementation will change a lot. (7/1/19)

> Zadie: I don't feel like it [health]'s something that they can necessarily put in the curriculum. But I feel like that's something that has to come within the teachers. I don't feel like it can be something that is part of the curriculum because something that I feel like a lot of the teachers would do is just get a lesson off of Google and play it during class and that's not how it works…. (4/22/19)
>
> I feel like once I get a start at redefining the school system I will help do that but I feel like it's totally up to my generation and the younger generations coming to deal with health and the way it's taught and the way it's spoken about. I feel like for adults to speak about it it's already too late. I say that because too many adults are in this mindset whether they know it or not, that it's like, 'I'm an adult. Why are you talking to me? I know what I'm doing.' You know? So many people think that it's teenagers that are like that when really it's teenagers that are more willing to listen even if they're not out there about it. It's more like I'm closing the door in your face but I still have my ear against the wall, like I'm still listening to you. And many adults think that because that door is closed like we've walked away, we're not listening, we're in our own world, but no, it's not like that.

Kimberly identifies adequate numbers of school counselors to support students at each school. She names the reality that for many NYCDOE schools, the mental health needs of students at their schools surpass the resources and counseling services available (Okoya, 2019), while also expressing gratitude that she had access to counseling at school if she needed it. Bryant makes similar recommendations to Maria in the first section of this chapter, wherein students have a "comfortable setting" (7/1/19) in which they can talk to a counselor. He also makes specific suggestions about the boundaries that school staff can set in that space to ensure that students respect each other. Finally, Zadie focuses on the care of the teachers, and adults in general: she doesn't want suggestions for health class to be boiled down to a curriculum change so teachers can "download it off Google" (4/22/19). Instead, she wants adults to actually listen to students to teenagers, the way teenagers are "more than willing to listen" to them, despite their reputation for otherwise.

She also commits that she and other members of her generation will be the ones "redefining the school system."

Suggestions for Health Class

Students provided a wealth of suggestions for specific content that should be included in health class, and activities that they believe would reach students and meet their needs: about mental health, nutrition, drugs and alcohol, body literacy, menstruation, sexual health, consent, LGBTQ inclusivity, body image, and healthy relationships, just to name a few. Azzarito, Macdonald et al. (2017) assert that "creating culturally relevant, community-based curricula that meet the specific needs of ethnically diverse young people in the local contexts of their daily lives might open up possibilities for them to find socio-educational spaces where their subjectivities are not denied but legitimated" (p. 215). Fitzpatrick (2014) adds that effective critical health education practices should be focused on "health issues (local and global) deemed important by students" (p. 184) and take into account the cultural contexts in which such programs occur, attending specifically to cultural politics and "economies of health" (p. 183). I agree that health education content is ideally guided by the local context. In order to ensure the following sections are useful to health educators in a variety of contexts, I have chosen to only include suggestions that can be universally applied. I maintain the recommendation that health educators should consult with their students, families, and neighboring communities to assess the health topics that are most significant and relevant in their students' lives. The specific recommendations that students made will be provided to the organization at which we conducted the interviews. In addition to imagining health content that meets students' needs, students also imagined general changes in education that can support students' health.

Focus on the positive. Abou, Leah, and Ijeoma suggested that schools address the "positives" of health, or what teachers "should" do, in order to engage students, in the excerpts below:

> Abou: Teach both the positives and negatives…. Live longer, because everybody wants to live longer. Maybe when you grow your nails, because girls, nails get stronger, I guess. Hair gets longer. We need to talk about both. Because there's a lot of people that do a lot of things. (4/17/19)
>
> Leah: I would try to kind of make it interesting and apply it to ... in our lives and kind of just, inform them of things that they can do in their own communities to better their health. Because a lot of us are getting breakfast in the morning from across the street. Tell us a better way to improve our diet in the morning time instead of a greasy sandwich. But something that doesn't taste like grass, please. Just introducing them to new things and letting them ... Kind of just trying to make them aware that you're not an adult. You need to eat right. And you need to stay healthy. (7/1/19)
>
> Ijeoma: I think make the topic more about what they should do instead of what not to do, if that makes sense. Yeah. And instead of kind of ... Because the topics are targeting girls a lot, if that make sense. It was more of ...Especially the sex topics it will always end up ... Like the girls will usually be the laughing stock of the class, if that makes sense. Teach kids that is ... I don't know. Health is for everybody. (7/24/19)

As mentioned previously, "pathogenic" health approaches are those that produce the dichotomy between healthy and diseased, presenting "disease and morally incorrect behaviour [sic] as things that deviate from the ideal norm" (Quennerstedt & Öhman, 2014, p. 190). Several critical health scholars agree that pathogenic approaches pervade school health education (Evans et al., 2008; Macdonald, Johnson, & Leow, 2014; Quennerstedt & Öhman, 2014), wherein the focus is teaching students to avoid risky behaviors. What Abou, Leah, and Ijeoma suggest instead, is that teachers build on this by teaching what students "should" do, instead of solely focusing on what should be avoided: Leah asks that they "tell us a better way." Abou suggests they start with topics that he knows people are interested in, like living longer or growing your hair. These

three excerpts point to the risk-avoidance discourse that permeates health education as a potential barrier to student engagement.

Ijeoma also raises an interesting point about the experience of girls in health class. Though she mentioned several positive experiences in health class in prior excerpts, here she states that some lessons "are targeting girls a lot" and that all genders should know that "health is for everybody." As mentioned previously, Agnew and Gunn (2019) argue that young women's bodies are painted as "problematic" when a "discourse of hygiene" prevails, specifically in the context of teaching about menstruation (p. 671). Additionally, Azzarito (2010) argues that public health discourses "implicitly fabricate racialized and classed girls' bodies" and that these discourses make their way into the classroom (p. 262). There is indeed a history of public discourse about women's bodies in general, and their sexuality specifically, that has constrained them and their understanding of their sexuality in and beyond the classroom (Fine, 1988; Fine & McClelland, 2007; Tolman, 2012). Ijeoma suggests that teachers make an effort to ensure that this targeting of girls is stopped, and that all genders recognize that they have something to learn about their health.

Start early. Interestingly, Zadie shared an idea very similar to the practices that Kimberly's mom employed from when Kimberly was younger, cited in Chapter IV. She stated,

> I feel like health, like small little bits of it have to be implemented from the very beginning, like kindergarten, because kids are like sponges. They absorb all of that stuff. Right? You don't have to tell them what sexual intercourse is. You don't have to go as far as that. But you can start putting little things about how your body is yours. Your body is your temple, you know? It's not up to anybody else to tell you how to groom your temple and to tell you how your temple looks best, you know? I feel like little things like that can be put and I feel like even if you're not saying your body, like love yourself. I feel like if you say things that kids will be like, "What the hell are you talking about?" I feel like just opening up the discussion from then would do so much more. Yeah. That's about it. (4/22/19)

New York State Law sets health education requirements for all students in grades K-12, wherein students in grades K-5 must have health instruction every year, and K-6 must have five HIV/AIDS lessons each year, though there is no specific time requirement (NYCDOE, 2019). New York State standards for elementary, middle, and high school students are shared on the website of the NY State Education Department (NYSED, 2014).

Be intentional about representation. There is an influx of recent research demonstrating the benefits of Teachers of Color for Students of Color: there is evidence, for example, that schools with larger numbers of Black teachers or a Black principal tend to have greater numbers of Black Students in gifted or honors programs, with similar data for Hispanic or LatinX teachers and students (Grissom, Rodriguez, & Kern, 2017); there is also evidence that students with a racially incongruent teacher are more likely to be suspended than their classmates with a race-congruent teacher (Holt & Gershenson, 2017). In the introduction to this chapter, Maria cited her admiration for her teacher, whom she identified as a “strong Black woman,” and the fact that “she used to be us.” In health education specifically, Tinning (2014) writes that because of the emphasis on the appearance of one’s body in health and physical education classes, it can become a very vulnerable space for students, made more or less vulnerable by the embodiment or identity of the teacher (Webb & Quennerstedt, 2010).

Evans-Winters (2011) suggests reframing the question from “does ‘race’ matter” to “do African American female students benefit from having an African American female teacher?” (p. 143). The excerpts below demonstrate students’ perceptions of the benefits of racial and ethnic representation among teachers:

Sade: I think the best way teaching people, especially young people about health, is having different people around them, having representation. You could have a super strong guy as a health teacher but people are gonna think, "Oh, he's just healthy 'cause he's all fit and stuff." No, but you can have different types, just representation, I think would matter. Yeah. Now that I think about

it, I never had a Black woman, a Black health teacher. Yeah, I never had a Black health teacher. Well, I had Ms. T,[6] but she was just ... I don't know. She was good but she tried to be more friends with the students instead of being a teacher and mentor. 'Cause usually it would be jokes and stuff like that when it came to health. It's all good and fun and games, but you also have to make sure that students are getting the message. Especially for girls, especially girls of color 'cause I feel like especially when it comes to physical, we can work more, we need to be pushed more. There's not more gym teachers of color, women of color inspiring Black girls to work and exercise and be healthy and stuff like that. 'Cause yeah ... Especially just women in general. We just need women in general 'cause I can count on.... I think I had two female gym teachers. We need more females to push people like, "Girls can be healthy. Girls can work. Girls can do pull ups and pushups, too, not just guys. (7/1/19)

Makayla: I mean, it's not a good thing, but at the same time in the world we live in [identity] definitely has an impact. Because if you talk about race, they prefer it with someone of their race or if you talk about ethnicity they prefer of their ethnicity, because they feel like they can relate more or gender wise. When you talk about gender wise, they're not going to want to talk about it with a male. They're going to want to talk about it with a female. Or if you talk about transgender stuff, they're going to want to ... They're more open and talk to someone who's transgender than someone who's not. Or someone who is lesbian, like things like that. So, I think it does impact a lot whether we know it consciously or unconsciously.

Because I mean, I do the same thing myself. Certain things I'm more comfortable with to talk about with certain people or like certain ethnicities or certain genders. If I was to talk about my period, I wouldn't want to ... I would feel more comfortable to talk about it with a female than I would with a male. Not saying that they're going to do anything or like they're not uncomfortable with it, but I would prefer from a female because I know well she's going to know what I'm going through. I mean, they could try their best to [address that], but I feel like it's still going to stay with them regardless of if they tell them like, "You know you should give this person a shot because they may know some stuff." But I feel like some may change and I feel like so may not. Because, some may will ... I mean some will listen to if you have ... Let's say you have more history about someone's ethnicity than the person who's actually the ethnicity. Then they listen but then again

[6]Pseudonym

> it's like, but you're still not in my shoes. So, I think you can probably address it and probably listen but most likely they're going to want to lean towards someone of their ethnicity or their gender or something like that. Because that's just who we are as human beings, we gravitate towards it whether we like it or not. We are judgmental as much as we try not to be, we still judge because that's just who we are. (6/12/19)

Both Sade and Makayla self-identified as Black women, and their comments here reflect Evans-Winters's (2011) findings that there are benefits of having Black female representation among teachers, especially for Black female students. They also express a desire for more representation of all kinds of people, in order for students to feel more comfortable with someone who has been through what they've been through despite Makayla's acknowledgment that "we gravitate towards it whether we like it or not." Both Sade and Makayla also identify a desire to see more female representation of any background, to show that "girls can be healthy," or to support young women in talking about their period, for example. Ijeoma shares that same desire below:

> It depends. I don't know. How about we just have both sex teach the class. Having both sex teach the class instead of just one because it's like ... Especially if you have someone like Mr. J who is a joker. And the case of joking, he will usually just laugh with them. Not like you need that. It defines the class. Some girls were laughing too, but it's more of like ... It's kind of a feeding cycle. (7/24/19)

Critical health scholars have indeed identified a pattern, among physical education teachers who teach health specifically—which is the case for Mr. J.—that their discourses typically reinforce a "masculinist and heteronormative expectation of male teacher identity" (Fitzpatrick & Russell, 2015, p. 167; Brown, 2005; Sykes, 2011). Andrew also identified preferring a female teacher, but for much different reasons than Ijeoma: "Well not me, but yeah. If it was a girl, cool, it's making me interested, but if it was a boy, then I'll be like, that's disgusting, and be like, I don't want to learn that no more because he's teaching it" (7/25/19). Andrew's comment may be more reflective of the heteronormative discourses cited above. Burke (2011) writes that a key tenet of performing one's masculinity in adolescence is to ensure the people around them are aware that they're

straight. Andrew, in the excerpt above, shares that he would much prefer learning about sexual health from a woman, perhaps in an attempt to perform either his masculinity or his heterosexuality.

Additionally, both Patricia and Kimberly noted the impact that the appearance of their health or physical education teacher has on their learning. Patricia shared:

> I feel like me personally, I learn more like when I can relate to the person. I don't want someone the complete opposite to be teaching me. In [my school] the teachers who taught it were physical education teachers, it was like, okay they must know what they're talking about or if I'm [here], some of them are athletes so they also must know what they're talking about. I wouldn't want someone who doesn't, I don't know, I guess someone who doesn't know the topic and sometimes it's easy to tell when you don't really know the topic. Someone who's comfortable with it. (7/29/19)

Patricia identifies someone who "must know what they're talking about" as someone who appears athletic; this reflects a finding of Webb, Quennerstedt, and Öhman (2008), who argue that teachers use their bodies as one of many instruments of their teaching, especially in the case of physical education teachers. Webb and Quennerstedt (2010) later build on this finding to add that physical education teachers felt pressure to manage their own bodies as well as the bodies of their students. Kimberly noted a similar sentiment among her friends:

> Yeah. I think but with, I guess you could tie it to gym or something. Because I remember one time my friend was, she was ... he made a comment that my gym teacher was fat. So it was like, "Oh, how can you tell me?" Like my gym teacher ... shouldn't you be doing this yourself, or something like that. So you wouldn't take it seriously. And you would, and so I guess, in a lot of students' minds you expect the gym teacher to be fit. So I'm not going to take someone who's not fit seriously to tell me to become fit. So they made that comment and I was just like, "Not everybody has to be fit," you know?
>
> We had three gym teachers and out of the three only one of them was unfit in their mind, and the other two were fit. So then one of them that's fit, she was our health teacher. And so there's, I guess you could, it's easier to take her word for it because it's, oh I can see how that reflects onto your body image. So oh you follow these rules, then maybe I should so that I could look like that. So I don't know, it's easier to take someone's word for it

> based on how they look. Especially depending on what you're saying. (4/15/19)

Kimberly acknowledges the contradictions of judging someone's effectiveness as a teacher by their body type, and concludes that for her classmates, "it's easier to take someone's word for it based on how they look," in the case of both health and physical education. This is reflective of the "culture of performativity" around health, especially in response to anxiety around the obesity epidemic, that ultimately has been shown to affect teachers' feelings about "the moral imperative and duty to be healthy themselves" (Webb, Quennerstedt, & Öhman, 2008, p. 788; Evans, Davies, & Rich, 2009).

Bryant had some interesting things to say about perceived societal ranking:

> Oh for sure. Say a homeless person came to be trying to promote health to me. Even if they might not look healthy, they're healthier than me in mindset and in body. I'm looking at them like, "Oh, you're homeless. You're at the bottom of our societal ladder, so I'm not going to pay attention to you. Your opinion means nothing to me." That's definitely one thing, and then it gets into the issues of color. Like if you go over to the South, you go to Alabama and you're Caucasian, you're Asian, you're just not Black, and you're trying to tell people how to take care of themselves. They're going to be like, "What do you even know about me? I'm different." That's the response you're going to get, and some of that is even from the message that you're saying, like you're giving them. It's just preexisting notions, and just expectations that kind of have been ingrained in them, certain values. It sucks, but you're going to encounter it. The only way you can counter it is by just thinking of those different ways to get the message to them that they will listen, because it's not going to be the same for every single person. It's like, you're always improving. (7/1/19)

Though Bryant equates the South in general, and Alabama specifically, as an area where there are more Black people than White or Asian, his point is clear: when speaking to an audience that's racially incongruent, there will be barriers to their reception of the information, because these "preexisting notions" are "ingrained." He also states that it depends on the person, and that there are ways to counter it.

Finally, Chris, Kevin, and Jupiter expressed caring less about a teacher's identity, and more about the relationship that person is willing to develop with their students, as well as their perceived relatability:

Chris: I wouldn't say it's more so the identity and more so the relationship with the person, so like me it more so hit with I think my family mostly and here than it did with school. And then, because I've known people here longer and of course my house people longer so I would say it's not mostly the identity for me, personally I would say it's more like the relationship I have with that person. (7/29/19)

Kevin: Everyone perceives things differently depending on who's telling the story and then they're more open depending on who it is. I mean, I don't really know what makes people feel more comfortable, but, I don't know, I try to bring someone that seems relatable to them, because usually you're more comfortable around people that you can relate to. (7/26/19)

Jupiter: Not really. Me personally, I think it's just how the person carries himself. If you're respectful and you're actually trying to connect with the students, they'll learn more than if you're just reading a book. I'm just an open-minded person. So, I don't care ... I don't mind whatever you are, just be respectful and actually try to teach me something. Make the lesson fun. (8/1/19)

These students appear more focused on relationships, level of comfort, and “how the person carries himself.” It should be noted that these are students talking to me, their racially incongruent educator, which may have impacted on how they chose to answer.

Caring, openness, and honesty from adults. In their imagination of a healthy life, students overwhelmingly expressed a desire for a shift in adults’ behavior and messaging around teenagers: they want care, openness, and honesty from health teachers specifically, school teachers more generally, and all adults in their lives.

The excerpts below demonstrate a desire for more honesty from teachers and adults in general:

Zadie: Finding a way to open kids up to adults and not having adults treat kids as just like, “This is my job and this is why I'm here.” If they could just present themselves as people, I feel like kids would be a lot more willing to go to adults about their problems, which is a necessity. (4/22/19)

Sharon: School isn't everything…. Life experiences are important too. I feel like teachers should tell students that they're humans and that they're going to f--- up. (4/12/19)

Both Zadie and Sharon express a similar need for more humanity from the adults around them. Below, Gloria shares how important it is for teachers to present themselves as someone they can reach out to, because of how difficult it can be for students to actually take that step:

> I think it just can depend on the person, because a person may be scared to reach out, not even in person. Sometimes they're scared to pick up a phone, or try to just type an email because they're so anxious. They get very concerned if what they're thinking or what they're concerned about is something dumb to be concerned about. So they live the rest of life wondering what is the exact concern. But they can't approach anyone about it, because they're too scared to think it's a smart question to ask. In the end, even if they think it's a dumb question, asking anyway. (7/31/19)

Gloria's anxiety about whether a concern is "smart" enough to warrant reaching out to someone suggests how significant it is to have a teacher who is intentional about expressing their care for their students. It echoes Zadie's idea that a teacher's attitude can encourage kids to be more "willing to go to adults about their problems" (4/22/19). Next, the following excerpts demonstrate students' thoughts on necessary qualities for a health teacher specifically:

> Shoshanna: Knowing that you have resources and there are people around you that can help you if you ever get into a situation where your health is not the best.... I still have my first teacher's number from 6th grade. (5/3/19)

> Fernando: When you can show them that they can talk to you. And it has to feel natural and not forced. Because you can always try to make somebody feel comfortable. But I feel like when you try, it just makes it uncomfortable. It has to just happen. I don't know, it's not easily explained, but sometimes just spending time around somebody, eventually you like just talk regularly and you feel more comfortable talking to someone after spending just regular time. (7/26/19)

> Leah: Creating an environment that people feel comfortable with sharing themselves. Because, you can't really get help if you're not being honest about what you're actually doing, and what you're allowing. So... We have to ... you can't be judgmental. You have remove judgment, because everyone is different. But we more or less, we have experienced the same things. So, just letting people know that

it's okay. That whatever it's ... like we can't judge. We're all just humans. We're all equals. So, we're not been able to judge the next person. Let them know that there's no reason for them to feel shameful about what they do, or how they feel about things. (7/1/19)

Ijeoma: Being open-minded and listening…. I guess to use personal experiences. I feel like when kids learn, they need to be thinking about the story so that they know what can actually happen. That's actually one of the ways that I learned too. Using personal experiences. Because it's always best to apply it to what could have happened to that person. If someone was there, if someone wasn't. (7/24/19)

Jupiter: I wouldn't say to always be sympathetic with them, and don't pity them cause nobody likes, or I'm not going to say nobody does, some people do. But don't pity them. It just seems like you're just feeling bad for them and not trying to understand them. You have to try to understand what goes through their minds because it can be, some people genuinely are sad sometimes and they don't know why, or there's an actual reason and they just want to talk about it. Don't push too hard because sometimes they'll get annoyed and this is themselves. I would say just be open and have an ear, but if they don't want to talk, then give them space, don't push the boundaries. (8/1/19)

Maria: Okay, teachers should be aware. They already know this, but they should come up front about it to the students. They should be like, "I know you're going through this, this, that." And they should stop being ashamed about what's going on in society because I know a lot of teachers, they try to.... Oh, they know these kids. I remember this teacher told me, "I know I wouldn't make a big deal if she didn't give an essay. If she's not acting like herself something probably might have happened at home." But instead of that you should just confront that person, like, "What's going on?" To make her talk. You shouldn't make a student still be quiet. I really don't like when teachers, they know that something's going on with that person and they don't want to talk to them because they like, "That's going to be stress. That's going to be trouble for me. I'm not talking to that kid." So they should go up to them and be like, "What is wrong?" If they are not talking to you, give them a minute where they establish a relationship with you and eventually she's going to talk because everybody needs a support system. (7/30/19)

Shoshanna identifies a desire for teachers to show their support, Fernando and Leah focus on creating a comfortable environment where students feel good about sharing, Ijeoma says she learns best when a teacher is open-minded and shares personal experiences, and Jupiter suggests that teachers try to understand their students without pitying them. In the last excerpt, Maria expresses a desire for an aspect of culturally relevant teaching as identified by Ladson-Billings (2009a) wherein teachers make "a link between classroom experiences and the students' everyday lives" (p. 102).

All of these students' comments are reflective of Fitzpatrick's (2013) finding in her ethnography of a critical health and physical educator: students' acceptance of their teacher's methods relied on their teacher's intentional creation of strong relationships with the students, among students, and an open, caring atmosphere in the classroom (p. 206). This is also echoed in several of Ladson-Billings's (2009a) recommendations that culturally relevant teaching requires intentional relationship building with students on behalf of the teacher. The students here crave deeper connections with their teachers, especially with regard to health, and extend that craving to a desire for more honesty from all adults.

I end this section with an in-depth share from Bryant about the specific steps he would take and strategies he would use to engage a health classroom as a teacher:

> If I was teaching health class ... it would definitely, if my optimal kind of health class setting would be small classroom, comfortable chairs. You know, maybe provide everybody with snacks, just start off the class asking how everybody feels, always have the expectations set on the board just so everybody knows what's going on, go over it before we start discussing our topics. As for what topics we would discuss, I would definitely talk about issues of mental health, how to talk about mental health. Not just knowing what it is and how to diagnose somebody with it, as if you can just diagnose that. More talking about sexual experiences and how that impacts you, not only physically, but mentally. Going into depth about contraceptives and birth control and all their side effects, and then maybe even cover some case studies, go through scenarios, because those scenarios that we would do here really put it into perspective.

> You would really think more about it instead of just hearing somebody saying like, "Oh, I take a look into my life," and then forget about it an hour later. I would go home and think about those scenarios, and I would make them thought-provoking. You can't just offer a boring one. Make them as realistic and thought-provoking as possible, just to get more opinions out there and get everybody's input.
>
> That would help me tailor the future lessons, because I can get a sense of how everybody's feeling this week, maybe what's going on with a certain kid, what issues seem to be big. It's really just about being kind of attentive and always improving and tweaking, not just having a set curriculum and going off of syllabus. (7/1/19)

Bryant’s focus at the end is the importance of checking in with students, being “attentive,” always “improving and tweaking,” and considering the necessity of tailoring lessons to students’ needs.

Ladson-Billings (2009a) writes that teachers are often burdened with resolving a wide array of school and community issues, especially in the public discourse, and I do not intend to imply that a change in teachers’ actions is the sole solution. Instead, I hope that presenting students’ suggestions for the qualities of a health teacher that they would like to see provides a glimpse into their imagination for a healthy life based on their lived experiences.

Individualize it. Finally, these last two excerpts demonstrate students’ perceptions of the individualization that teaching health requires. Below, Mia and Jupiter share ideas highlighting the individual process of understanding health:

> Jupiter: I think people just have to figure it out over time, that this may work for me, may not work for somebody else, but it helps me. I think you can give suggestions, but it might not always work. (8/1/19)
>
> Mia: I don't think that there's a right or wrong way to kind of take care of yourself, because what works for me might not work for anyone else. Someone else. Because we have different life experiences and different belief systems and come from different backgrounds. (5/4/19)
>
> [In health class,] we don't really talk about the things that are important to me, and I feel like we should have a say in that. A say

> in what we want to learn. School is probably the best place to find out what people want to hear. So I think that people should go into schools and just ask kids what they want to hear, because I think that that's important.

Health scholars have long argued whether the purpose of health education should be to teach students for specific health outcomes, or about the study of health (e.g., Fitzpatrick, 2014; Fitzpatrick & Tinning, 2014b); here, both Mia and Jupiter state that what works for one, “might not always work” for another. Mia encourages acknowledgment of “different life experiences and different belief systems” and makes the suggestion that teachers and schools ask students what they want to hear.

Summary

Throughout this chapter, I have explored some of the students’ suggestions and imaginations for a healthy life. I aimed to present students’ thoughts and ideas in the context of their experiences around health, as well as stories that demonstrate the ways school-based and societal health messaging has shaped their perceptions of themselves, in order to position students as agents of change in informing future health programming. Students wanted to express messages to young people about being themselves, learning how to reach out for help, and determining who they are apart from their social contexts in order to live a healthy life. They also provided suggestions for structural changes in their communities that can create increased access to affordable food and mental health resources, in addition to support structures at school that can support students’ health. Finally, they provided a wealth of suggestions about specific content that they believe should be taught in a health class, but those will be shared with the organization at which these interviews take place, in order to ensure that health programming remains context-specific and true to the local cultural context (Fitzpatrick, 2014). Instead, I presented students’ suggestions for representation of the student body in their health teachers as well as their desires for intentional demonstrations of care, openness, and honesty from

their teachers. Greene (1995) describes her desire for educators to "come together in making pathways through [the] world with their students, leaving thumbprints as they pass" (p. 16). Greene asserts that we must creatively imagine pathways out of structural inequities that constrain education, and in this chapter, I applied this concept to students' imagination for a healthy life.

Chapter VI

DISCUSSION

The "problem" of adolescent health is a significant interest of mainstream media and academic research (Fitzpatrick & Tinning, 2014a). The homepage of the CDC's Adolescent and School Health section features a "Back to School" section that begins by outlining the health risks for adolescents, stating that health risk behaviors are linked to lower academic grades (CDC, 2019e). According to the 2017 Youth Risk Behavior Survey, "health risk behaviors and experiences, such as violence, substance use and sexual behaviors continue to contribute to negative health outcomes for adolescents" (CDC, 2019e). They go on to cite youth connectedness as a significant protective aspect for one's health, stating that "youth who feel engaged and supported at school and at home are less likely to experience negative health outcomes later in life" (CDC, 2019e). As a result, they suggest steps schools and families can take to provide safe and supportive environments, including delivering high quality health education that focuses on building skills and connecting students to health services they need and supportive adults, in order to reduce health risk behaviors and improve academic performance. To reach these goals, the CDC states that they will continue to monitor youth behaviors and related school policies, in addition to conducting research to increase the effectiveness of school-based health. There is no doubt value in encouraging schools to notice students' sense of connectedness to their school and family communities. Such evidence for continued monitoring, though, in order to reduce the potential for negative health

outcomes and increase the potential for strong academic performance, closely supports many critical health scholars' (e.g., Azzarito, 2009a, 2009b; Azzarito, Macdonald et al., 2017; Fitzpatrick, 2013; Fitzpatrick & Tinning, 2014a; Leahy, 2014) assertions that school-based health programming enacts a form of governmental control over individual health behaviors and bodies that tends to marginalize individuals and communities who fall outside the assumed White norms.

Throughout this document, I have attempted to address the historical and contemporary contexts of discriminatory governmental practices that have created health disparities. I have also added to the existing literature by exploring what students themselves understand about health and what they would like to see from the adults in their lives who say they are invested in their well-being. In Chapters I and II, I contended that the traditional narratives in the field of health education pathologize and problematize adolescents, especially Adolescents of Color, and regularly overlook the impact of the social structures that have historically denied and still continue to deny equitable access to health and well-being across lines of race and class. Deficit narratives that have been consistently placed on Youth of Color do not acknowledge the historicity of health disparities and place the burden of change on individuals and communities who are already burdened by inequitable health and educational policies (Evans-Winters, 2011, 2019; Fitzpatrick & Tinning, 2014a; Yosso, 2005). They do so by dismissing or ignoring the history of racist and xenophobic governmental policies that have created the disparities we see to begin with, and ignoring the impact of stress as a result of racial discrimination in schools and health care settings that have a significant impact on health outcomes (Washington, 2019). These inequitable social structures and power imbalances require that we take culture-centered approaches (Dutta, 2007, 2010) to prioritize the voices and experiences of the individuals and communities disenfranchised by these policies, and that we challenge the messages of pathology that may shape how young people understand health, themselves, and their communities.

This study responded to research that has focused on pathology and deficits (Evans-Winters, 2011, 2019) and sought to center youth voices in order to articulate their lived experience of health through postmodern tenets and critical race feminist lenses. It employed a culture-centered approach that prioritized student agency through semi-structured qualitative interviews, and acknowledged the structural dimensions at play in health disparities in order to politicize the pursuits of health education research (Dutta, 2007, 2010; Fiddian-Green et al., 2007). Dutta (2007) asserts that health-related research can lead to social change when "community lies at the core of the definition of the problem and at the development of solutions" (p. 311). My selected methodological approach of qualitative interviews with student-participants, therefore, was essential in my pursuit for a critical inquiry that centers the humanity (Evans-Winters, 2019) of youth, especially Youth of Color, and provides an opportunity to reinterpret and reimagine taken-for-granted assumptions about health within the field. I employed tenets of postmodernism in order to shift the traditional lens of health and education research toward individuals who have been placed in the margins. I conducted qualitative, semi-structured interviews in order for student-participants in this study to present pictures of their own lives and present multiple narratives around their experiences with understandings of health. I was supported in doing so by a critical race feminist framework with the goal of centering the experiences of individuals who exist at the intersections of race, class, and gender, recognizing that students' health and educational experiences are affected by the positioning imposed upon them by power relations in society (Evans-Winters & Esposito, 2010; Lane, 2015). By involving students in the process and including the intended audience as the locus of change (Dutta, 2007, 2010), this study attempted to disrupt oppressive social structures, which may in turn transform health messaging, research, and educational endeavors, in order to move toward critical health studies.

I wrote in my Foreword that I am committed to the construction of reality that states that our dominant beliefs about health disparities and the supposed "problem" of teenage health are oppressive and perpetuate stereotypes. This study, therefore, aimed to enhance the "historical literacy"—a term coined by Khalil Gibran Muhammad (Gibson, 2018)—in the field of health education, and to challenge the power dynamics that are inherent in health and educational research by centering the voices of Youth of Color. I sought to explore young people's understanding of health through their upbringing and experiences at home, in the health classroom in school and after-school, and in society at large. All of the students in the study were 11th and 12th grade high school students through college freshmen who had taken at least one health class in high school, and who were either current or former participants in the after-school program at which I was employed during the course of the study. All students self-identified their racial/ethnic identity in an open-ended format, featured in Chapter III. The participants' racial and ethnic identities are especially significant given the "erasure discourse" (Evans-Winters, 2019, p. 47) that academics and researchers typically use to describe entire groups of young people—non-White students, students from low-income families, and sexual minorities—as being "at-risk" of poor health outcomes. This study centered participants' personal narratives in an attempt to challenge the "at-risk" narrative that has become so prevalent health and educational research; as Evans-Winters (2019) writes, "Are not all children and adolescents at-risk of emotional, physical, medical, or academic stressors that is by virtue of being a human child during a vulnerable stage of development?" (p. 47).

Merging postmodern tenets and critical race feminist theory—looking to Evans-Winters's 2011 ethnography, which led the way in doing so—this study centered the voices of young people in order to understand students' imaginings of health in the context of our social categorizations and challenge who we view as "experts" in social change (Dutta, 2007). It sought to create pathways away from health disparities as we

understand them in order to reimagine (Greene, 1995) what health education can do. In Chapters IV and V, I shared pieces of students' stories to demonstrate what matters about health to student-participants and what is memorable, critically analyzing students' discourses of health and looking for storylines of what constitutes a healthy person. This study adds to the health education literature by exploring how a sample set of individuals from communities who have been historically pushed to the margins of society came to understand and conceive of health through their experiences and upbringing, in order to provide a counter-narrative to the discourses of deficiency in which they are often found (Evans-Winters, 2019). By doing so, I assert the need to shift toward critical health research, policy, and pedagogical practices that recognize adolescents, and especially Adolescents of Color, in their "full humanity" (Evans-Winters, 2019, p. 70).

In this chapter, I summarize the main findings of the study by addressing the "common" themes and the "unusual" or unique responses that appeared most relevant to the four research questions (Stake, 2006, p. 90): (1) What are participants' thoughts and feelings about health? (2) What are the ways youth navigate health? (3) What messages do participants recommend as being most important to communicate to youth? and (4) How do youth imagine a healthy life, and what do they want or need to get there? I recognize, as I have stated previously, that my selected methodology limits me to presenting my findings as "partial and complex truths" motivated by my politics (Evans-Winters, 2011, p. 16); that, like Greene (1995), "my interpretations are provisional. I have partaken in the postmodern rejection of inclusive rational frameworks in which all problems, all uncertainties can be resolved" (p. 16). After I present a brief summary of students' stories, I share some of the implications of the study for research, policy, and pedagogical practices. Lastly, I briefly discuss the study's limitations.

Summary of Findings

This study emphasized how variable students' understandings of health are, that individuals absorb mainstream discourses of health differently, and that their understanding and experiences of health and the stories they tell about themselves, their friends, and communities may be influenced by the identity contingencies of race, class, gender identity, age, and cultural background. Many students told stories about health as something to perform—something they can be *good* or *bad* at, something they and others should be working toward, something that can be measured by their physicality—yet another achievement they're expected to pursue. Others recognized it was something more intangible, less visible—something they need to pay attention to, but that is more of an internal process. Several students identified positive experiences they have had in health class with caring teachers, while others expressed a desire for more adults who can demonstrate their care and speak to them about health honestly. Finally, there were noticeably several students who identified how their experiences in schooling and in their neighborhoods hindered their well-being: the stress that came with racial stratification (Brown, 2003), the ideals of American culture, and the access to health resources by neighborhood were identified by students as standing in the way of their health. This study suggested that many students' understanding of health was influenced by dominant discourses they may have been exposed to in school, at home, or in the media. Still, for a few students, their ideas about health appeared to stand completely outside of and unaffected by mainstream discourses of health, and they generated their own ideas through self-reflection and personal research.

In Chapters IV and V, I attempted to present what matters to students in their definitions of health, in the ways they navigate health, what messages they want to communicate to youth about health, and the ways they imagine a healthy life; I'll remind the reader, though, that the interpretations presented are largely a reflection of my own

subjectivities and "baggage" as researcher (Scheurich, 1997, p. 73). In the following sections, I was guided by McCall's (2014) work to read the interview texts together and identify what students' stories have in common (Stake, 2006) that are relevant to the research questions. Later, I read the texts apart (McCall, 2014) to present "the unusual" or unique responses in students' understandings as they relate to the research questions (Stake, 2006, p. 90).

Interview Texts: What is There in Common?

As I mentioned in Chapter III, I explored each students' answers to the interview questions in one large document according to pieces of Stake's (2006) methods of exploring commonalities, guided by McCall's (2014) work. Stake (2006) writes that "comparison is a search for similarity *and* difference in cases," in this case, in students' interview texts (p. 82, emphasis mine). Though I did not present this study as a multicase study due to the fact that I chose not to share detailed descriptions of each student, nor to collect multiple data sources about each student's experiences in health, it remained useful to my analysis and organization of the data to view all students' answers to the interview questions together in order to illuminate what the texts shared in common.

This section explores the common relationships that appeared throughout the interviews. When I viewed students' answers to the same questions all together, I identified traditional discourses of health, of risk, shame, and fear, throughout the texts, and I placed these discourses in the context of larger social structures, especially the intersections of race, class, and gender. In addition, I attempted to identify storylines about what constitutes a "healthy" person, and how students have experienced health class and health messaging throughout their upbringing. This allowed me to explore and consider how student-participants' socialized identities and experiences have led to common understandings and experiences navigating health. The commonalities that appeared most relevant to the research questions are the performativity of health; low

school investment in health education; discourses of fear, risk, and shame in health class; and students' desires for openness and honesty from caring adults.

The performativity of health in a raced, classed, and gendered society. Webb and Quennerstedt (2010) argue that the culture of performativity in health, which "describes a focus on judgments, comparisons, incentives, and sanctions" (p. 787), is a result of increased public anxiety over adolescent health issues and subsequent surveillance of health behaviors in schools. In this study, discourses of health for many students reflected neoliberal health messaging that encourages individual responsibility in working toward and maintaining a desired health behavior or outcome (Fitzpatrick & Tinning, 2014b). Students' ideas about what makes someone healthy as something that can be viewed externally, or as something that can be performed, may in fact be impacted by neoliberal "moral imperative[s]" to be healthy (Webb & Quennerstedt, 2010, p. 788). Students' subscriptions to performativity in health complicated their feelings about their own health, about themselves, and even about their health teachers. Many students seemed to agree that what makes someone healthy is the food they eat and their level of exercise. When asked about the healthiest person they know, and about their friends' habits regarding health, many students focused specifically on who eats the most vegetables or who gets the most exercise. A few students, or their classmates, in Kimberly's case, also allowed this focus on performativity to affect their idea of what makes a good health or P.E. teacher (Webb et al., 2008). Kimberly shared that when it comes to the credibility of a teacher for health or P.E., "it's easier to take someone's word for it based on how they look" (4/15/19).

These normative ideals created uncertainty in some students that they had the power to make meaningful changes with regard to their health: the resources that guaranteed health were highly limited by their status and positioning, and even by their regional context in the U.S. This is especially harmful when students are blamed—in the classroom, in societal messaging, or in the doctor's office—or blame themselves, for

their perceived failure to achieve health, or “the normative standard” (Öhman, Almqvist, Meckbach, & Quennerstedt, 2014, p. 207).

Several students named the resources that supported their definition of health as highly limited by their status and positioning, and even by their regional context in the U.S. Abou, for example, expressed, “I know what the problem is. I don’t have the power, because I don’t have money. My parents have money, but they’re working hard” (4/15/19). Tim, a college student living at home, stated, “I probably just want more vegetables … but I can’t really control that, ‘cause I can’t really buy stuff” (4/18/19). Samira argued, “I don’t think, especially in America, living healthy lifestyle is not a priority” (4/10/19). Sade said one thing that would help her reach her goals for her well-being is “lowering down prices of the foods that many people don’t have access to” (7/1/19). Bryant stated, simply, “I need groceries, man” (7/1/19). Kimberly said she needed “money and access … we had to go … 50 blocks from my house” (4/15/19) to get a salad her sister wanted. Maria shared, “I was telling my mom if I was born into money maybe a lot of stuff … maybe the situations would be happier” (7/30/19). Finally, Maria also expressed serious concern over her positioning and what that meant for her health, and the health of her neighbors and classmates. She lamented “the drugs in the … Spanish and Black communities … these kids do not deserve this” (7/30/19), and she recalled feelings of being failed by the system at school and in her neighborhood in ways that, for some time, made her question her value. These students’ feelings of powerlessness over changing these habits, either due to their age, their student status, the surrounding culture, or their social class and its impact on their subjectivities, suggest the potential damage of neoliberal health imperatives and normative cultural definitions of health.

Students’ perception and/or awareness that their access to the health behaviors they deem important are limited by their positioning point to the usefulness for critical and social justice lenses in health education curricula so that students are not further burdened

by discourses of personal responsibility (Azzarito, Macdonald et al., 2017; Öhman et al., 2014; Fiztpatrick & Allen, 2019). Students' concerns about the stress imposed by larger societal structures require collaborative changes across fields: solutions in health education alone are insufficient to address the daily stressors created by governmental neglect and institutional racism that some of the students identified.

Low school investment in health education. Several students told stories about their health teachers' lack of training or passion for the topic. A common thread throughout the interviews was school-based health teachers teaching directly out of the textbook, to the point where students felt like they didn't learn anything their entire semester of health class. Zione shared about her high school health class, "We didn't really do anything, to be honest … they didn't want to be bothered. It was just textbooks" (6/5/19). Similarly, Tim, who attended a different high school in a different borough, shared the following about his health class: "I stepped in, on the smart board she had a textbook and she said, 'Copy that down.' That moment was basically every day for the rest of the school year … it's really not worth the class. I'm just taking the class for the credit" (4/18/19). Zione and Tim, in addition to several other students, recognized that having a teacher who didn't seem to care about the topic made for students who didn't care. Zione elaborated, "Health is treated as a burden … just something that people don't want to do because it's not treated as something important" (6/5/19). These stories, among others, point to a need for subject-specific teacher training and certification so that teachers are not expected to teach health if they have no experience with it, or asked to add it on as an additional class on their already-busy schedule. Poor teacher attitudes around health appeared to trickle down to students, according to students' stories in this study. Though the NYC DOE recommends that health education be taught by a certified health teacher, they also allow teachers who do not have a health education certificate to teach one health class (NYC DOE, 2019).

Discourses of fear, risk, and shame. For many students, no matter their teacher's teaching style, and no matter what school they attended, they experienced discourses of fear, risk, and shame in the health classroom. Leah, for example, recalled hearing worst case scenarios such as, "Your arteries are going to get clogged up" (7/1/19), without receiving direction for what to eat that might not clog her arteries. Shoshanna shared a comparable experience when learning about sexual health: "They really made it feel scary, like your life would be over if you don't use a condom" (5/3/19). Zione received similar messages: "They taught us about STDs, and the way they taught us was scaring us" (6/5/19).

In addition to learn through risks and fear-based messaging, several students expressed experiencing feelings of shame, either because of the shame-based discourses their teachers were employing, or because of their teacher's inability, or unwillingness, to address students' comments or laughter. Ijeoma, for example, recalled feeling "like I don't want to be there. I don't want to look at the picture of a vagina. I don't" (7/24/19). There is plenty of evidence in the literature on the harmful impacts of health messaging that include discourses of fear, risk, and shame, and the impact that these messages have on young people's subjectivities, especially for young women (e.g., Agnew & Gunn, 2019; Azzarito, 2010; O'Flynn, 2010). In this study, these discourses in the health classroom produced feelings of avoidance, of frustration, and of confusion for many students. Two students, though, stated that their teachers' fear-based tactics "worked." Shoshanna shared, "I don't think it [fear] is the right way, but it worked" (5/3/19). Maria agreed that her teacher's strategies of showing photos of STIs taught her when to walk away from a sexual encounter. In these cases, "worked" meant teaching students to delay sexual initiation or avoid unsafe sexual practices. Fine and McLelland (2006, 2007), however, have written on the harms of sexuality education that places its focus on fear and risk, especially in the development of sexual identity among young women, and they therefore advocate for sexuality education that also includes discourses of pleasure and

desire. Shoshanna asserted that fear alone wasn't the appropriate strategy, but did not have an alternative solution.

Desires for open, honest discussions with caring adults about health. Importantly, the dominant discourses around positive experiences in students' health classes in the interview texts showed students' desires for teachers or adults of any kind who want to talk to young people about health, to provide openness and honesty about the realities of taking care of oneself, and to offer nurturing spaces for discussions. Student-participants who shared stories of their positive experiences in health class highlighted their health teachers' "motherly qualities," the way their classroom felt like family, or the open-mindedness of the teacher. Maria, for example, shared a story about an emotional and personal topic that came up in health class that, thanks to the teacher's demonstration of love and care for the students, they got through together, because the class felt like family (7/30/19). Students' admiration of and appreciation for their teachers who created nurturing spaces with a familial feel is reminiscent of Gloria Ladson-Billings's (2009a) ideas of classroom connectedness, in which teachers create a classroom environment where students feel safe and become "members of an extended family" (p. 82); she identifies this intentional "community-building," which goes beyond the classroom as a necessary quality for culturally relevant teaching (p. 78). Further, Kevin expressed feeling more comfortable when adults are honest and real with kids, and Jupiter shared a positive relationship with a health teacher, saying, "I was able to be honest with him because he spoke to me like an adult" (8/1/19). This feeling of mutual respect and honest conversation is reflected in Ladson-Billings's (2009a) assertion that "the give and take of dialogue makes struggling together for meaning a powerful experience in self-definition and self-discovery" (p. 190). Finally, Makayla and Bryant, who attended different schools from Maria, Jupiter, and Kevin, shared that when adults made it clear that all types of questions are acceptable, students felt much safer asking questions or pushing themselves deeper into the discussion. This reminds me of

Fitzpatrick's (2013) finding in her ethnography of a critical health and physical educator that students' acceptance of their teacher's critical pedagogical methods relied on their teacher's intentional creation of an "open atmosphere" (p. 206). Students' storylines about and desires for openness and honesty from caring adults—health teachers or not—appeared repeatedly throughout the interview texts, and these qualities should be seriously considered in the field of health education.

There is also an important point to be made here about students' thoughts regarding representation among health teachers. I preface this by noting that students were speaking with me, a racially incongruent educator-researcher, which may have had a significant impact on what they felt they could honestly share. Acknowledging this limitation, many students shared similar ideas about the identity of the individual teaching them. Both Sade and Makayla named that there are certain topics about which they feel more comfortable speaking to someone of the same gender or of the same ethnic background. Sade stated that she would benefit from seeing more Black women health teachers, and more women health and P.E. teachers in general. Makayla also suggested that classes on LGBTQ issues should be taught by individuals who identify as LGBTQ, even if it's just a guest speaker. Ultimately, they agreed with several other students, who weren't as concerned with their teacher's identity as they were with how willing that teacher was to develop a relationship with them, and to create an atmosphere where students feel comfortable reaching out. Students recognized that judgment is a universally human activity, and there will always be students who are judgmental toward a teacher, perhaps due to categorizations of identity, but that relationships, care, and expertise on the topic can overcome that. Given our country's history of systematically excluding Black teachers from schools since school desegregation (Howard, 2010), Sade's and Makayla's suggestions for intentionally enhancing more diverse representation in the health classroom should still be considered.

Interview Texts: The Unique, Unusual, or Contradictory

In the last section, I presented the analysis that arose when reading the interview texts all together, organized as every student's answer under the same interview question, for commonalities that stood out. In this section, I explore the "unusual" or unique answers that arose in the interview texts when I read the interview transcripts as completely separate texts (Stake, 2006, p. 90), as guided by McCall (2014). Indeed, as Stake (2006) suggests, "both the collective and the specific are worth knowing" (p. 7). McCall (2014) argues that "differences matter politically for access to knowledge and matter theoretically for the production of subjects in that knowledge" (p. 244). This is significant in this study because I began with the belief that different adolescents experience and internalize school and societal health messaging differently depending on their social experiences, and that these experiences are largely tied to their socialized identities as defined by the racist practices that are embedded in society. Though I mentioned in the last section that a commonality in the interviews focused on health as an external process, which was affected by many students' perceived constraints and limitations to changing their habits, there were still noticeable differences in the students' understanding of and priorities around health in each interview. In this section, I explore students' answers that stood out from the rest: the "hot spots" that inspired contradiction (MacLure, 2013a, p. 172). My goal for reading the interview transcripts separately was to highlight difference, and to deconstruct assumptions about the monolithic experiences about Youth of Color or "at-risk youth" (Evans-Winters, 2011). It is especially important to highlight students' differences when intentionally developing counter-narratives to the traditional health and educational research that has long grouped Students of Color together as having the same experiences or, worse, ignored their stories altogether (Solórzano & Yosso, 2009). The unique, "unusual" (Stake, 2006, p. 90), and even contradictory responses that arose, though difficult to categorize under themes, showed up in students' stories about their internal processes of health, the impact of American

culture on health behaviors, the messages they wanted to communicate to youth, and the changes they felt they needed to reach their imagination of a healthy life.

Ignoring mainstream discourses: Health is an internal process. It is significant to note that there were a number of students who did not define their health according to dominant discourses at all, and instead shared completely unique conceptions of how they understand health.

Sharon, for example, named herself as the healthiest person she knows because of her growth with regard to her internal processes. She shared, “In terms of introspection … I’m proud of myself, in terms of always thinking about my actions as much as I can” (4/12/19). Sharon has been very open and active about the management her mental health requires for many years, and has consistently sought out and received professional support. Throughout the interview, she frequently highlighted the ways she has evolved in this regard, focused far more on her mental and emotional processes than anything else.

Mia shared a similarly unique view about the way she sees herself as a plant: it’s her responsibility to nourish herself with water, good food, and a safe environment where people support and help each other. Both Mia and Sharon rarely touched on aspects of physical health that concerned diet and exercise. Mia, in fact, stated that she was “relieved” that the whole interview wasn’t focused on those topics. She said she typically thinks of health as what she eats, because that’s how school portrays it, but that she prefers when that definition is expanded.

Mia also identified healthy boundaries as an important process to maintain one’s health, specifically as it relates to healthy relationships: “If you don’t have healthy boundaries with the person, then there’s no way that relationship can grow, prosper” (5/4/19). Sharon similarly shared a journaling exercise that she took herself through earlier in the year in order to identify which relationships were most supportive and

nourishing for her, with her peers and with the adults in her life, "because adults can be toxic, too" (4/12/19).

We also saw through several of Makayla's excerpts in Chapters IV and V that, while she did have plenty to share about health as it relates to food, she also considered healthy relationships, especially knowing oneself well before dating somebody, to be crucial in a healthy life.

Finally, it is also important to note Shirley's unique understanding of health. Shirley named her two younger sisters as the healthiest people she knows, because they're "not damaged yet." She continued:

> They're so young and so energetic. And I don't think there's anything wrong with them. They're so pure … they're not damaged yet. When you're so young, you still don't know what can hit you in the future. As people get older, they start to realize how hard life is. (5/1/19)

This description stood out to me as something completely distinctive from other students' responses. Shirley describes health as a product of one's life experiences, and she appears to conceive of life as something that is inevitably difficult and damaging. How is this related to her upbringing and school experiences, as affected by her raced, classed, or gendered identity? Because she did not explicitly state her personal experiences as a driving force for this worldview in this interview, I will not impose my biases. It is important to note the immense sadness that arises when one considers the societal forces that affect a teenager's experiences in this way, shaping her view of the world as innately damaging to one's attainment of their well-being, and her subsequent concerns for her younger sisters who may have to experience the same "damage[s]."

These concepts are important to point out because it is clear that there are students who are learning about and prioritizing their own understandings of health, separate from what schools or mainstream discourses tell them. Though I came into this study with several assumptions about the impact of health discourses in an inequitable society, students' experiences and understanding are not monolithic: they are varied, complicated,

insightful, and have plenty to teach us about the way we research, teach, and make policy decisions about health. Attending to and valuing the richness of students' thoughts and feelings about health can provide much-needed contributions to the field.

Impact of American culture on health behaviors. A few student-participants who were either born outside of the U.S., or whose families recently moved to the U.S., told stories that demonstrated the impact, and perceived limitations, of American culture on their health behaviors. These storylines stood out because they came specifically from students who maintained close cultural connections to their and their families' home countries. Ijeoma, for example, stated that the reason she knows she is healthy is because she only eats her family's or her own cooking, which are traditional West African dishes. Shoshanna also stated that her definitions of and understanding of health completely changed when she moved to the U.S., because of the new cultural norms around food, community, and achievement she was introduced to. Shoshanna shared, for example, "Ever since I left Africa I've never talked to a neighbor or got close to them … back home, that's like your family. Here, there's always tension somewhere" (5/3/19). Finally, Samira had a lot to say on the constraints of American culture, and how the pressures that come with "chasing the American dream" make it difficult for her and the people around her to experience health and happiness along the way. These storylines painted American culture—specifically the cost of food, the access to fast and sugary foods, the perceived loss of community, and the hustle—as a barrier to achieving health behaviors that the students defined as important to their well-being. The limitations that American culture puts on certain health behaviors for these students are contradictory to the Western discourses of health that ask individuals to pursue and manufacture physical perfection and happiness (Azzarito, 2009; Wright, 2004a). Graham and colleagues (2011) suggest that "dominant cultural customs" in the U.S. are presented as the norms that those with different cultural orientations are expected to adapt to (p. 85), but these students' experiences suggest that many of these customs are not supportive to the well-being of

young people. Health and educational researchers, policymakers, and educators have plenty to learn from their students' cultural backgrounds: students' critiques of American cultural norms suggest how necessary it is for teachers to develop an "in-depth knowledge" of their students' experiences (Ladson-Billings, 2009a, p. 136), so that their health messaging does not do more harm than good (Fitzpatrick & Russell, 2015), and so that we learn from the "community cultural wealth" that Students of Color have access to (Yosso, 2005, p. 70).

Contradictions between community support and individualism. Two contradictory discourses that arose in this study were those focused on the collective and those focused on the individual: the need for community and the need to focus on oneself. A few students expressed the ways they support their friends by paying attention to their health behaviors. Andrew, for example, said he kept his friends healthy by ensuring they stay inside to play video games in order to avoid violence. Sharon also took the responsibility of educating her friends when she feared they didn't have enough information or drive to engage in safe sexual behaviors. Their stories demonstrated the way students contribute to "communities of care" among their friends (brown, 2019a, p. 59), and, in Andrew's case, contextualize students' experiences as shaped by their racialized, classed, and gendered identity—the need to avoid violence by staying indoors is one unique to a neighborhood that experiences past and present governmental neglect. Furthermore, when asked what they would share about health with a young person in their lives, there were many students who focused on encouraging young people to learn how to reach out and feel comfortable asking for help. Shoshanna, for example, wanted to share: "If you ever feel overwhelmed, don't be afraid to step out of your comfort zone and ask someone to help you" (5/3/19). Similarly, Samira would share, "Always ask for help … there's nothing embarrassing about it" (4/10/19). Many students expressed similar sentiments about hoping the young people in their lives would learn how

important it is to reach out and receive support from people in their lives who care about them in order to engage in healthy behaviors.

On the other hand, there were several students who wanted to share individualist sentiments for the youth in their lives: Aissatou, for example, would tell a young person in her life to “do what you want to do and look after yourself,” and Ijeoma would tell them, “Focus on you and your needs” (7/24/19). Tim wanted to share the following with young people: “The only person you can really take care of is you. You can’t really depend on everybody … not everybody has the best interest for you, besides you, most of the time” (4/18/19). These comments, among others, suggest that some students have received and potentially internalized neoliberal discourses of mainstream health education: that it is the responsibility of each individual to monitor themselves, avoid risk, and maintain a certain health status (Beck, 1992; Foucault, 1980). It may also point to personal negative experiences that students have had with others. Some students shared a combination of both messages, indicating a need to reach out to one’s community and to learn how to look out for oneself.

Their messages are not necessarily negative; they may simply point to larger societal discourses around individualism, personal responsibility, and achievement. They also suggest a use for culturally relevant teaching strategies, where students are encouraged to feel part of a “collective effort” (Ladson-Billings, 2009a, p. 82) in the health education classroom. Ladson-Billings suggests that the practice of community building in the classroom is especially important for students who have grown up in communities that have been affected by governmental neglect and isolation that have led to under-employment, under-funding of schools, among other plagues. Growing up in these contexts can create “an innate pessimism,” and a shortage of examples of how to succeed “unless it is at the expense of others”; teachers, therefore, have to put in intentional effort to help them see the “real strengths” of their communities, and believe in the collective (p. 78); the health education classroom is an excellent place to create

such a collective (Fitzpatrick, 2013; Fitzpatrick & Allen, 2019). Students' contradictory ideas about cultivating a strong sense of community versus pointing their focus toward oneself demonstrate how different individuals attach to meaning and stories depending on their personal experiences.

Individual vs. structural changes. I came into this study with several assumptions about health messaging: that students' experiences are largely shaped by their raced, classed, and gendered experiences (Evans-Winters, 2011), and that health messaging that promotes individualism is therefore problematic if systemic racism ensures that access to individual health behaviors is inequitable (Fitzpatrick & Tinning, 2014a). While there were indeed students in this study whose stories embodied these same assumptions and biases, there remained students who focused on individual and personal change through the traditional, bio-medical discourse (Primdahl et al., 2018) when asked what they need to reach their imagination of a healthy life. Samira, for example, named "discipline" as a need; Shoshanna said she needed "a plan;" Leah, Sharon, and Zadie said they desired alone time; Patricia said she wanted more time in her schedule, and Makayla said she needed to "push more for positivity" in herself. In many ways, the individual needs stated here can be perceived as products of the increased pressures young people feel in a competitive global society (Lee & Soon-Mook, 2014), but I cannot make assumptions, despite my desires to do so, since they did not name their needs as creating stress. Their answers do raise questions about the long-term impacts of their perceived needs: when students name individual characteristics as their sole needs for reaching their imagination of a healthy life, but we know that in the context of the U.S., access is structurally limited, will this ultimately empower them as agents of change or damage them as they perceive any failures to be healthy as personal ones? If the answers from this study are any indication, it will depend on the person.

In contrast, several students explicitly pointed to the limitations that hinder the behaviors they perceive to be conducive to a healthy life, and expressed desire for

structural changes. Gloria and Maria identified structural inequalities as barriers to their health. Gloria shared,

> In a community where there's better jobs and things like that, people getting better pay, it can take a toll on others who aren't making so much as a good pay. Prices for things go up, like produce and food and things that people need. Those prices can go up, rent can go up, which can cause people to stress out about what exactly they can afford, and what exactly they need to save money for, even if that means they put themselves on the line. (7/31/19)

Gloria makes a unique point here: while one community may thrive in terms of jobs and finances, this has the potential to negatively impact the experiences of individuals and families in lower-income communities with resulting cost and rent increases, to the point that it both creates stress and hinders the ability to spend money on healthier food. This reminds me of one of Matthew Desmond's findings in his 2017 ethnography *Evicted*: the majority of low-income families do not have access to adequate nutrition because of rising costs of rent coupled with sluggish income increases. In a city like New York, where neighborhoods and schools are deeply segregated by race and class (Hannah-Jones, 2016), young people like Gloria are witnessing the costs of growing inequality each day. Maria, as well, consistently identified the pain that she, her classmates, and her neighbors have felt growing up witnessing gentrification and structural changes that take place around her, that are done "for money" as opposed to on behalf of the people. Several of her excerpts included the sincere pain she felt, constructing her sense of self in response to her social class and the experiences of stress, her desires for self-harm when she was younger, and her classmates' hopelessness over their positioning. How can health education respond to the pain that Gloria and Maria shared in ways that empower and emancipate?

Other students shared their desires for health that related to structural changes. Kimberly explicitly stated that she needs "money and access," in her imagination of a healthy life. Bryant also named "access to healthy foods … convenience, [and] location"

(7/1/19)" as did Sade, who said she needed "healthier options, more available to everyone, not just a certain class or rich people" (7/1/19). All three of these students named downtown New York City—where there tends to be a greater concentration of wealth—as having significantly more access to a variety of healthy food options, but the further up one travels, the scarcer these options become. When healthier options are available, students perceive them as more expensive and out of reach to many. How can we expect traditional health messages about eating right and getting more exercise without acknowledging socio-political determinants of health to support students when they consistently witness the ways that inequities in housing, education, and regional location shape their access to behaviors deemed healthy?

Students' desires and imaginations for a healthy life are indeed varied, as seen in this section and in Chapter V, with several students focusing solely on their personal responsibility, while others identified an expansion in access that needs to occur before a healthy life is available to everyone. Their responses pointed to more questions than answers, but contribute significantly to the literature in that they legitimate the knowledge and experiences of youth who fall into categories that have long been pathologized in health and educational research (Azzarito, Macdonald et al., 2017; Dagkas, 2014), and demonstrate the value of culture-centered approaches that attend to local cultural contexts and identify community members as experts on their experience in the development of future programming (Dutta, 2007, 2010).

Implications for Health Education

This study illustrated the personal narratives and experiences of adolescents with regard to their conceptualizations and imaginations of health, and how their experiences within and outside the health classroom illustrated their thoughts and feelings about health, the ways they navigate health, what health messages they deem important to

communicate to youth, and what they imagine for a healthy life. The study drew from participants' answers in a semi-structured qualitative interview to show how they consumed health messages and how they navigate health within their current social context. As expected, there are more questions and uncertainties than answers that I can lay out.

In Chapters IV and V, I presented the ways that students in this study come to understand health, and the stories they tell about themselves and their friends, families, schools, and communities with regard to their health, in the backdrop of a racialized, classed, and gendered society. In this chapter, I have presented commonalities and contradictions that arose in the interviews. Commonalities include students' understanding of health as something that can be performed, and how their perceived control, or lack of control, over their health behaviors complicates this idea; their schools' low investment in health education; and their desires for openness and honesty from caring adults. Unique responses largely concerned internal processes of health, the impact of American culture on health behaviors, the contradictions between a need for community support and focusing on oneself, and desires for individual versus structural changes in order to reach their imagination of a healthy life. This section describes the implications of the study as it relates to research, policy, and pedagogical practices, and urges more scholars and practitioners to embrace the emerging field of critical studies in health education.

Research Methodology

Much of this study's implications for future research lie not necessarily in what researchers take up, but in how they enact their research. Evans-Winters (2019) urges researchers and educators who are committed to social change to persist in challenging "erasure discourse"—for example, "at-risk," "urban minority," "high needs students"—that exposes and preserves institutionalized assumptions of these students' deficits

(p. 47). She writes, “These categorizations objectify and dehumanize the very children for whom civil rights activists have struggled to get school actors to recognize their humanity for centuries” (p. 47). Indeed, Fitzpatrick and colleagues (2019) conclude that the studies of health education that serve “as a platform for individual behavior change [are] largely flawed” (p. 623). Evans-Winters (2019) also encourages researchers to diverge from the voyeurism in research that has been fed by the discourse of pathology and “erasure discourse” that has become a part of the public conversation (p. 47). One way to do this is by carefully shifting from research *on* individuals and communities that are characterized as “at-risk” to research *with* them (Dagkas, 2014)—as long as, Evans-Winters (2019) argues, the methodological practices employed are transformative and cater to the humanity of the participants, which in her case for many studies are Black women and, in the case of critical inquiry into health education, are all marginalized racial and ethnic groups (Dagkas, 2014; Hill & Azzarito, 2012). This is supported by Dutta’s (2007) call for culture-centered approaches that engage community members as experts of their own experiences, or as “central to the articulation of health problems and corresponding solutions” (p. 307). In the context of health education studies specifically, this requires a shift away from the enmeshment with risk and individual responsibility that permeates the field (Fitzpatrick et al., 2019).

Research in education—and as I have argued, health education—has long existed to meet the needs of social institutions, so it is essential and urgent that we embrace theoretical frameworks and methodology that prioritize agency for youth, especially Black girls, as Evans-Winters (2011, 2019) argues, and all communities that are pathologized and experience health issues, as Dutta (2007, 2010) suggests. Evans-Winters (2011) urges educational researchers in the field to use methodology and theoretical frameworks that locate the humanity of Black female students first, in order to understand their unique educational experiences (p. 15); critical health scholars Dutta (2007) and Dagkas (2014) extend this to all marginalized racial and ethnic groups.

Berlant (2011), Leahy and colleagues (2016), and Fitzpatrick and colleagues (2019), all echo this call, urging for new frames and theories in the emerging field of critical studies in health education, asking researchers to study health "in all its complexity, drawing from diverse disciplinary perspectives ... challenging social and political values, but also pedagogical norms, norms of knowledge production, and of representation" (Fitzpatrick et al., 2019, p. 623). Graham and colleagues (2011) also insist, through the application of critical race theoretical frameworks in public health research, that researchers engage in more transparency about how their personal experiences and political investments contributed to their study design, data collection, and interpretation of the data. For years, health and educational research has employed what Evans-Winters (2019) calls "erasure discourse" (p. 47), like "at-risk youth," "urban minorities," and "sexual minorities"—labels that have long functioned for researchers to demonstrate the urgent need for their projects, educational interventions, and institutional funding that, while good-intentioned, may not always have the community knowledge to be effective, or supportive for the people it claims to serve (Dutta, 2007). Indeed, it is these labels and demonstration of significant disparities in health that piqued my interest and drive in health education to begin with, and that have perpetuated the funding of the after-school program at which I worked and where students in the study attended: board members and donors viewed their dollars as supportive of students *"in need"* of athletic and academic support. This is not all bad, especially when the funding produces programming that is student- and community-led. But the stark gaps in health and educational outcomes across racialized and classed lines require significant responsibility on the part of the researcher so that we do not continue to put the assumption of deficiency or the burden of individual change on individuals and communities that have been systemically disenfranchised, especially the children born into these social contexts and structures that do not adequately serve them. We saw from students like Maria and Gloria, and several others, that many young people are pained by the lack of societal support they receive in their neighborhoods and

schooling experiences; as researchers, we have a particular responsibility to be intentional about the language we use, the approaches we choose, and the interpretations we make, so that we can find solutions for these gaps at the direction of the people in question. Dutta (2007) suggests that in order for researchers and theorists to shift the status quo, we must "respond to the cultural needs of communities" (p. 326); Yosso (2005) adds that engaging critical race theory and its related frameworks works toward the emancipatory potential of schooling.

One way to shift away from the potentially unintended consequence of burdening individuals with the weight of inequitable social structures is to bring historical literacy—as coined by race historian Khalil Gibran Muhammad (Gibson, 2018)—to the light in our literature reviews, as was done here. Another way is to commit to personal deconstructions of knowledge: Evans-Winters (2019) encourages researchers to confront themselves consistently throughout the research process, asking the following questions: "What is the moral and ethical obligation of the researcher?" (p. 76). Additionally,

> Who can research whom?... Who gets to determine 'good' research, ethical research, data, and representation of data as it relates to Black girls and women?... Is there an anything goes mentality in theorizing and researching young people's, poor people's, and women's lives, as long as good intentions are involved? (p. 74)

Further questions that Evans-Winters (2019) suggests researchers ask themselves before embarking on a project include: Is the human potential and agency of the participants at the center of the research methodology? Am I connected to my participants, or am I only connected to the topic I am interested in? Is my focus on what individuals and communities lack? If so, what impact does this have on my participants and their societal stereotypes? How will this research benefit the participants and their communities in the short- and long-term? (Evans-Winters, 2019). Graham and colleagues (2011), along with the authors in Taylor, Gillborn, and Ladson-Billings (2009) suggest that critical race theory and its related frameworks allow analysis, interpretation, and

presentation of findings that challenge traditional narratives and transform solutions to racialized, classed, and gendered power imbalances. Graham and colleagues (2011) build on this by asserting that these methodological approaches are especially appropriate for studies of psychosocial health, where the topics can be personal and sensitive.

In the conclusion of his 2017 exploration of poverty and economic exploitation, *Evicted*, Matthew Desmond confronts a difficult truth: “In fixating almost exclusively on what poor people and their communities lack—good jobs, a strong safety net, role models—we have neglected the critical ways that exploitation contributes to the persistence of poverty” (p. 306). Though this quote focuses specifically on class exploitation, we can extend this knowledge to racialized exploitation as well. In fact, Solórzano and Yosso (2002) assert that class- or gender-based theoretical frameworks alone will not adequately address the experiences of People of Color in the United States, and that theoretical frameworks instead must always center race and its “intersections with other forms of subordination” (p. 32). Before embarking on the research process, we must ask: How will this project disrupt the persistence of poverty along racial lines? Of inequities in health and educational outcomes across lines of race and class? Of narratives of pathology and deficiency for Individuals of Color? In what ways am I exploiting a community for personal gain? In order to ensure we do not contribute to the continued exploitation that so many institutions continue to enact, we must follow the direction of critical theorists like Evans-Winters (2019), Graham and colleagues (2011), and the authors in Taylor et al. (2009), and engage research that can be practically applied to changes in curriculum, in policy, and in pedagogical practices, and then we must take action and do so. We cannot assume that because of our affiliation with esteemed institutions, our research is inherently good or beneficial—Winfield (2012) asserts that “direct expression[s] of eugenic ideology” like “surveillance and control” for those we define as “at-risk” have never left the field of education (p. 144), and should be considered as the “foundational root for much of the current school reform agenda”

(p. 158). We see this as close to home as Thorndike Hall in Teachers College—named after one of the "Fathers of Curriculum" and proud supporter of White racial superiority as defined by IQ score (Winfield, 2012, p. 147). Research endeavors in health education, and in all fields, must start with deep observations into ourselves, our intentions, our institutions, and our fields, through an exploration of history (Graham et al., 2011), a deconstruction of taken-for-granted assumptions (Evans-Winters, 2011), and an insistence on culture-centered approaches that center community members as experts of their own experiences (Dutta, 2007, 2010). In this way, we avoid situating health and educational inequities that result from decades of systemic exclusion, within the child, the individual, or the community (Evans-Winters, 2019; Fitzpatrick et al., 2019).

Research Topics

Future research will be needed to explore the conditions of school-based health improvements in New York City, especially on the heels of Chancellor Richard Carranza's $24 million investment in comprehensive health education initiatives introduced in 2018. In this study, there were far too many examples of students who were unsatisfied with their experience of health education at school. As the NYC Department of Education implements these investments, it will be imperative that researchers use critical frameworks to explore students' experiences of the health classroom, as well as teachers' experiences of their own curriculum, pedagogy, and expanded opportunities for professional development. Critical studies that embrace postmodern and poststructuralist tenets, and that place racism at the center of U.S. society and its inequities, should be pursued in order to adequately understand how students and teachers navigate these new elements of health education in their schools.

My study attempted to challenge the deficiency frameworks that are typically placed upon Adolescents of Color in order to shift the focus of the research and resulting action to their stories around their understandings of health. The next line of inquiry and

research should continue to uproot these frameworks, not by focusing on what New York City public school students are missing or lacking in their health classrooms, but on seeking out positive examples of teachers who enact critical health pedagogy and "provide historical depth" in the field of health, so that they may act as models for other educators (Graham et al., 2011, p. 91). Fitzpatrick and Allen (2019) provide a recent example of such a study in New Zealand, and this work should be reproduced in the U.S. because of our unique historical contexts. In this study, there was a cluster of students who acknowledged the positive aspects of their health teacher and on the effectiveness of their teaching, including their expertise, and the safety and closeness of their classroom communities (Fitzpatrick & Allen, 2019). These are important qualities of effective health educators and should be studied further: we need examples of health educators that students respond positively to, and who meet students' needs, more than we need examples of inadequate health teaching. Additionally, exploring the ideas raised in this study further would mean exploring how health teachers/educators, in-school or after-school, bring a historical understanding to their health lessons, through classroom observations, teacher and/or student interviews, and document analysis of their selected curricula. I imagine there are health teachers in both in-school and after-school settings that bring the contemporary politics and history of race, class, and gender to the health classroom in order to help students understand the larger social structures at play. If the curricular and pedagogical practices of these educators are documented well enough through research so that they may be replicated, the Department of Education may come to see the value in adding the historical context of health disparities, accompanied by examples of classroom projects that empower students to organize within their communities in order to resolve them, to the scope and sequence of NYC Health Education Standards. The goal is not to increase individual burdens of students, teachers, or even schools, but to situate the current health statistics on the social structures that

have created disparities in health outcomes by race and class and to provide students and teachers with the tools and skills to collaborate and call for change.

Additionally, future research should take up the question of stereotype threat (Steele, 2011) and whether Students of Color feel the burden of racialized stereotypes in the health classroom. Although the potential applications of stereotype threat were mentioned in Chapter II, they were not adequately explored in the interview process with the participants. My suggestion for a more effective exploration into stereotype threat in the health education classroom is as follows: future researchers take a critical race lens to explore teachers' knowledge around the historical context of health disparities, their implicit biases around the demographics of their students, how this knowledge and these biases do or do not influence their curricular and pedagogical practices, and further examine and compare these findings to students' reception of the information. I imagine a multiple case study of a health classroom wherein the teacher engages students in the history of health and educational disparities and their own racialized and classed identities, compared to one who neglects to do so. This will require that both students and teachers have great trust in the researcher in order to ensure honesty around these complicated storylines (Fitzpatrick & Russell, 2015). Steele also provides plenty of examples in his 2011 book on the subject, *Whistling Vivaldi.*

A distinction that is undoubtedly necessary in health education research is one that acknowledges the similarities and differences of an adolescent who is born in this country and one whose family immigrated here. Too often, government bodies like the CDC acknowledge individuals' racial classifications while ignoring their country of origin, or their self-identified ethnic culture. Even theoretical frameworks frequently ignore multi-ethnicity, for example, regularly including racial categories like Black under umbrella ethnic categories like African-American (Evans-Winters, 2011). Such common conflations "tend to reduce the experience of blackness in the US to a mono-ethnic experience with a singular racial narrative" (Morgan, in brown, 2019a, p. 91). Though

Morgan specifically addresses Blackness here, this assumption of mono-ethnicity can easily be extended to other racial descriptions. Morgan's "Pleasure Politics" asks theorists in all fields to consider

> how eliding the burgeoning identities of millions of Black immigrants and their descendants compromise not only our understanding of race but inhibit our ability to develop what anthropologist David Scott refers to as the "new problem-spaces" necessary for establishing new directions in critical inquiry. (Morgan, in brown, 2019a, p. 96)

When we distinguish race from country of origin, we only just begin to acknowledge the wide array of experiences that have for too long fallen under the same ambiguous categories of "Black," "LatinX," or "other." We offer individuals and communities an opportunity to explore how their family's origin story, pathways toward, and experiences within the U.S. affect their understanding of health, social welfare, and community, to start. We begin to recognize that students who are placed into "minority" categories or who live in urban areas do not experience life in the same way (Evans-Winters, 2011, p. 19). Flintoff and Fitzgerald (2012), supported by the work of Azzarito, Macdonald, and colleagues (2017), further argue that including Black and other minority ethnic groups under the same umbrella categories in statistical representations of health outcomes ignores important characteristics related to ethnic background and promotes homogeneity, diminishing opportunities to provide health education programming and services that are "culturally appropriate" (p. 210). In this study, I allowed students to self-identify their race or ethnicity in an open-ended format, eliciting 14 different responses. We must allow children, individuals, and communities to self-identify their race or ethnicity in a way that feels true and authentic to them, instead of imposing our traditional categories onto them for the sake of ease. There is nothing easy about living with the consequences of others' assumptions.

Furthermore, I would like to hear from students and families for whom health is not defined by external factors like the school, the city, or the state. I am inspired by

adrienne maree brown's (2019a) description of self-defined care as "falling in love with myself through the terrain of my body" (p. 116). I imagine that students and young adults who have defined their health for themselves, unobstructed by external definitions, do not feel shameful, burdened, or fearful about statistics regarding health or health disparities as the culture dictates, but feel empowered to look after themselves, their bodies, and their communities because of the way they feel about themselves, and because they view their health in their own terms, as opposed to absorbing the storylines of risk, shame, or fear that classroom or societal messaging imposes. My research methodology and site selection allowed me to speak to students who are also currently athletes, or who have been athletes in the past, some who found it easy and natural to prioritize behaviors around exercise and nutrition because they wanted to become their self-defined version of the best athlete they can be. However, I am interested in exploring the imagination of health for all students, beyond those who have willingly participated in an athletic-based after-school program, in order to further explore the social contexts and personal characteristics of individuals who feel empowered to define and care for their own health and the health of their communities on their own terms. I am inspired by the student Sharon, who expressed empowerment in her growth in taking care of herself over time, and Shoshanna, who told the story of her family's community in their home country, who naturally looked after each other because they all felt connected as family. Where else do these individuals and communities exist, how do their experiences impact their imagination of health, and how can we embed these qualities in the study of health education in order to create emancipatory curricula?

Policy

Desmond (2017) asserts that emphasizing the significance and impact of continued exploitation on the lives of individuals, families, and communities "means uncovering the ironies and inefficiencies that arise when policymakers try to help poor families without

addressing the root causes of their poverty" (p. 307). I don't share this quote to imply that the student-participants in this study are all poor or living in poverty. I do share it, though, to urge policymakers to examine the roots—the local and national historical context—of health and educational inequity deeply before making policy and funding decisions. Indeed, Gillborn (2009) states that there is an urgent need to view education policy through a critical race lens in order to highlight "conflicts at the heart of education policy and race inequity" (p. 53). The questions that must be asked include: "Who or what is driving education policy? Who wins and who loses as a result of education policy priorities?... What are the effects of policy?" (p. 58).

The personal experiences and stories of the student-participants in this study indicate a need for health education policy to take a "whole" child approach. The CDC's website for their Adolescent and School Health initiative features a page detailing the usefulness of schools in supporting adolescent health (CDC, 2019b). The language used on this particular page, although it includes an ample amount of risk-based and interventionist discourse, suggests that school health initiatives should take a collaborative approach that addresses societal influences on adolescents and "views each adolescent as a whole person, recognizing and drawing upon his or her assets and not just focusing on risks," which is undoubtedly a positive step (CDC, 2019b). Their Whole School, Whole Community, Whole Child approach will be effective when it includes "programs and policies at both the local and national level" that engage families and communities in addition to schools, as Evans-Winters (2011) suggests that these three support sites promote youth resiliency when working together, which happens when policymakers initiate policies that avoid putting responsibility on any one unit. She suggests that policymakers be held "accountable for assuring that all three entities have the resources (funding, staffing, etc.) each need" to adequately support their children, especially by promoting research and advocacy programming that "serve to eradicate the

boundaries" between home life, community organizations, and schools, due to systems of oppression (p. 145).

In May 2018, New York City Schools Chancellor Richard Carranza announced the launch of Health Ed Works. Health Ed Works is a four-year, $24 million investment in comprehensive health education, with the goal that all New York City middle and high schools will meet both city and state requirements by June 2022 (NYC DOE, 2018). The program provides "professional development opportunities for teachers, increases family and community engagement around health education, and offers individualized support to 500 schools" (NYC DOE, 2018). Additionally, in September 2017, the Mayor appointed "approximately 30 members to the City's first-ever Sexual Health Education Task Force" (NYC DOE, 2018). These are important steps in municipal investments in New York City public school students' health and education, and it will be incredibly important for the Department of Education to ensure that teachers are delivering critical health information illuminated by the historicity of health disparities through thorough research and oversight, and that families and communities are provided with resources and skills to engage with their children on issues of equity in health. Increasing family and community engagement may require redefining what family means, and how parental involvement is defined, in order to remove the boundaries that often live between schools and families (Evans-Winters, 2011).

While an important piece of oversight for Chancellor Carranza's new investment might be to ensure that each student is reaching city and state standards of one semester of health in middle and high school, students' stories in this study suggest that there were benefits to receiving health instruction, when taught well, each year. Currently, the New York State Education Department requires only one semester of daily health education, or the equivalent of 54 hours of instruction, throughout all of middle school, and again throughout all of high school (NYC DOE, 2016). While this is a start, this may not be enough. Samira and a handful of students specifically stated that they understood their

health because they learned about it each year in middle school. This does not imply that increasing the quantity of semesters of health education alone is an adequate solution. On the contrary, it should be supplemented by enhanced teacher training and community support: the Chancellor's recent investment in health education includes additional trainings for teachers and expanded professional learning opportunities. It is essential that one or more of these trainings brings historical context to the field through incorporating the works of Dorothy Roberts and Harriet Washington, for example, so that educators understand the practices and policies embedded in U.S. society that have created health disparities and can communicate them to students effectively and without additional burden. More suggestions for critical health pedagogical training and practices will be included in the next section. There were also a few students who expressed a desire to see more representation for diverse identities teaching health, including more women, and more Black women specifically, and LGBTQ individuals. Training and hiring practices should be intentional to include any identity categories that have for too long been underrepresented in the teaching force.

Further, health education policy must take place in concert with local food and housing assistance programs. There is no amount of reform in health education policy alone that can change a student's experience with unstable housing or food insecurity. First, there is evidence that there is a lack of alignment between Supplemental Nutritional Assistance Program (SNAP) benefits with county-level meal costs, leaving larger gaps between meal costs and SNAP benefits in high-cost urban areas including New York City (Urban Institute, 2018) than in lower-cost areas. Gundersen, Kreider, and Pepper (2018) have suggested that SNAP benefits be increased in order to support families enough to create food security, and the Urban Institute (2018) has added that this is especially necessary in higher-cost cities. Health education programming alone will be ineffective if children and families are unable to afford the cost of meals, as these studies suggest. Further, Desmond (2017) suggests that the majority of lower-income families are not

getting adequate nutrition, because income must go to rising rent and utility costs first. In fact, the majority of lower-income families are spending most of their income on housing (p. 303). Desmond urges the affordable housing crisis to be moved to the top of the U.S. domestic policy, stating that that the provision of stable housing is too critical to stabilizing communities, that it is "too fundamental a human need, too central to children's health and development, too important to expanding economic opportunities" to be overlooked, or worse, treated as a business (p. 311).

On the national scale, public initiatives for affordable housing "are the most meaningful and effective anti-poverty programs in America," allowing families to devote more of their resources to health care, transportation, and food (Desmond, 2017, p. 302). Indeed, Kottke and colleagues (2018) provide evidence for hospitals, health plans, and public health organizations to engage with initiatives to end housing insecurity: they provide examples of model programs in St. Paul, Minnesota, where a health clinic has collaborated on a housing initiative for recent immigrants and refugees in order to provide health services and community activities within the housing complex; and in Washington, DC, where investments were made to finance a clinic and affordable housing at the same time, so that affordable housing and health education programming and outreach are available all in one place. To use an example from the study, student-participant Samira, one of the most resourceful teens I know, shared that the one thing she and her family needed more support with was housing, but that the many organizations she was a part of didn't quite know how to help with that. Effective health education policy requires engagement with efforts aimed at enhancing access to affordable food and safe, stable housing.

I agree with Washington (2019) when she states that "any effective, permanent solution must come from regulatory changes imposed upon the responsible industry or municipal government" (p. 267). It is important to note, though, that schools have long been pressured by the goals of the city and/or state municipality to improve local health

trends and are often asked to respond to public health concerns in ways that are not feasible without collaboration and ample support from other sectors (Fitzpatrick & Tinning, 2014a; Gard & Wright, 2004). This section has celebrated the progress made by New York City's public investments in health education programming, while providing suggestions for how to improve these initiatives by collaborating with food and housing policy, enhancing professional development for teachers to include historical literacy, and incorporating student-participants' responses from this study in addition to recent research.

Practice: Moving Toward Critical Health Education in Schools

This section describes my call for critical health education in pedagogical practices and training. I recognize that these ideas are complex, nuanced, and require a great overhaul in several social institutions—these are not simple solutions.

Pedagogical practices. Recent years have demonstrated great progress in bringing a critical lens to the field of health education: in May 2018, for example, the first Critical Studies in Health Education conference was held in New Zealand with the vision of providing a space for scholars who wish to challenge mainstream discourses of health in education and envision new practices (Fitzpatrick et al., 2019). The issues at the forefront of this conference were the "prevalence of moralistic, risk-based and alarmist forms of health education," in addition to "oppressive body pedagogies and racist, colonizing, fatphobic and homophobic practices" (p. 622). The conference subsequently led to a themed symposium in *Health Education Journal*, which focused on embracing a critical approach in the research, study, and practice of health education. Critical studies in health education remain an emerging field, created by academics and practitioners who are no longer interested in a field that "ignores subjectivity, that claims to be neutral or immune to politics, and that bolts itself to certainty" (p. 622).

This study adds to that research by deliberately placing the government-sanctioned practices of oppression that have led to the current state of health disparities in the U.S. at the center of the literature review, and by exploring the perceptions, feelings, and navigation of health of youth who happen to fall into historically marginalized categories within the dominant discourse. Inspired by the work of Evans-Winters (2011), McCall (2014), and the critical health scholars cited above, among so many others, this study poses new questions about critical health education practices in order to move away from platforms of individual behavior change, toward individual and collective empowerment and liberation. More studies about health education and the way health messaging affects adolescents' understanding of themselves and the larger world should explore where critical health educators are successful in creating an emancipatory space in which their students can learn about themselves and contribute to personal and collective development; one example is Fitzpatrick and Allen's recent publication in October 2019. One crucial implication is that the content of the health education classroom commit to culture-centered approaches (Dutta, 2007, 2010) in development of lesson plans and activities, thereby committing to three tenets:

> (1) a focus on local cultural contexts informing meanings and experiences of health, (2) prioritizing agency, which is predicated on a dialogic/process-oriented approach that engages participant voices and acknowledges the co-construction of knowledge, and (3) an acknowledgement of structural dimensions, which both constrain and facilitate agency, and, through a deep analysis of social inequality, politicize the endeavor of public health research (Fiddian-Green et al., 2017, pp. 5-6; Dutta, 2008)

These tenets should be applied to the content of the health education classroom when educators, as supported by administrators, prioritize students' and families' wants and needs for health, engage students and families in the development of supplemental activities, and create opportunities for students and families to engage in social change efforts that impact their community's health. I am inspired by Monique Tula's bottom line for harm reduction approaches that are "community-centered and people-centered …

to remind them they are worth more than what the rest of the world tells them, that they are valued, and that they don't have to hide themselves" (in brown, 2019a, p. 252).

The findings from this study, though I do not aim to pretend they are representative of the wants, needs, and desires of all youth across New York City, provide a glimpse into the kinds of conversations that I suggest critical health educators have with their students (and, ideally, families) before, during, and after a health education course together. Students across the city, and across the country, have different experiences, hardships, and celebrations—while a general scope and sequence of training and content is supportive, as New York City has provided, critical health education, and culturally relevant teaching, requires that teachers are aware of who their students are as individuals and what matters to them when it comes to defining and learning about health (Fitzpatrick & Russell, 2015; Ladson-Billings, 2009). Student Mia specifically pointed to this need when she stated:

> What works for one person might not work for the other. I feel like health should be taught in a broader sense.... It should be talked about in terms of mind, body and spirit, and we should respect that. Like people come from different backgrounds and cultures where health looks different. (5/4/19)

It is my desire that the content of health education classes be fluid, and that teachers constantly re-evaluate the content based on students' and families' wants and needs. I recognize that the burden of change is often put on teachers, many of whom are already overburdened and under-compensated. The success of these approaches also requires administrative support: administrators must see the value in adapting health programming to specific local contexts, especially with regard to students' and families' wants and needs. Below are general examples of content that should be included based on student-participants' insights from this study, and supported by tenets of critical health education and culturally relevant teaching:

(1) Create community-based classrooms that allow students "to develop to their full humanity" (Evans-Winters, 2019, p. 71).

   a. Students overwhelmingly cited positive experiences with health teachers who made them feel safe, loved, known as individuals, and presented themselves as someone they could turn to for years to come. This is especially important in a class that focuses on a topic that can become as personal as health. adrienne maree brown (2019a) writes that "one of the ways we actually create abundant justice, [is through] the understanding that there is enough attention, care, resource, and connection for all of us to access belonging, to be in our dignity, and to be safe in community" (p. 407). Gloria Ladson-Billings (2009a) similarly asserts that in order to effectively teach in ways that are culturally relevant to students, students must feel "psychological safety," comfort, and support by their teachers and classmates in their classroom community (p. 78), and teachers must know their students individually. These tenets must be a priority in every health education classroom.

   b. There is evidence that "stress caused by such factors [as racism] can be curtailed, or 'turned off' only when safety is perceived" (Washington, 2019, p. 282). It is critical that educators who work in contexts where students are experiencing interpersonal, environmental, and societal discrimination prioritize creating a sense of safety and community for their students in order to minimize the effects of racialized stress and support students' learning. Fitzpatrick and Russell (2015) suggested that effective health educators take a "humanist approach" that prioritizes relationships, communication, and "the collective experience" (p. 165). This requires that teachers know their students' lived experiences deeply so that they

may build relationships and include messaging that is relevant to their daily lives.

c. Teach with the assumption that every individual has the right to their health and well-being. Recognize that educators must be in a "rigorous practice" of love for their field, their students, and their communities: students, their families, and entire communities that are marginalized,

> have a deeper socialization to overcome, one that tells us that most of us don't matter—our health, our votes, our work, our safety, our families, our lives don't matter—not as much as those of white men. We need to learn how to practice love such that care—for ourselves and others—is understood as political resistance and cultivating resilience. (brown, 2019a, p. 59)

This requires that teachers are passionate about the health topics they are employed to teach, and passionate about their students (Ladson-Billings, 2009a). This was echoed by Samira's and Shirley's appreciation for their teachers who were experts in the content and who kept their classmates engaged.

(2) Allow students to define health for themselves and recognize all cultural definitions as valid and valuable.

a. Ladson-Billings (2009a) writes that culturally relevant teaching views knowledge as "continuously recreated, recycled, and shared by teachers and students. It is not static or unchanging" (p. 89). Almost every student-participant in the study looked to me as the researcher-educator authority in defining health for them at the beginning of the interview. Teachers should prioritize individualized definitions so that students have a goal that feels realistic and authentic to their experiences, their families, their cultures, and their upbringings, that is free of fear, shame, and risk discourse, and that affirms them in wanting to find realistic ways to live a long and healthy life.

b. Fitzpatrick and Allen (2019) argue that health education programs that value critical methods will also value conventional forms of health information, while consistently challenging them and asking students to do the same. This is echoed by Ladson-Billings's (2009a) assertion that culturally relevant educators view knowledge critically, viewing it "as a vehicle for emancipation, to understand the significance of their cultures" (p. 102). Allowing students to define health for themselves based on their personal and familial values, as well as their upbringing, will allow them to connect the content of the health classroom to their daily lived experiences.

c. "Combatting racism, sexism, and homophobia effectively in the midst of multiple pressures of neoliberalism, the current economic crisis, the decline of the US empire, require nuanced, careful interpretations of race, ethnicity, gender, nationhood, citizenship, and identity" (Morgan, in brown, 2019a, p. 88). The same care should be extended toward students' definitions of health, and the health classroom offers excellent opportunities for educators to take critical and social-justice oriented lenses in order to affirm students' identities (Azzarito, Macdonald et al., 2017) through allowing them to define something so personal for themselves.

(3) Allow students opportunities to practice navigating their own healthcare.

a. Include tours of local health centers, assignments that ask students to interview health professionals about the process of making an appointment for a specific health concern, and research projects on navigating different modes of insurance. Students in this study shared that key factors that helped them understand their health were experiences with their family's or their own health issues or questions, and tours to health clinics that they

went on with their after-school program. The opportunity to build skills in this area empowers them to take charge of health concerns that arise, and follows the culturally relevant teaching tenet of helping students "develop necessary skills" (Ladson-Billings, 2009a, p. 104).

(4) Prioritize embodiment.

a. brown (2019a) asserts that "discrimination, social inequality, and injustice are manifestations of our inability to make peace with the body, our own and others" (p. 345). Fitzpatrick and Russell (2015) offer suggestions for critical health and physical educators to practice embodiment in the classroom by challenging the gender binary in the way they move and dress. While the specific suggestions they make may be difficult for other health educators to emulate, there is evidence that an embodied and critical approach to the physical act of teaching may challenge the silence around race and sexuality in schools (Fitzpatrick & Russell, 2015). Some students in this study expressed concern that their peers don't know enough about their bodies as they should, and an embodied approach by educators enables students to question power relations around the body in their own ways.

b. Currently, many popular digital educators and influencers are publicly grappling with overcoming culturally-imposed messages about their own bodies. One example is Sonya Renee Taylor, who wrote a book and curates an Instagram page for her movement, "The Body is Not an Apology," in order to foster "global, radical, unapologetic self-love which translates to radical human love and action in service toward a more just, equitable, and compassionate world" (Taylor, in brown, 2019a, p. 345). As more and more students empower themselves with personal research online, digital essays or other content shouldn't be dismissed as

nonacademic or as having no place in schools; in contrast, teachers should intentionally expose students to empowering messages and public declarations of transformation through self-love in the form of reading and writing assignments that not only teach them how to use their own social media pages and feeds mindfully, but teach them to develop critical thinking skills about the messages they receive about their bodies and their health and how that impacts their understanding of themselves and their communities. Lupton and Leahy (2019) supported these ideas in their recent attempts to engage pre-service health teachers in employing digital health technologies in the classroom, though future efforts should prioritize alternative and emancipatory messaging.

(5) Provide opportunities for students to understand the political, economic, cultural, and historical context of health at the local and national levels.

a. Destabilize the "usual calls for behaviour [sic] change and morality," allow educators to separate themselves from the problematic and harmful task of "becoming saviours" [sic], and allow students to understand themselves separate from the stories that social institutions have imposed on them (Fitzpatrick et al., 2019, p. 624). This requires a constant "questioning and exposing" of taken-for-granted assumptions about health disparities (p. 624), and asks the teacher to turn the "critical lens inward," both in formal teaching and in informal conversations with students (p. 625). Several students in this study stated that they wished teachers would be more honest with them, and recognize that they're human and they can make mistakes, too. Studying critical topics in the health classroom allows students to learn how to deconstruct teachers' authority while teaching them to critically examine societal power imbalances that create disparities (Fitzpatrick & Russell, 2015; Wright, 2004).

b. Include opportunities for students to develop their "emancipatory consciousness" (Evans-Winters, 2019, p. 50) by teaching interdisciplinary work in the fields of race, class, gender, sexuality, mental health, "food studies, movement, physical education, fat studies," and beyond (Fitzpatrick et al., 2019, p. 623). Employ multi-modal formats for in-class and homework assignments that include podcasts, YouTube videos, health and sexuality education blogs and websites, and the Instagram pages of subversive educators that have been vetted by the teacher so that students have access to multiple formats and their preferred learning style.

c. Challenge the stigma—"the severe social disapproval of a person's characteristics or beliefs, which are considered to be unacceptable to dominant cultural norms" (Tula, in brown, 2019a, p. 247)—of traditionally defined health problems, i.e., unwanted pregnancy, sexually transmitted diseases, obesity, etc. Students in this study mentioned positive experiences with adults who reduced stigmatized conditions such as mental health issues or sexually transmitted infections. Borrow principles of harm reduction by engaging several of its basic principles: prioritizing students' health and dignity, meeting them where they are, involving them in the process, providing autonomy, valuing their customs, beliefs, and experiences, all while being pragmatic, or "not ignoring the very real and tragic harms associated with some behaviors" (Tula, in brown, 2019a, p. 248).

(6) Provide opportunities and projects for students to see themselves as agents of change in the face of inequitable social structures.

a. Harriet Washington demonstrates in her 2019 book exploring racist housing policies that have led to unstable and unsafe environments for Communities of Color that "even without significant wealth or political

clout, Communities of Color acting jointly have begun to transform the environment of health and marginalized people assailed by invisible poisoning" (p. 271). She includes steps to help people organize for the environmental health of community on pages 284-291. The health education classroom that teaches the history of inequitable social structures is an ideal place to provide meaningful skills and resources for students and their families to get involved in social change. Teachers should empower students to take these steps in a small project in their school or neighborhood so they are able to see change on their horizon and do not feel powerless in the face of institutional oppression. This is one additional way to engage families and community members in health education initiatives.

Azzarito, Macdonald et al. (2017) assert the following:

> Creating culturally relevant, community-based curricula that meet the specific needs of ethnically diverse young people in the local contexts of their daily lives might open up possibilities for them to find socio-educational spaces where their subjectivities are not denied but legitimated. (p. 215)

It is my hope that educators will take culturally relevant teaching strategies, the findings from this study. and findings from critical health studies before it seriously in order to transform our health education classrooms so that students are valued, appreciated, and affirmed in ways they want to live a healthy lifestyle.

Training for health educators. In order to ensure that health educators can meaningfully and effectively engage critical health content in their classrooms, they must be adequately trained to do so before stepping into the classroom or through ongoing professional development. Gloria Ladson-Billings (2009a) has provided guidelines for pre-service teacher training in order to prioritize cultural relevance in the classroom and school community (p. 142-149), and these should be considered and incorporated in any

teacher training program. It is my hope that any educational institution that trains health educators ensures their required coursework includes cultural connections, historical context, and self-reflexivity.

"Cultural connections." This term, coined by Venus Evans-Winters (2011, p. 148), acknowledges the importance of educators from communities outside those in which they find themselves teaching to be educated on the context and community in which they teach so that their "culture shock" does not encourage them to engage in practices that negatively impact students' educational experiences, for example, through punitive disciplinary methods (p. 148). Educational institutions that train health teachers should prepare them to study the local context in which they will be teaching and use a critical lens to appreciate the resources already available to their students that will support their development (Evans-Winters, 2011). This will help teachers prepare their students to effectively use the resources around them to their advantage in their pursuits, and to "question, critique and challenge the injustices" they experience within their social institutions (p. 152). Evans-Winters (2011) suggests that to build these skills and connections with their students, institutions train teachers on how to do the following: (1) research demographic information about the neighborhood in which they teach, including the racial/ethnic makeup and the average income level, in addition to the "social, political, and economic history about the school's community" (p. 153); (2) introduce in-class assignments that ask students for their own descriptions of their neighborhoods, communities, and cultures; and (3) learn to "feel comfortable visiting and interacting in those locations and contexts that students have described" to them, for example, a "church, a community organization, or a family's dinner table"—not as a voyeuristic pursuit, but in an effort for teachers to embed themselves in the community that surrounds the school (p. 154). Training health teachers in how to enact these steps ensures that teachers move toward engaging in culturally relevant pedagogy that meets students' needs and desires (Ladson-Billings, 2009a).

Further, teachers from outside their school community must prioritize learning about their students' situations inside and outside the classroom and recognize that their role as outsider, whether it's a visible difference such as race or gender, or a more subtle difference such as class or country of origin, urges relationship building and the development of a safe and trusting community before any meaningful learning can occur.

Historical context of health disparities. As previously stated, the recent investment in health education initiatives in New York City includes continued opportunities for professional development and community-building among health educators. It is absolutely critical that these professional development and community-building sessions operate from foundational lenses that help teachers understand how larger social structures and the intersections of race, class, and gender affect health and educational outcomes, and as a result, their students' educational experiences (Evans-Winters, 2011). This will allow them to engage their students on critical health topics (Fitzpatrick & Russell, 2015) and provide them opportunities to critique the social institutions of which they are a part to help them choose their role as change agent or defender of norms (Ladson-Billings, 2009a). Further, it is my belief that one or two required courses on the history of health disparities in the U.S. in the health teaching certification process is not enough—there should be a foundational understanding of the institutionally sanctioned racism that has created disparities in health and educational outcomes in each of the courses that are required for certification. This includes certification that allows individuals to teach in the public school setting, and certification as a health education specialist (CHES or MCHES).

Self-reflexivity. "Reflexivity" is a term I have used throughout this document, through the work of critical theorists (e.g., Ladson-Billings, 2003), to ensure that researchers reflect on how their own subjectivities influenced their selection of methodology and interpretation of the data. Evans-Winters (2011) uses the term "self-reflexivity" to bring a close observation of the self to the practice of teaching as well as

research (p. 164). Most new educators receive messages about Youth of Color and their cultural deficiencies in their institutions of learning and bring those assumptions into the classroom (Evans-Winters, 2011). Applying a critical race lens to American culture embeds racism at the center of it (Ladson-Billings, 2009b), suggesting that many teachers come into the profession without the skills needed to examine their own biases (Evans-Winters, 2011). Required training for health—ideally, all—educators must provide them with these skills to observe their own relationships with racism and how they perpetuate it. The following questions, suggested by Evans-Winters (2011), should be explored in a semester-long critical education course with multi-modal assignments and opportunities for examination:

> How does racism affect who I am as a person? How has racism affected the decisions that I have made in my life and career? How does racism determine where I live, whom I sleep with, and whom I spend my leisure time with?... Do I view behavior as Black behavior or student behavior? How does my own Whiteness (or Blackness) determine power relations in the classroom? As a victim and benefactor of racism, how can I help to eradicate and/or alleviate the negative effects of racism and patriarchy in my own life and those of my students? (pp. 164-165)

Jamila Lyiscott (2017) also provides a free resource for reflexive questions for critical pedagogy that pre-service teaching courses can and should use to help them guide their praxis. These opportunities for reflection should be accompanied by critical texts that allow for ongoing learning for pre-service and practicing teachers to become regularly self-reflective, more authentic as individuals and professionals, and determined to speak out against racist ideals and practices in their professional and personal lives (Evans-Winters, 2011, p. 165). Dr. Yolanda Sealey-Ruiz has long offered such a course for pre-service teachers at Teachers College, and it should be looked to as a model for other teacher training programs, specifically, in the context of this study, health teachers.

Parent/family education. Several students mentioned their parents and family members as key role models in health and as the individual from whom they learned the

most about health. This is further evidence of the need for schools to engage parents and families in their health education initiatives in order to ensure that parents have the information they want and need to support their students. Consistent inclusion and engagement of parents and families in ways that view them as experts of their own experiences provide students with opportunities to remain connected to and see the strengths of their cultures and families (Ladson-Billings, 2009a). It should not be the expectation that parent engagement in health initiatives is measured by the amount of times parents are able to attend school-led events; this is unrealistic given many parents' and families' work schedules. Teachers should provide alternative and innovative ways to engage students on health topics: sending surveys home asking about specific topics they would like support in, in addition to recommended resources they can use to talk to their children about health and taking care of themselves. Teachers should have these books available in their classrooms for parents to rent out if they are not interested in or able to purchase them, or they should help support them in obtaining them from the local library. Teachers might also consider hosting family health nights based on families' responses to health topics they need support talking to their kids about with digital applications like Zoom or Google Hangouts so that parents who are not able to attend in person have the option of tuning in remotely or view a recording in a webinar-style format at a time that is convenient for them. I recognize that teachers' time is very limited and the expectations are already great: if these suggestions create too much strain or an unrealistic burden on teachers, an alternative option is that teachers compile a list of recommended online courses, books, or workshops that they themselves have taken and can happily recommend that parents and families engage in. Administrators should also be clear about their expectations for parent and family engagement in health initiatives and hire an additional health educator whose role focuses solely on parent and family engagement if they have funding available and choose to invest in this. These alternative ways of involving parents and families allow schools and teachers to provide ongoing

education that can support their child’s development without pressuring them to be present in a way that is burdensome to their likely already busy schedule.

After-school programs. Several students indicated that their after-school program provided positive experiences in health workshops that supplemented what many of them weren’t learning at school. While Azzarito, Macdonald, and colleagues (2017) warn against the outsourcing of health and physical education programming in order to avoid continued disinvestment in public school funding, as it stands now, the youth in this study consistently reported receiving school-based health education that did not meet their needs. Unfortunately, in New York State, enrollment in teacher education programs has declined 47% since 2009-2010, and heath/ physical education are identified as areas of teacher shortages (NYSUT Research and Educational Services, 2019). Though the NYC DOE recommends that health education be taught by a certified health teacher, they also allow teachers who do not have a health education certificate to teach one health class (NYC DOE, 2019). Although students in New York City are required to receive at least one semester of health education in both middle and high school, after-school health programming is an important supplement in the case that these policies are not being enforced, and a potentially helpful reinforcement of health messages.

Any after-school program that teaches health education workshops or classes must do so by hiring certified health education specialists or collaborating with organizations that employ and contract health educators to teach student and family workshops. Individuals who teach topics that can become as personal and as sensitive as health without a background in that subject can do more harm than good, and the need for well-educated and well-trained health teachers should not be taken lightly. Priority should be given to family and community mentors from the community in question (Evans-Winters, 2011). If the after-school program takes place in an area where the organizations do not have access to health educators or organizations they can feasibly collaborate with, they should consider providing students with educational resources like books, websites, and

YouTube videos that follow the principles listed above and are specifically designed to reach youth, and are intentionally selected to support the specific socialized context of the youth in question, before asking an untrained educator to teach health to students and risking the provision of misinformation. Additionally, it is critical to continually assess the wants and needs of the students and families who attend the program in order to ensure it meets their needs, and to consider alternative and innovative ways to be sure that funds are being redirected to support children and the adults in that community by adopting intentional hiring practices.

Summary

This study employed a culture-centered approach (Dutta, 2007, 2010), combining postmodern tenets with critical race feminist theory (Evans-Winters & Esposito, 2010) in order to explore how a small sample of high school students and recent high school graduates understand and imagine health in the context of racial, wealth, and health disparities in contemporary U.S. society. These disparities, when understood through a critical race lens, are a result of historical and contemporary forms of institutional racism that have long segregated and marginalized groups who fall outside of the White norm (Roberts, 2012). Though my chosen methodology imposed limits on my interpretations and their application to the larger population, it was a pursuit that aimed to challenge traditional discourses in the field of health education and legitimize the voices and experiences of youth who have long been marginalized (Azzarito, Macdonald et al., 2017; Dagkas, 2014).

Youth in this study shared a variety of stories that had commonalities with each other. Common themes included the performativity of health (Webb & Quennerstedt, 2010), low school investment in health education, discourses of fear, risk, and shame in health class, and students' desires for openness and honesty from caring adults—health

teachers or not. In addition to commonalities, what also showed up in the interview texts were the “unusual” (Stake, 2006, p. 90). Unique or uncommon responses, while it was difficult to categorize them under the same theme, included students’ ideas about health as an internal process, and the hindrance of American culture on individuals’ well-being. There were also contradictions that arose: between the importance of leaning on one’s community and learning how to take care of yourself, and between students’ perceived needs for structural and individual changes in their imagination of a healthy life.

Subscribing to normative health ideals affected students’ ability to see themselves as agents of change when they were simultaneously aware of the constraints that their social positioning had on their well-being and their access to health behaviors. If being “healthy” meant eating more fruits and vegetables and exercising every day, but they lived in a neighborhood where they rarely saw affordable produce or safe routes for physical activity, how could they be expected to make a difference or take meaningful action to change their health behaviors? If “health” means happiness, but they witness inequities in housing, education, employment, and income levels throughout their daily experiences in a segregated city, and gentrification in their neighborhoods, how can they feel supported in their pursuit of happiness? These contradictions suggest the usefulness of critical and social justice lenses in health education research, practice, and pedagogy (Azzarito, Macdonald et al., 2017; Fitzpatrick & Allen, 2019; Fitzpatrick et al., 2019) so that students are not encouraged to blame themselves for “failing” to engage in behaviors that were not made accessible to them to begin with.

This study’s methodological decisions placed limits on its generalizability across populations; the findings, however, point to the richness of students’ experiences, thoughts, and feelings about health and the ways we can refocus the lens away from the academy and toward the students, families, and communities we aim to support in order to inform research, policy, and pedagogical practices in the field of health education.

Conclusion

> Mia: You're taught to take care of yourself by like eating right, eating healthy foods and stuff like that. But that doesn't really help. We shouldn't really look at health that way. I kind of learned that lesson probably throughout high school and just being here, you know, being surrounded by people who do create conversations about what health actually looks like. So I think that by doing that I've learned to just think about the things that I can do to take care of myself. (5/4/19)

I intend for the findings from this study to inform the co-creation of lesson plans and workshops that center students' desires for health, which I will ultimately share with the organization at which I was employed and where the students attended during the time of the interviews in a way that is conducive to their needs. My hope is that this study begins to normalize postmodern tenets with a focus on the intersections of race, class, and gender (Evans-Winters, 2011), in addition to the use of culture-centered approaches (Dutta, 2007, 2010), within the field of health education, in order to contribute to a shift toward critical health education research and practice (Fitzpatrick et al., 2019). I hope to see health educators with the support and availability to create health initiatives and programming shaped by what matters to students, families, and communities; I hope to see students, families, and communities feel supported by the health education resources they have access to; and I hope this study provided a foundational framework for creating these conditions. "Ideological literacy" and critical thinking will be a fundamental aspect of any lesson plan creation so that students are allowed to make more informed decisions about what they are exposed to in and out of school (Camangian, 2013, p. 119). Any future lesson plans that are developed as a result of this study will have the ultimate goal of enhancing protective factors through the development of empowerment and agency that critically address the oppressive nature of social institutions on Youth of Color with regard to their experiences of health. This study ultimately seeks to position health

education “as a liberatory tool to subvert the oppressive conditions” that take place for many Students of Color in urban schooling (Lane, 2015 p. 168).

adrienne maree brown (2019a) writes that falling in love with and healing her body required “changing habits that … liberate[d] [her] from [her] socialization” and “started with pleasure, not with dieting and exercise” (p. 118). Health education teachers have a unique opportunity to subvert this socialization and teach students about health in a way that empowers them to define their health for themselves and view themselves as the expert in their own experience and the nexus for social change. In this section, I have laid out general suggestions for researchers, teachers and schools to move toward critical health education using insights from student-participants in this study, critical health scholars (e.g., Fitzpatrick et al., 2019), and critical race theorists (e.g., Ladson-Billings, 2009a, 2009b; Taylor et al., 2009), and critical race feminists (e.g., Evans-Winters, 2011, 2019). I maintain that health educators should consult with their students and families to determine which supplemental activities can and should be restructured to meet the needs of local contexts and desires. The future of health education in a particular context should always begin with the wants and needs of the community members, as opposed to the wants and needs of the educators or administrators.

It is my hope that more health and educational researchers will see the value of pursuing alternative research methods that employ postmodern tenets and prioritize the impact of the intersection of race, class, and gender on students’, families’, and communities’ educational experiences and health outcomes through culture-centered approaches. Postmodern tenets allow researchers to embrace difference and deconstruct the historical and contemporary marginalization of Communities of Color (Evans-Winters, 2011; Mirón, 1996), and culture-centered approaches allow us to replace ourselves as experts with the members of the communities we aim to serve (Dutta, 2007, 2010). Embracing postmodernism in health education research with a critical eye on race, class, and gender allows outdated assumptions to be exposed in research methodology

and topics, as well as in policy decisions, and supports a shift toward critical health education content and training.

Limitations

I wrote in Chapter III about the ethical dilemmas present in this study that qualify as limitations, but I would like to restate the following: this study employed critical race feminist theory, therefore centering raced, classed, and gendered experiences (Evans-Winters & Esposito, 2010). It did not explore students' sexual identities unless they specifically brought them up, and my analysis of queerness and sexuality throughout Chapters IV and V was therefore limited. There is a need for further inquiry that takes up how students' sexual identities contribute to their understandings of health and their stories about themselves so that we may develop critical health pedagogy and research that are supportive of the multitude of sexual orientations of youth without pathologizing difference.

I presented my subjectivities and personal investments in previous chapters to acknowledge my limitations for interpreting participants' understanding and experiences of health: given my commitment to challenging the traditional deficit-oriented labels with which the students in this study are typically burdened, I have made it clear that my interpretations of participants' narratives are shaped by the tenets of critical race feminist theory. I wonder still, at what point does viewing participants' experiences through the lenses of race and gender further strengthen these categories? In an attempt to recognize the social, cultural, and environmental factors that affect health status, I fear that I am further confining students to the racialized categories I claim I am trying to rid the field of.

Finally, it is important to note the significant limitations of my racialized and gendered identity as an educator-researcher. Desmond (2017) writes the following about

researcher identity: “Everything about you—your race and gender, where and how you were raised, your temperament and disposition—can influence whom you meet, what is confided to you, what you are shown, and how you interpret what you see” (p. 325).

These limitations include what students felt comfortable sharing with me. Despite our existing relationships, there is no reason for me to assume that students would have felt comfortable sharing with me their ideas about ideas they fear I might not understand, such as teacher identity for example, than if they were discussing these topics with a researcher who was racially congruent with them. Future research might gain additional, unique insights when researchers share similar characteristics as the target audience, including gender, race, or perceived class.

Looking Forward

> Many of us are terrified to govern, much more comfortable with critiquing what is than with creating and practicing what will be. (brown, 2019b)

I spent a great deal of time and energy in this document critiquing the existing systems and the mainstream discourses of health and health disparities, specifically with regard to youth. I am reminded of something a former professor, Dr. Robert Fullilove, shared with our HIV/AIDS Epidemiology and Education class: graduate students are incredible at eloquently and articulately stating and restating the problem, but not so equipped at finding the solution (paraphrase from an in-class discussion, April 2017). We saw in this study that several students determined their ability to lead a healthy life by their own personal responsibility, while others desired structural shifts in access to affordable food, jobs, and a more cohesive community. In this chapter, I have attempted to present solutions on both individual and structural levels. I have indeed spent more time “critiquing what is,” in the words of adrienne maree brown (2019b) above, but

beyond this study, I hope there will be opportunities for practicing and imagining new solutions, as Greene (1995) encourages educators to do.

The title of this dissertation is about imagination: how do youth imagine a healthy life? There is indeed tension and contradiction in students' responses with regard to individualistic versus structural changes that are required. While I have shared the potential implications of students' responses in health education research, policy, and pedagogical practices, I want to use this section to imagine what access to a healthy life for all individuals might look like in the U.S. Indeed, what would health look like in the U.S. if we deconstructed the assumptions around who is healthy and who is not? What if we listened to and legitimized the voices of young people? What would health disparities look like if we believed everybody to be equally capable of defining health for themselves and reaching those definitions on their own, so long as we provide the social structures necessary to make those definitions accessible to all? What would they look like if we eliminated the need to "save" young people or individuals of any age that we label "at-risk," and instead shifted our energy to eliminate the structural exploitation that creates disparities in access?

In previous sections, I looked to Edgar Villanueva's definition of altruism from his 2018 book, *Decolonizing Wealth*: "doing things for others, unselfishly, without expectation of reward or acknowledgment, and maybe even at some cost to oneself" (p. 175). Such a concept, he argues, is inherently related to the assumption of our separation. He writes:

> When you look more closely altruism is actually a fundamental reflection of the separation paradigm, the Us vs. Them mindset … altruism also is a linear concept: it moves in one direction, from the Have to the Have Not, a one-way flow of resources. Altruism is the poster child for white saviors. (p. 176)

Contemporary U.S. society is undoubtedly shaped by separation. In previous chapters, I brought readers' attention to Dorothy Roberts's (2012, 2017) and Harriet

Washington's (2006, 2019) works that remind us of the ways taken-for-granted assumptions about categorizations of race in the U.S. have led to systemic governmental separation and subjugation, producing profane differences in the health and educational status and outcomes among racialized groups. Our natural response up until now has been to conduct altruistic research from the distance of an institution, provide altruistic resources and funding to programs aimed at intervening with those who are in "need." We have named "those who had benefited most from the system of wealth consolidation" as "the experts and the saviors of those who had been exploited and harmed by it" (Buffett & Buffett, 2018, p. xi). And still, there is more evidence than ever that our country's foundation of racism has produced, and continues to produce, inequities in access to: affordable and unbiased health care (Interlandi, 2019; Villarosa, 2019), steady work and income (Desmond, 2019; Lee, 2019), equitably funded education (Jones, 2016), and safe and affordable housing (Lee, 2019; Washington, 2019). The disproportionate numbers of Black Americans we see incarcerated also find their roots in our foundation of slavery (Stevenson, 2019). Villanueva (2018) calls systemic issues within the current system of philanthropy "mere symptoms of a virus that has pervaded every aspect, every cell, every interaction" (p. 4); these labels can indeed be applied to the health and educational disparities we see today: the inequities listed above are just symptoms of the infected foundation.

Instead of altruism, Villanueva (2018) directs our attention to the Native concept of reciprocity. He writes:

> Reciprocity is based on our fundamental interconnection—there is no Other, no Us vs. Them, no Haves vs. Have Nots. Reciprocity is the sense that I'm going to give to you because I know you would do the same for me. No one is just a giver or just a taker; we're all both at some point in our lives. (p. 176)

What if the money that we're used to spending on "urgent" interventions for "communities in need" were shifted toward investments in reciprocity, wherein those

community members decide where the money goes and how it is used? What would it look like for those of us in positions of power, who feel comfortable in the identity of an "altruistic" person, were to recognize that the people who have long been marginalized might have the best answers for "healing, progress, and peace, by virtue of [their] outsider perspectives and resilience" (Villanueva, 2018, p. 6)? Villanueva suggests we consider Native healing processes to heal from our country's history of violence and trauma in order to reconnect with our sense of community and shift toward reciprocity. The steps he suggests—grieve, apologize, listen, relate, represent, invest, and repair—are not short-term or simple solutions, but are cyclical, nonlinear, and time-consuming in nature (pp. 9-10), and they must happen at both the individual and institutional level. Similarly, adrienne maree brown (2019b), in her imaginings of a future that empowers all who have long been marginalized, suggests that we "start small." She continues: "Democratize your home, your relationship with your neighbor, with your lover, with your family. If we can't budget together, we can't be mad that our government struggles to."

When I try to imagine the systemic shifts that are needed in our social structures—neighborhood and school segregation, access to health care, inequitable schooling practices, incarceration, skyrocketing housing prices, educational debt—that create health disparities, I buckle. I stand by and will attempt to employ the suggestions I made previously with regard to research, policy, and pedagogical practices wherever my positioning allows me to, but beyond that, it can be paralyzing to imagine all the changes that must be made—what Dr. Martin Luther King, Jr. called paralysis of analysis. When I imagine starting small, change seems possible. I recognize how this contradicts my previous sentiments about the need to address the role of social structures in health disparities, but from my position as an individual member of a community, it starts with applying the postmodern tenets and critical race feminist theoretical framework used throughout this study in my daily life. To me, that means deconstructing the discourses in

which we find ourselves and asking why certain people and groups are defined as being "in need" or "at risk," and why I or other members of "elite" social institutions are given the opportunity to fill the very real gaps that have been created by our infected foundation. It means shining a light on the root causes of health disparities as opposed to remaining attached to labels or misconceptions about the deficits of certain individuals or communities. And it means moving out of the self-satisfaction of altruism toward reciprocity, wherein the expertise, agency, and humanity of the very people from whom access to what is needed for a healthy life have been deprived are centered as the locus of change. The deconstruction of self-identity and labels of others that I have attempted to demonstrate throughout this document may be the beginning of true reciprocity, and, brown (2019b) suggests, subsequent structural change: when we can't change the structures we take issue with, we look for the ways we can change ourselves.

What benefit will this study have beyond my self-satisfaction that I committed to something that challenged the traditional paradigms? Will this study shift the status quo in the distribution of resources or direction of research, or simply gain me my degree and, as a result, further institutional power? If I gain it, how will I use it? This document and study have been practices in unwavering commitment to self-reflection and close examination of the social conditions by which I have come to understand myself and the world, only to deconstruct such a self-concept and assumed conception of others entirely; these practices will indeed continue beyond just my writing as I move forward. It is my hope that these reflections will encourage the same among readers: the reflexivity that Ladson-Billings (2003) argues breaks the "canons of traditional research" to transform the relationships between those conducting research and those being researched (p. 268), and that Evans-Winters (2011) calls necessary to ensure that educators, and I argue, researchers, work "on behalf of students" (p. 164) to become "a more self-reflective and authentic individual" (p. 165). Perhaps this is where my imagination of a healthy life for all begins.

REFERENCES

Acosta, K. (2010). How could you do this to me? How LGBTQ Latinas negotiate sexual identity with their families. *Black Women, Gender, and Families, 4,* 63–85.

Adler, N. E., & Rehkopf, D H. (2008). U.S. disparities in health: Descriptions, causes, and mechanisms. *Annual Review of Public Health, 29*, 235-52.

Afterschool Alliance (2019). *This is afterschool in New York.* Retrieved from: http://www.afterschoolalliance.org/documents/NY-afterschool-facts.pdf

Agnew, S. & Gunn, A. C. (2019). Students' engagement with alternative discursive construction of menstruation. *Health Education Journal,* 78(6), 670-680.

Aiken, K. (2018). *"White people food" is creating an unattainable picture of health*. Retrieved from: https://www.huffpost.com/entry/white-people-food_n_5b75c270e4b0df9b093dadbb?guccounter=1&guce_referrer=aHR0cHM6Ly93d3cuZ29vZ2xlLmNvbS8&guce_referrer_sig=AQAAAGaKHqc6r0K_lGXBLSd22KHMn8V6NpaiTfH2xOXykby8PprIt_9SK1YHWn-ReMWjmqbqIpjX3xuVRHAywS1ip5oatyCb5ffqAi6ke-Z6DDTjkLKXtOdjGpxa7_u3T0cpKr8RN2PQOqQAw9wq4Z2biH0GNClIEh-eBHTUVMdZcnnj

Airhihenbuwa, C. O. (1995). *Health and culture: Beyond the western paradigm.* Thousand Oaks, CA: Sage.

Antonovsky, A. (1979). *Health, stress, and coping.* San Francisco, CA: Jossey-Bass.

Antonovsky, A. (1987). *Unraveling the mystery of health.* San Francisco, CA: Jossey-Bass.

Apple, M. W. (2014). *Official knowledge: Democratic education in a conservative age.* New York, NY: Routledge.

Augustine, J. M., Prickett, K. C., & Kimbro, R. T. (2017). Health-related parenting among U.S. families and young children's physical health. *Journal of Marriage and family, 79*(3), 816-832.

Ayo, N. (2012). Understanding health promotion in a neoliberal climate and the making of health conscious citizens. *Critical Public Health, 22*(1), 99-105.

Azzarito, L. (2009a). The panopticon of physical education: Pretty, active, and ideally White. *Physical Education and Sport Pedagogy, 14*(1)*, 19-39.*

Azzarito, L. (2009b). The rise of corporate curriculum: Fatness, fitness, and Whiteness. In J. Wright & V. Harwood (Eds.), *Bio-pedagogies: Schooling, youth, and the body in the "obesity epidemic"* (pp. 183-198). London, England: Routledge.

Azzarito, L. (2010). Future girls, transcendent femininities and new pedagogies: Toward girls' hybrid bodies? *Sport, Education, and Society, 15*(3), 261-275.

Azzarito, L., Macdonald, D., Dagkas, S., & Fisette, J. (2017). Revitalizing the physical education social-justice agenda in the global era: Where do we go from here? *Quest, 69*(2), 205-219.

Azzarito, L., Simon, M., & Marttinen, R. (2017). "Up against Whiteness": Rethinking race and the body in a global era. *Sport, Education and Society, 22*(5), 635-657.

Barr, D. A. (2014). *Health disparities in the United States: Social class, race, ethnicity, and health* (2nd ed.). Baltimore, MD: Johns Hopkins University Press.

Barrie, M. (1997). Literacy as dialectic: Maxine Greene's "Releasing the imagination." *ProQuest Dissertations Publishing.* 1385911.

Beck, U. (1992.) *Risk society: Towards a new modernity.* London, England: Sage.

Bell, C., & Encel, S. (1978). Introduction. In C. Bell & S. Encel (Eds.), *Inside the whale.* Oxford, England: Pergamon Press.

Bensley, L. B. (2010). This I believe: A philosophy on health education. In J. M. Black, S. Furney, H. M. Graf, & A. E. Nolte (Eds.), *Philosophical foundations of health education.* San Francisco, CA: Jossey-Bass.

Berbary, L. A. (2014). Too good at fitting in: Methodological consequences and ethical adjustments. *International Journal of Qualitative Studies in Education, 27*(10), 1205-1225.

Black, J. M., Furney, S., Graf, H. M., & Nolte, A. E. (2010). *Philosophical foundations of health education.* San Francisco, CA: Jossey-Bass.

Bloom, L. R. (1997). Locked in uneasy sisterhood: Reflections on feminist methodology and research relations. *Anthropology & Education Quarterly, 28*(1), 111-122.

Bordo, S. (2004). *Unbearable weight: Feminism, Western culture, and the body* (10th anniv. ed.). Berkeley: University of California Press.

Bowleg, L. (2012). The problem with the phrase woman and minorities: Intersectionality—an important theoretical framework for public health. *American Journal of Public Health, 102*(7), 1267–1273. doi:10.2105/AJPH.2012.300750

Brah, A., & Phoenix, A. (2009). Ain't I a woman? Revisiting intersectionality. In E. Taylor, D. Gillborn, & G. Ladson-Billings (Eds.), *Foundations of critical race theory in education.* (pp. 247-258). New York, NY: Taylor & Francis.

Braidotti, R. (2002). *Metamorphoses: Towards a materialist theory of becoming*. Cambridge, England: Polity Press.

Brockenbrough, E. (2013) Introduction to the special issue: Queers of color and anti-oppressive knowledge production. *Curriculum Inquiry, 43,* 426–440.

brown, a. b. (2019a). *Pleasure activism.* Chico, CA: AK Press.

brown, a. b. (2019b). *Build as we fight: Remarks from the 2019 American Studies Association annual meeting.* Retrieved from: http://adriennemareebrown.net/

Brown, D. (2005). An economy of gendered practices? Learning to teach physical education from the perspective of Pierre Bourdieu's embodied sociology. *Sport, Education and Society 10*(1), 3–23.

Brown, T.N. (2003). CRT speaks to the sociology of mental health: Mental health problems produced by racial stratification. *Journal of Health and Social Behavior, 44,* 292–301.

Buffett, J., & Buffett, P. (2018). Foreword. In E. Villanueva, *Decolonizing wealth: Indigenous wisdom to heal divides and restore balance* (pp. xi-xiii). Oakland, CA: Berrett-Koehler Publishers, Inc.

Burke, K. J. (2011). *Masculinities and other hopeless cases at an all-boys Catholic school.* New York, NY: Peter Lang.

Burns, P., & Gimpel, J. G. (2013). Economic insecurity, prejudicial stereotypes, and public opinion on immigration policy. *Political Science Quarterly, 115*(2), 201-225.

Burrows, L. (2011). "I'm proud to be me": Health, community and schooling, *Policy Futures in Education*, *8*(3), 341–352.

Burrows, L., & Sinkinson, M. (2014). Mental health in corporeal times. In K. Fitzpatrick & R. Tinning (Eds.), *Health education: Critical perspectives* (pp. 157-170). New York, NY: Routledge.

Burrows, L., Wright, J., & McCormack, J. (2009). Dosing up on food and physical activity: New Zealand children's ideas about health. *Health Education Journal, 68,* 157-169.

Calmore, J. O. (1995). Critical race theory, Archie Shepp, and fire music: Securing an authentic intellectual life in a multicultural world. In: K. Crenshaw et al. (Eds.), *Critical race theory: The key writings that formed the movement* (pp. 315-328). New York, NY: New Press.

Camangian, P. R. (2013). Seeing through lies: Teaching ideological literacy as a corrective lens. *Equity and Excellence in Education, 46*(1), 119-134.

Cameron, N. O., Muldrow, A. F., Stefani, W. (2018). The weight of things: Understanding African American women's perceptions of health, body image, and attractiveness. *Qualitative Health Research, 28*(2), 1242-1254.

Centers for Disease Control and Prevention (CDC). (2012). *Health education curriculum analysis tool (HECAT): Overview*. Retrieved from: https://www.cdc.gov/healthyyouth/hecat/pdf/HECAT_Overview.pdf

Centers for Disease Control and Prevention (CDC). (2015). *National health education standards*. Retrieved from: http://www.cdc.gov/healthyschools/sher/standards/index.htm

Centers for Disease Control and Prevention (CDC). (2016). *Healthy teens. Successful futures.* CDC Division of Adolescent and School Health: DASH-Strategic Plan for Fiscal Years 2015-2020. Retrieved from: https://www.cdc.gov/healthyyouth/about/pdf/strategic_plan/dash_strategic_plan.pdf

Centers for Disease Control and Prevention (CDC). (2018a). *Adolescent and school health: Health disparities*. Retrieved from: https://www.cdc.gov/healthyyouth/disparities/index.htm#1

Centers for Disease Control and Prevention (CDC). (2018b). *How CDC prepares healthy youth for successful futures.* Retrieved from: https://www.cdc.gov/healthyyouth/about/pdf/DASH_Snapshot.508.pdf

Centers for Disease Control and Prevention (CDC). (2018c). *Division of nutrition, physical activity, and obesity: REACH 2018 recipients.* Retrieved from: https://www.cdc.gov/nccdphp/dnpao/state-local-programs/reach/current_programs/recipients.html

Centers for Disease Control and Prevention (CDC). (2018d). *Mental health*. Retrieved from: https://www.cdc.gov/mentalhealth/index.htm

Centers for Disease Control and Prevention (CDC). (2019a). *About the Division of Adolescent and School Health*. Retrieved from: https://www.cdc.gov/healthyyouth/about/index.htm

Centers for Disease Control and Prevention (CDC). (2019b). *Why schools? Schools: The right place for a healthy start*. Retrieved from: https://www.cdc.gov/healthy youth/about/why_schools.htm

Centers for Disease Control and Prevention (CDC). (2019c). *About CDC 24/7: Mission role, and pledge.* Retrieved from: https://www.cdc.gov/about/organization/mission.htm

Centers for Disease Control and Prevention (CDC). (2019d). *National Center for Chronic Disease Prevention and Health Promotion*. Retrieved from: https://www.cdc.gov/chronicdisease/index.htm

Centers for Disease Control and Prevention (CDC). (2019e). *CDC features: Back to school*. Retrieved from: https://www.cdc.gov/features/teens-back-to-school/index.html?s_cid=hy-carousel-037

Childers, S. M., Rhee, J., & Daza, S. L. (2013). Promiscuous (use of) feminist methodologies: The dirty theory and messy practice of educational research beyond gender. *International Journal of Qualitative Studies in Education. 26*(5), 507-523.

Chomsky, N. (1999). Profit over people: *Neoliberalism and the global order.* New York, NY: Seven Stories Press.

Coleman, R., & Ringrose, J. (2013). *Deleuze and research methodologies.* Edinburgh, Scotland: Edinburgh University Press.

Colen, C. G., Ramey, D. M., Cooksey, E. C., Williams, D. R. (2018). Racial disparities in health among nonpoor African Americans and Hispanics: The role of acute and chronic discrimination. *Social Science & Medicine, 199*, 167-180.

Collins, P. (2000). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment* (2nd ed.). New York, NY: Routledge.

Crawford, R. (1980). Healthism and the medicalization of everyday life. *International Journal of Health Services, 10*9(3), 365-388.

Crenshaw, K., Ocen, P., & Nadna, J. (2015). *Black girls matter: Pushed out, overpoliced and underprotected.* Retrieved from: https://www.law.columbia.edu/sites/default/files/legacy/files/public_affairs/2015/february_2015/black_girls_matter_report_2.4.15.pdf

Cunningham, T.J., Croft, J. B., Liu, Y., Lu, H., Eke, P. I., & Giles, W. H. (2017). Vital signs: Racial disparities in age-specific mortality among Blacks or African-Americans – United States, 1999-2015. *MMWR Morbidity and Mortality Weekly Report, 66*, 444-456. doi: http://dx.doi.org/10.15585/mmwr.mm6617e1External.

Dagkas, S. (2014). Who has health problems? Class, racialization, and health. In K. Fitzpatrick & R. Tinning (Eds.), *Health education: Critical perspectives* (pp. 75-86). New York, NY: Routledge.

Darling-Hammond, L. (2007). The flat earth and education: How America’s commitment to equity will determine our future. *Educational Researcher, 36*(6), 318-334.

Darling-Hammond, L. (2014). Foreword. In H. R. Milner & K. Lomotey (Eds.), *Handbook of urban education*. New York, NY: Routledge.

Darling-Hammond, L. (2018). *Education and the path to one nation, indivisible.* Retrieved from: https://learningpolicyinstitute.org/sites/default/files/product-files/Education_Path_To_One_Nation_BRIEF.pdf

Datnow, A., & Cooper, R. (2009). Peer networks of African American students in independent schools: Affirming academic success and racial identity. In E. Taylor, D. Gillborn, & G. Ladson-Billings (Eds.), *Foundations of critical race theory in education.* (pp. 190- 209). New York, NY: Routledge.

Delgado, R., & Stefancic, J. (2001). *Critical race theory: An introduction.* New York, NY: New York University Press.

Desmond, M. C. (2017). *Evicted: Poverty and profit in the American city.* New York, NY: Penguin Random House.

Desmond, M. (2019). *In order to understand the brutality of American capitalism, you have to start on the plantation*. Retrieved from: https://www.nytimes.com/interactive/2019/08/14/magazine/slavery-capitalism.html

Dillard, C. B. (2000). The substance of things hoped for, the evidence of things not seen: Examining an endarkened feminist epistemology in educational research and leadership. *International Journal of Qualitative Studies in Education, 13*(6), 661-681.

Dutta, M. (2007). Communicating about culture and health: Theorizing culture-centered and culture-sensitivity approaches. *Communication Theory, 17,* 304-328.

Dutta, M. J. (2010). The critical cultural turn in health communication: Reflexivity, solidarity, and praxis. *Health Communication, 25*(6-7), 534-539.

Dutta-Bergman, M. J. (2005). Theory and practice in health communication campaigns: A critical interrogation. *Health Communication, 18*(2), 103-122.

Ehrenreich, B. (2009). *Is it now a crime to be poor?* Retrieved from: https://www.nytimes.com/2009/08/09/opinion/09ehrenreich.html

Esposito, J., & Evans-Winters, V. E. (2007). Contextualizing critical action research: Lessons from urban educators. *Educational Action Research, 15*(2), 221-237.

European-American Collaborative Challenging Whiteness. (2005). When first-person inquiry is not enough. *Action Research, 3*(3), 245-261.

Evans, J., & Davies, B. (2011). New directions, new questions? Social theory, education and embodiment. *Sport Education and Society, 16*(3), 263–278. doi: 10.1080/13573322.2011.565960

Evans, J., Davies, B., & Rich, E. (2008, 12-14 July). *Bernstein, body pedagogies and the corporeal device*. Paper prepared for the fifth International Annual Basil Bernstein Conference, Cardiff, Wales.

Evans, J., Davies, B. & Rich, E. (2009). The Body Made Flesh: embodied learning and the corporeal device, *British Journal of Sociology of Education*, 30(4). http://dx.doi.org/389-391. 10.1080/01425690902954588

Evans, J., Davies, B., & Wright, J. (2004). *Body knowledge and control*. London, England: Routledge.

Evans, J., De Pian, L., Rich, E., & Davies, B. (2011): Health imperatives, policy and the corporeal device: Schools, subjectivity and children's health. *Policy Futures in Education, 9*(3), 328-340.

Evans, J., Rich, E., Allwood, R. & Davies, B. (2008) Body pedagogies, P/policy, health and gender, *British Educational Research Journal*, 14(3), 387-411. http://dx.doi.org/10.1080/01411920802042812

Evans-Winters, V. E. (2011). *Teaching Black girls: Resiliency in urban classrooms* (2nd ed.). New York NY: Peter Lang.

Evans-Winters, V. E. (2019). *Black feminism in qualitative inquiry: A mosaic for writing our daughter's body.* New York, NY: Routledge.

Evans-Winters, V. E., & Esposito, J. (2010). Other people's daughters: Critical race feminism and Black girls' education. *Educational Foundations, 24*(1/2), 11-24.

Fiddian-Green, A., Gubrium, A. C., & Peterson, J. C. (2017) Puerto Rican Latina youth coming out to talk about sexuality and identity. *Health Communication, 32,* 1093-1103.

Fine, M. (1988). Sexuality, schooling, and adolescent females: The missing discourse of desire. *Harvard Educational Review, 58*(1), 29–53.

Fine, M., & McClelland, S. (2006.) Sexuality education and desire: Still missing after all these years. *Harvard Educational Review*, 7*6*(3), 297–338.

Fine, M., & McClelland, S. I. (2007). The politics of teen women's sexuality: Public policy and the adolescent female body. *Emory University School of Law, 56,* 993-1038.

Fitzpatrick, K. (2013). *Critical pedagogy, physical education, and urban schooling.* New York, NY: Peter Lang.

Fitzpatrick, K. (2014). Critical approaches to health education. In K. Fitzpatrick & R. Tinning (Eds.), *Health education: Critical perspectives* (pp. 173-189). New York, NY: Routledge.

Fitzpatrick, K. (2019). What happened to critical pedagogy in physical education? An analysis of key critical work in the field. *European Physical Education Review, 25*(4), 1128-1145.

Fitzpatrick, K., & Allen, J. A. (2019). What does critical health education in schools look like? Two ethnographic narratives of critical practice. *Health Education Journal, 78*(6), 647-661.

Fitzpatrick, K., Leahy, H., Webber, M., Gilbert, J., Lupton, D., & Aggleton, P. (2019). Critical health education studies: Reflections on a new conference and this themed symposium. *Health Education, 78*(6), 621-632.

Fitzpatrick, K., & Russell, D. (2015). On being critical in health and physical education, *Physical Education and Sport Pedagogy, 20*(2), 159-173.

Fitzpatrick, K., & Tinning, R. (2013). Health education's fascist tendencies: A cautionary exposition. *Critical Public Health.* doi: 10.1080/09581596.2013.836509.

Fitzpatrick, K., & Tinning, R. (2014a). *Health education: Critical perspectives*. New York, NY: Routledge.

Fitzpatrick, K. & Tinning, R. (2014b). Considering the politics and practice of health education. In K. Fitzpatrick & R. Tinning (Eds.), *Health education: Critical Perspectives* (pp. 1-13). New York, NY: Routledge.

Flintoff, A., & Fitzgerald, H. (2012). Theorizing difference and (in)equality in physical education, youth sport and health. In F. Dowling, H. Fitzgerald, & A. Flintoff (Eds.), *Equity and difference in physical education, youth sport and health: A narrative approach* (pp. 11–37). London, England: Routledge.

Foucault, M. (1972). *The archaeology of knowledge* (A. Sheridan-Smith, Trans.). New York, NY: Harper & Row.

Foucault, M. (1979). *Discipline & punish: The birth of the prison.* New York, NY: Vintage.

Foucault, M. (1980). *Power/knowledge: Selected interviews and other writings 1972-1977* (C. Gordon, Ed., C. Gordon, L. Marshall, J. Mepham, & K. Soper, Trans.). New York, NY: Vintage.

Foucault, M. (1990). *The History of sexuality, Vol. 1: An introduction.* New York, NY: Vintage.

Foucault, M. (1996). Ethics of the concern for self, self as a practice of freedom. In S. Lotringer (Ed.), *Foucault live: Collected interviews, 1961-1984, Michel Foucault* (pp. 432-449). New York, NY: Semiotex(e).

Foucault, M. (2000). *Power.* New York, NY: New Press.

Foucault, M. (2003). *Society must be defended: Lectures at the College de France, 1975-1976* (D. Macey, Trans.). New York, NY: Picador.

Fountain, R. (2017). *Black single mothers are more than scapegoats*. Retrieved from: https://www.huffpost.com/entry/black-single-mothers-are-_b_9619536

Free Figure Revolution. (2017). *The fat census 2017.* Retrieved from: https://www.freefigure.org/thefatcensus2017

Freire, P. (2013). *Pedagogy of the oppressed.* New York, NY: Bloomsbury Academic.

Freudenberg, N. & Ruglis, J. (2007). Reframing school dropout as a public health issue. *Preventing Chronic Disease, 4*(4).

Friedman, S. R., Cooper, H. L. F., & Osborne, A. H. (2009). Structural and social contexts of HIV risk among African Americans. *American Journal of Public Health, 99*(6), 1002-1008.

Garcia, L. (2009). “Now why do you want to know about that?”: Heteronormativity, sexism, and racism in the sexual (mis)education of Latina youth. *Gender and Society, 23,* 520–541. doi: 10.1177/0891243209339498.

Garcia, S. B., & Guerra, P. L. (2004). Deconstructing, deficit thinking: Working with educators to create more equitable learning environments. *Education and Urban Society, 36*(2), 150-168.

Gard, M., & Leahy, D. (2009). Dicing with death: Tensions, contradictions and awkward positions in school health education. In M. Dinan-Thompson (Ed.), *Health and physical education: Issues for curriculum in Australia and New Zealand* (pp. 183-197). Melbourne, Australia: Oxford University Press.

Gard, M., & Wright, J. (2005). *The obesity epidemic: Science, morality and ideology.* London, England: Routledge.

Gardner, R. (2013). *Reading race in a community space: A narrative post-intentional phenomenological exploration* (PhD diss., University of Georgia). Retrieved from: https://getd.libs.uga.edu/pdfs/gardner_roberta_p_201308_phd.pdf

Gardner, T. A. (1994). Racism in pornography and the women’s movement. In A. M. Jaggar (Ed.), *Living with contradictions: Controversies in feminist social ethics.* (pp. 105-114). New York, NY: Routledge.

Garland-Levitt, S. (2017). Exploring discursive barriers to sexual health and social justice in the New Zealand sexuality education curriculum. *Sex Education, 17*(2), 121-134.

Gay, G. (2013). Teaching to and through cultural diversity. *Curriculum Inquiry, 43*(1), 48-70.

Gibson, L. (2017). *Writing crime into race: Historian Khalil Gibran Muhammad studies one of the most powerful ideas in the American imagination*. Retrieved from: https://harvrdmagazine.com/2018/07/khalil-muhammad-condemnation-of-blackness

Gilbert, J. (2014). *Sexuality in school: The limits of education.* Minneapolis: University of Minnesota Press.

Gill, R. (2008). Culture and subjectivity in neoliberal and postfeminist times. *Subjectivity, 25*(1), 432-445. doi: 10.1057/sub.2008.28

Gillborn, D. (2009). Education policy as an act of White supremacy: Whiteness, critical race theory, and education reform. In E. Taylor, D. Gillborn, & G. Ladson-Billings (Eds.), *Foundations of critical race theory in education* (pp. 51-69). New York, NY: Routledge.

Ginwright, S. A. (2010). *Black youth rising: Activism and radical healing in urban America.* New York, NY: Teachers College Press.

Girl Scouts of America (2019). *Reminder: She doesn't owe anyone a hug. Not even at the holidays.* Retrieved from: https://www.girlscouts.org/en/raising-girls/happy-and-healthy/happy/what-is-consent.html

Giroux, H. A. (1998). Public pedagogy and rodent politics: Cultural studies and the challenge of Disney. *Arizona Journal of Hispanic Cultural Studies, 2,* 253-266.

Giroux, H. A. (2009). Critical theory and educational practice. In A. Darder, M. P. Baltodano, & R. D. Torres (Eds.), *The critical pedagogy reader* (2nd ed., pp. 27-52). New York, NY: Routledge.

Glesne, C. (2011). *Becoming qualitative researchers: An introduction.* White Plains, NY: Longman.

Golen, C. G., Ramey, D. M., Cooksey, E. C., & Williams, D. R. (2018). Racial disparities in health among nonpoor African Americans and Hispanics: The role of acute and chronic discrimination. *Social Science and Medicine, 199,* 167-180. https://doi.org/10.1016/j.socscimed.2017.04.051

Graham, L., Brown-Jeffy, S., Aronson, R., & Stephens, C. (2011). Critical race theory as theoretical framework and analysis tool for population health research. *Critical Public Health, 21*(1), 81-93.

Graves, J. L. (2002). *The emperor's new clothes: Biological theories of race and the millennium.* New Brunswick, NJ: Rutgers University Press.

Greene, M. (1995). *Releasing the Imagination: Essays on education, the arts, and social change.* San Francisco, CA: Jossey-Bass.

Grissom, J. A., Rodriguez, L. A., & Kern, E. C. (2017). Teacher and principal diversity and the representation of students of color in gifted programs: Evidence from national data. *Elementary School Journal, 117*(3), 396- 422.

Gubrium, A., & DiFulvio, G. (2011). Girls in the world: Digital storytelling as a feminist public health approach. *Girlhood Studies, 4,* 28–46. doi: 10.3167/ghs2011. 040204.

Gundersen, C., Kreider, B., & Pepper, J. V. (2018). Reconstructing the Supplemental Nutrition Assistance Program to more effectively alleviate food insecurity in the United States. *RSF: The Russell Sage Foundation Journal of the Social Sciences, 4*(2), 113-130.

Halse, C. (2009). Bio-citizenship: Virtue discourses and the creation of the bio-citizen. In J. Wright & V. Harwood (Eds.), *Governing bodies: Biopolitics and the "obesity epidemic"* (pp. 45-59). New York, NY: Routledge.

Hannah-Jones, N. (2016). *Choosing a school for my daughter in a segregated city*. Retrieved from: https://www.nytimes.com/2016/06/12/magazine/choosing-a-school-for-my-daughter-in-a-segregated-city.html

Hardt, M., & Negri, A. (2009). *Commonwealth*. Cambridge, MA: Harvard University Press.

Harrison, L., & Leahy, D. (2006). Pursuing HPE outcomes through health education. In R. Tinning, L. McCuaig, & lisahunter (Eds.), *Teaching health and physical education in Australian schools* (pp. 150-158). Frenchs Forest, Australia: Pearson Education.

Hartmann, K., & Rivadeneyra, R, & Toro-Morn, M. I. (2016). A study of Mexican immigrant mothers and adolescents in the heartland: "Mi mama nada mas me dice que me cuide mucho" (my mom just tells me to take care of myself a lot). *Journal of Latino-Latin American Studies, 8*(1).

Harvey, D. (2005). *A brief history of neoliberalism.* Oxford, England: Oxford University Press.

Harwood, V. (2009). The place of imagination in inclusive pedagogy: Thinking with Maxine Greene and Hannah Arendt. *International Journal of Inclusive Education, 14*(4), 357-369.

Hill, J., & Azzarito, L. (2012). Representing valued bodies in PE: A visual inquiry with British Asian girls. *Physical Education and Sport Pedagogy, 17*(3), 263-276.

Hokowhitu, B. (2014). If you are not healthy, then what are you? Healthism, colonial disease, and body-logic. In K. Fitzpatrick & R. Tinning (Eds.), *Health education: Critical perspectives* (pp. 31-47). New York, NY: Routledge.

Holmes, D., Murray, S. J., Perron, A., & Rail, G. (2006). Deconstructing the evidence-based discourse in health sciences: Truth, power, and fascism. *International Journal of Evidence-Based Health, 4,* 180-186.

Holt, S. B., & Gershenson, S. (2017). The impact of demographic representation on absences and suspensions. *Policy Studies Journal, 47*(4). 1069-1099.

hooks, b. (1984). *Feminist theory: From margin to center.* (1st ed.) Boston, MA: South End Press.

hooks, b. (1994). *Teaching to transgress: Education as the practice of freedom.* New York, NY: Routledge.

Howard, T. C. (2010). *Why race and culture matter in schools: Closing the achievement gap in America's classrooms*. New York, NY: Teachers College Press.

Howard, T. C., & Navarro, O. (2016): Critical race theory 20 years later: Where do we go from here? *Urban Education, 51*(3), 253-273. https://doi.org/10.1177/0042085915622541

Interlandi, J. (2019). *Why doesn't the United States have universal health care? The answer has everything to do with race.* Retrieved from: https://www.nytimes.com/interactive/2019/08/14/magazine/universal-health-care-racism.html

James, C. E. (2010). *Seeing ourselves: Exploring race, ethnicity & culture.* Toronto, Canada: Thompson Educational Publishing.

Johnston-Robledo, I., Sheffield, K., Voigt, J., Wilcox-Constantine, J. (2007). Reproductive shame: Self-objectification and young women's attitudes toward their reproductive functioning, *Women & Health, 46*(1), 25-39. doi: 10.1300/J013v46n01_03

Jones, A. (1997). Teaching post-structuralist feminist theory in education: Student resistances. *Gender and Education, 9*(3), 261-269.

Kawachi, I., Daniels, N., & Robinson, D. E. (2005). Health disparities by race and class: Why both matter. *Health Affairs, 24*(2). doi:10.1377/hlthaff.24.2.343

Kawachi, I., & Kennedy, B. P. (2006). *The health of nations: Why inequality is harmful to your health.* New York, NY: New Press.

Kelly, P. (2014). Young people, alcohol and a social science of risk: Bauman and the problem of ambivalence. In K. Fitzpatrick & R. Tinning (Eds.), *Health education: Critical perspectives* (pp. 105-117). New York, NY: Routledge

Kinloch, V. (2010). *Harlem on our minds: Place, race, and literacies of urban youth.* New York, NY: Teachers College Press.

Koffman, J., Morgan, M., Edmonds, P., Speck, P., & Higginson, I. J. (2012). "The greatest thing in the world is the family": The meaning of social support among Black Caribbean and White British patients living with advanced cancer. *Psycho-Oncology, 21,* 400-408.

Kottke, T., Abariotes, A., & Spoonheim, J. B. (2018). Access to affordable housing promotes health and wellness and reduces hospital visits. *The Permanente Journal, 22,* 17-079.

Koval, R. (1986). *Eating your heart out: Food, shape, and the body industry.* Australia: Penguin Books.

Kreps, G. L. (1989). Setting the agenda for health communication research and development: Scholarship that can make a difference. *Health Communication, 1*, 11-15.

Kumar, S., & Preetha, G. S. (2012). Health promotion: An effective tool for global health. *Indian Journal of Community Medicine, 37*(1), 5-12.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviews.* Thousand Oaks, CA: Sage.

Ladson-Billings, G. (2003). Racialized discourses and ethnic epistemologies. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research: Theories and issues* (pp. 398–432). Thousand Oaks, CA: Sage.

Ladson-Billings, G. (2009a). *The dreamkeepers: Successful teaching for African-American students.* San Francisco, CA: Jossey-Bass

Ladson-Billing, G. (2009b). Just what is critical race theory and what's it doing in a *nice* field like education? In E. Taylor, D. Gillborn, & G. Ladson-Billings (Eds.), *Foundations of critical race theory in education.* New York, NY: Routledge.

Ladson-Billings, G., & Tate, W. F. (1995). Toward a critical race theory of education. *Teachers College Record, 97*(1), 47-68.

Lagermann, L. C. (2015). Sticky categorizations: Processes of marginalization and (im)possible mo(ve)ments transcending marginalization. *International Journal of Qualitative Studies in Education, 285*, 573-593.

Lane, M. (2015). Black girl interrupted: A reflection on the challenges and possibilities from the community to the academy. In V. Evans-Winters & B. Love (Eds.), *Black feminism in education: Black women speak back, up, & out.* New York, NY: Peter Lang.

Lane, M. (2017). Reclaiming our queendom: Black feminist pedagogy and the identity formation of African American girls. *Equity & Excellence in Education, 50*(1), 13-24.

Lather, P. (1992). Critical frames in educational research: Feminist and post-structural perspectives. *Theory into Practice, 31*(2), 87-99.

Lauderdale, D. S. (2006). Birth outcomes for Arabic named women in California before and after September 2011. *Demography, 43*, 185.

Lawrence, R. S., Gootman, J. A., & Sim, L. J. (Eds.). (2009). *Adolescent health services: Missing opportunities.* Washington, DC: National Academies Press.

Leahy, D. (2014). Assembling a health(y) subject: Risky and shameful pedagogies in health education. *Critical Public Health, 24*(2), 171-181.

Leahy, D., & Simovska, V. (2017) Critical perspectives on health and wellbeing education in schools. *Health Education, 117*(5), 430–433.

Lee, K. C., & Soon-Mook, C. (2014). The Korean national curriculum for physical education: A shift from edge to central subject. *Physical Education and Sport Pedagogy, 19*, 522–532. doi:10.1080/ 17408989.2014.915299

Lee, T. (2019). *A vast wealth gap, driven by segregation, redlining, evictions and exclusion, separates Black and White America.* Retrieved from: https://www.nytimes.com/interactive/2019/08/14/magazine/racial-wealth-gap.html

Leistyna, P., Woodrum, A., & Sherblom, S. (1996). *Breaking free: The transformative power of critical pedagogy.* Cambridge, MA: Harvard Educational Review.

Linaberger, M. (2007). Releasing our technological imaginations: A translation of Maxine Greene's aesthetic educational theory into the language of instructional technology. *ProQuest Dissertations Publishing.* 3253100.

Luke, A. (1995-1996). Text and discourse in education: An introduction to critical discourse analysis. *Review of Research in Education, 21*, 3-48.

Lupton, D. (1994). Toward the development of critical health communication praxis. *Health Communication, 6,* 55–67.

Lupton, D. (1999). *Risk.* New York, NY: Routledge.

Lupton, D. (2014). The reproductive citizen: Motherhood and health education. In K. Fitzpatrick & R. Tinning (Eds.), *Health education: Critical perspectives* (pp. 48-60). New York, NY: Routledge.

Lupton, D., & Leahy, D. (2019). Reimagining digital health education: Reflections on the possibilities of the storyboarding method. *Health Education Journal.* Retrieved from https://doi.org/10.1177/0017896919841413

Lyiscott, J. (2017). *If you think you're giving students of color a voice, get over yourself.* Retrieved from https://medium.com/@heinemann/if-you-think-youre-giving-students-of-color-a-voice-get-over-yourself-cc8a4a684f16

Macdonald, D. (2012). Like a fish in water: Physical education policy and practice in the era of neoliberal globalization. *QUEST, 63*(1), 36-45.

Macdonald, D., Johnson, R., & Leow, A. (2014). Health education and health promotion: Beyond cells and bells. In K. Fitzpatrick & R. Tinning (Eds.), *Health education: Critical perspectives* (pp. 17-31). New York, NY: Routledge.

Macdonald, D., Pang, B., Knez, K., Nelson, A., & McCuaig, L. (2012). The will for inclusion: Bothering the inclusion/exclusion discourses of sport. In S. Dagkas & K. Armour (Eds.), *Inclusion and exclusion through youth sport* (pp. 9-24). London, England: Routledge.

MacLure, M. (2013a). Classification or wonder? Coding as an analytic practice in qualitative research. In R. Coleman & J. Ringrose (Eds.), *Deleuze and research methodologies.* Edinburgh, Scotland: Edinburgh University Press.

MacLure, M. (2013b). Promiscuous feminists postscript. *International Journal of Qualitative Studies in Education, 26*(5), 625-628.

Maté, G. (2019). *There is only one boat: The myth of normalcy by Dr. Gabor Maté.* Retrieved from: https://www.oldvictheatre.com/news/2019/10/there-is-only-one-boat-the-myth-of-normalcy-by-dr-gabor-mate?utm_source=Twitter&utm_medium=Cracked&utm_campaign=Socials&fbclid=IwAR2l_J_E3vdN9vuv8mIPg1wAioq08-KLU-3qhnlJ2YqzrhUt0caWRYZD-Kg

Matias, C. E. (2013). Check yo'self before you wreck yo'self and our kids: Counterstories from culturally responsive White teachers? … to culturally responsive White teachers! *Interdisciplinary Journal of Teaching and Learning, 3*(2), 68-81.

Mazzei, L. A. (2013). Desire undone: Productions of privilege, power, and voice. In R. Coleman & J. Ringrose (Eds.), *Deleuze and research methodologies* (pp. 96-110). Edinburgh, Scotland: Edinburgh University Press.

McCall, S. D. (2014). What kind of "girl"? Curricular knowledge and the making of girls and young women in two all-girls schools. *ProQuest Dissertations Publishing.* 36222268.

McCarthy, C. (1988). Rethinking liberal and radical perspectives on racial inequality in schooling: Making the case for a nonsynchrony. *Harvard Educational Review, 58,* 265-269

McCarthy, C. (1990). *Race and curriculum.* London, England: Falmer Press.

McClintock, A. (2002). Soft-soaping empire: Commodity racism and imperial advertising. In N. Mirzoeff (Ed.), *The visual culture reader*. New York, NY: Routledge.

McGee, E. O., & Stovall, D. (2015). Reimagining critical race theory in education: Mental health, healing, and the pathway to liberatory praxis. *Educational Theory, 65*(5), 491-511.

McRobbie, A. (2007). Postfeminism and popular culture: Bridget Jones and the new gender regime. In Y. Tasker & D. Negra (Eds.), *Interrogating postfeminism: Gender and the politics of popular culture* (pp. 27-40). London, England: Duke University Press.

Miller, L. A., & Harris, V. W. (2018). I can't be racist—I teach in an urban school, and I'm a nice White lady! *World Journal of Education, 8*(3), 1-11. doi: 10.5430/wje. v8n3p1

Milner, H. R. (2015). *Rac(e)ing to class: Confronting poverty and race in schools and classrooms.* Cambridge, MA: Harvard Education Press.

Mirón, L. F. (1996). *The social construction of urban schooling: Situating the crisis.* Cresskill, NJ: Hampton Press.

Mohanty, C. (2003). *Feminism without borders: Decolonizing theory, practicing solidarity.* Durham, NC: Duke University Press.

Molina, N. (2006). *Fit to be citizens? Public health and race in Los Angeles, 1879-1939.* Berkeley: University of California Press.

Mossakowski, K. N. (2003). Coping with perceived discrimination: Does ethnic identity protect mental health? *Journal of Health and Social Behavior, 44*(3), 318–331.

Muhammad, C. G., & Dixson, A. D. (2008). Black females in high school: A statistical educational profile. *Negro Educational Review, 59*(3-4), 163-180.

Murdoch, S. (2007). *IQ: A smart history of a failed idea.* Hoboken, NJ: Wiley.

New York City Department of Education (NYCDOE). (2018). *Chancellor Carranza announces $24 million investment in Health Ed Works*. Retrieved from: https://www.schools.nyc.gov/about-us/news/announcements/contentdetails/2018/05/22/chancellor-carranza-announces-$24-million-investment-in-health-ed-works

New York City Department of Education (NYCDOE). (2019a). *Health education requirements*. Retrieved from: https://www.schools.nyc.gov/school-life/learning/subjects/health-education/health-education-requirements

New York City Department of Education (NYCDOE). (2019b). *New York City grades 9-12 health education scope and sequence.* Retrieved from: https://www.weteachnyc.org/media2016/filer_public/a3/9c/a39c0e6e-c3a3-4696-8c63-6999567a8075/he_9-12_scope-sequence_rev_110819.pdf

New York State Department of Health. (2013). *New York State asthma surveillance summary report: October 2013.* Retrieved from: https://www.health.ny.gov/statistics/ny_asthma/pdf/2013_asthma_surveillance_summary_report.pdf

New York State Division of the Budget (NYSDOB). (2019). *New York State school funding transparency form: 2019 guidance document.* Retrieved from: https://www.budget.ny.gov/schoolFunding/2019/guidance-sft-2019.pdf

New York State Education Department. (2014). *Learning standards for health, physical education, and the consumer sciences at three levels*. Retrieved from: http://www.nysed.gov/common/nysed/files/programs/curriculum-instruction/healthpefacslearningstandards.pdf

New York State Education Department. (2016). *Student support services: School health education.* Retrieved from: http://www.p12.nysed.gov/sss/schoolhealth/schoolhealtheducation/

New York State United Teachers. (2019). *Fact sheet: Teacher shortage in New York State*. Retrieved from: https://www.nysut.org/~/media/2019_11_12_factsheet_19_17_nys_teacher_shortage.pdf?la=en

Nguyen, C. (2019). Practice: Cultural humility with Chinese Progressive Association. *Healing Justice Podcast.* Retrieved from: https://www.healingjustice.org/podcast/generation2p

Oakley, A. (1981). Interviewing women: Contradiction in terms. In H. Roberts (Ed.), *Doing feminist research.* London, England: Routledge and Kegan Paul.

Ochieng, B. M. N. (2010). "You know what I mean": The ethical and methodological dilemmas and challenges for Black researchers interviewing Black families. *Qualitative Health Research, 20*(12), 1725-1735.

O'Flynn, G. (2010). The business of "bettering" students' lives: Physical and health education and the production of social class subjectivities. *Sport, Education and Society, 15*(4), 431-445.

Ogbu, J. U., & Simons, H. D. (1998). Voluntary and involuntary minorities: A cultural-ecological theory of school performance with some implications for education. *Anthropology & Education Quarterly, 29*(2), 155-188.

Öhman, M., Almqvist, J., Meckbach, J., & Quennerstedt, M. (2014) Competing for ideal bodies: A study of exergames used as teaching aids in schools. *Critical Public Health, 24*(2), 196-209.

Okoya, W. (2019). Adoption of trauma sensitive practices in NYC elementary-level community schools. *ProQuest Dissertations Publishing.* 13882432.

Oliffe, J., & Thorne, S. (2007). Men, masculinities and prostate cancer: Australian and Canadian patient perspectives of communication with male physicians. *Qualitative Health Research, 17,* 149-161.

O'Sullivan, D. (2012). Justice, culture and the political determinants of indigenous Australian health. *Ethnicities, 12*, 687–705. doi:10.1177/1468796811432697

Painter, N. I. (2010). *The history of White people.* New York, NY: Norton.

Parks, C., Wallace, B. C., Emdin, C. & Levy, I. P. (2016). An examination of gendered violence and school push-out directed against urban Black girls/adolescents: Illustrative data, cases and a call to action, *Journal of Infant, Child, and Adolescent Psychotherapy, 15*(3), 210-219. doi: 10.1080/15289168.2016.1214451

Peshkin, A. (1988). In search for subjectivity: One's own. *Educational Researcher, 17(7).*

Petersen, A. (1997). Risk, governance, and the new public health. In A. Petersen & R. Bunton (Eds.), *Foucault, health, and medicine* (pp. 189-206). New York, NY: Routledge.

Petersen, A., & Lupton, D. (1996). *The new public health: Health and self in the age of risk.* St. Leonards, Australia: Allen and Unwin.

Peterson, J. C., Antony, M. G., & Thomas, R. (2012). "This right here is all about living": Communicating the "common sense" about home stability through CBPR and photovoice. *Journal of Applied Communication Research, 40,* 1–24.

Petherick, L. & Beausoleil, N. (2015). Elementary teachers' biopedagogical practices: How health discourse circulates in Newfoundland elementary schools. *Canadian Journal of Education, 38*(1), 1-29.

Phillips, E. A., Comeau, D. L., Pisa, P. T., Stein, A. D., & Norris, S. A. (2016). Perceptions of diet, physical activity, and obesity-related health among Black daughter-mother pairs in Soweto, South Africa: A qualitative study. *BMC Public Health, 16*(1).

Powell, D., & Fitzpatrick, K. (2013). "Getting fit basically means, like, non-fat": Children's lessons in fitness and fatness. *Sport, Education and Society, 20*(4), 463-484.

Primdahl, N. L., Reid, A., & Simovska, V. (2018). Shades of criticality in health and wellbeing education. *Journal of Curriculum Studies, 50*, 733-753.

Quarmby, T., & Dagkas, S. (2013). Locating the place and meaning of physical activity in the lives of young people from low-income, lone-parent families. *Physical Education & Sport Pedagogy, 18*, 459–474. doi:10.1080/17408989.2012.690384

Quennerstedt, M., & Öhman, M. (2014). Salutogenic approaches to health and the body. In K. Fitzpatrick & R. Tinning (Eds.), *Health education: Critical perspectives* (pp. 190-203). New York, NY: Routledge.

Rajan, S., Roberts, K. J., Guerra, L., Pirsch, M. & Morrell, E. (2017). Integrating health education in core curriculum classrooms: Successes, challenges, and implications for urban middle schools. *Journal of School Health, 87*(12), 949-957.

Rash, J. K. (2010). Philosophical bases for health education. In J. M. Black, S. Furney, H. M. Graf, & A. E. Nolte (Eds.), *Philosophical foundations of health education.* San Francisco, CA: Jossey-Bass.

Rashatwar, S. (2019). *Hey there, nice to meet you!* Retrieved from: https://www.sonaleer.com/#home-about

Rasmussen, M. L., & Harwood, V. (2010). Performativity, youth and injurious speech. *Teaching Education, 14*(1), 25-36.

Rich, E. (2012). Beyond school boundaries: new health imperatives, families and schools. *Discourse: Studies in the Cultural Politics of Education, 33*(5), 635-654.

Roberts, D. (2012). *Fatal invention: How science, politics, and big business re-create race in the twenty-first century.* New York, NY: New Press.

Roberts, D. (2017). *Killing the Black body: Race, reproduction, and the meaning of liberty.* New York, NY: Vintage.

Rose, N. (2006). *The politics of life itself: Biopower and subjectivity in the twenty-first century.* Princeton, NJ: Princeton University Press.

Sallee, M. W., & Harris, F., III. (2011). Gender performance in qualitative studies of masculinities. *Qualitative Research, 11*(4), 409-429.

Salmon, A. (2011). Aboriginal mothering, FASD prevention and the contestations of neoliberal citizenship. *Critical Public Health, 21*(2), 165-178. doi:10.1080/09581596.2010.530643

Satel, S. (2002). I am a racially profiling doctor, *New York Times Magazine.* https://www.nytimes.com/2002/05/05/magazine/i-am-a-racially-profiling-doctor.html

Scheurich, J. (1997). *Research method in the postmodern.* Bristol, PA: Falmer Press.

Sealey-Ruiz, Y. (2016). Why Black girls' literacies matter: New literacies for a new era. *English Education*, *48*(4), 290-298.

Seidman, I. (2013). *Interviewing as qualitative research* (4th ed.). New York, NY: Teachers College Press.

Seligman, M., Ernst, R., Gillham, J., Reivich, K., & Linkins, M. (2009). Positive education: Positive psychology and classroom interventions. *Oxford Review of Education, 35*(3), 293-311.

Shapiro, E. (2019). *Segregation has been the story of New York City's schools for 50 years.* Retrieved from: https://www.nytimes.com/2019/03/26/nyregion/school-segregation-new-york.html

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care.* Washington, DC: National Academies Press.

Smith, P. J., (1999). Our children's burden: The headed hydra of the educational disenfranchisement of Black children. *Howard Law Journal, 42*(2), 133-239.

Solórzano, D., & Yosso, T. (2002). Critical race methodology: Counterstorytelling as an analytical framework for education research. *Qualitative Inquiry, 8*(1), 23-44.

Søndergaard, D. M. (2002). Poststructuralist approaches to empirical analysis. *Qualitative Studies in Education, 15*(2), 187-204.

Souto-Manning, M. (2007). Immigrant families and children (re)develop identities in a new context. *Early Childhood Education Journal, 34*(6), 399-405.

Spradley, J. P. (2016). *The ethnographic interview.* Boulder, CO: Waveland Press.

Stake, R. (2006). *Multiple case study analysis.* New York, NY: Guilford.

Steele, C. (2009). A threat in the air: How stereotypes shape intellectual identity and performance. In E. Taylor, D. Gillborn, & G. Ladson-Billings (Eds.), *Foundations of critical race theory in education.* (pp. 190- 209). New York, NY: Routledge.

Steele, C. (2011). *Whistling Vivaldi: How stereotypes affect us and what we can do (Issues of our time).* New York, NY: Norton.

Steinberg, M. P., & Lacoe, J. (2017). *What do we know about school discipline reform?* Retrieved from: https://educationnext.org/files/ednext_xvii_1_steinberg.pdf

Stevens, H. (2019). *For 3 million women in America, their first sexual encounter was a rape. Our kids deserve better odds and better guidance.* Retrieved from: https://www.chicagotribune.com/columns/heidi-stevens/ct-heid-stevens-tuesday-1-in-16-women-first-sexual-encounter-rape-0917-20190917-tmsrqzrumbbt 5ayn6hfqihrozq-story.html

Stevenson, B. (2019). *Slavery gave America a fear of Black people and a taste for violent punishment. Both still define our criminal justice system*. Retrieved from: https://www.nytimes.com/interactive/2019/08/14/magazine/prison-industrial-complex-slavery-racism.html

Stevenson, H. M., & Burke, M. (1991). Bureaucratic logic in new social movement clothing: The limits of health promotion research. *Health Promotion International, 6*(4), 281-289.

St. Pierre, E. A. (2000). Poststructural feminism in education: An overview. *International Journal of Qualitative Studies, 13*(5), 477-515.

Sykes, H. (2011). *Queer bodies: Sexualities, genders and fatness in physical education*. New York, NY: Peter Lang.

Tamayo-Starver, J. H., Hinze, S. H., Cydulka, R. K., & Baker, D. W. (2003). Racial and ethnic disparities in emergency department analgesic prescription. *American Journal of Public Health, 93*(2067).

Tanner, C., Maher, J., & Fraser, S. (2013). *Vanity: 21st century selves.* New York, NY: Palgrave Macmillan.

Teachers College, Columbia University. (2019). *Department of Health and Behavior Studies: Health education.* Retrieved from https://www.tc.columbia.edu/health-and-behavior-studies/health-education/

Terris, M. (1992). Concepts of health promotion: Dualities in public health theory. *Journal of Public Health Policy, 13*(3), 267-276.

Tinning, R. (2014). Getting *which* message across? The (H)PE teacher as health educator. In K. Fitzpatrick & R. Tinning (Eds.), *Health education: Critical perspectives* (pp. 204-19). New York, NY: Routledge.

Todd, K. H., Deaton, C., D'Adamo, A. P., & Goe, L. (2000). Ethnicity and analgesic practice, *Annals of Emergency Medicine, 35*(11).

Tolman, D. L. (2012). Female adolescents, sexual empowerment and desire: A missing discourse of gender inequity. *Sex Roles, 66,* 746-757.

Toro-Morn, M. I. (2007). Beyond gender dichotomies: Toward a new century of gendered scholarship in the Latina/o experience. In H. Rodriguez, R. Saenz, & C. Menjivar, *Latinas/os in the United States: Changing the face of America* (pp. 277-293). New York, NY: Springer US.

Tuhwai-Smith, L. (2012). *Decolonizing methodologies: Research and indigenous peoples* (2nd ed.). London, England: Zed Books.

Tyson, K., Darity, W., & Castellino, D. R. (2005). It's not "a Black thing": Understanding the burden of acting White and other dilemmas of high achievement. *American Sociological Review, 70*(4), 582-605.

United States Census Bureau. (2015). *Income and poverty in the United States: 2014*. Retrieved from: http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-252.pdf

Urban Institute. (2018). *How far do SNAP benefits fall short of covering the cost of a meal?* Retrieved from: https://www.urban.org/sites/default/files/publication/96661/how_far_do_snap_benefits_fall_short_of_covering_the_cost_of_a_meal_2.pdf

U.S. Department of Health and Human Services. (2016a). *Healthy people 2020: Adolescent health*. Retrieved from: https://www.healthypeople.gov/2020/topics-objectives/topic/Adolescent-Health#Ref_30

U.S. Department of Health and Human Services. (2016b). *About healthy people*. Retrieved from: https://www.healthypeople.gov/2020/About-Healthy-People

U.S. Department of Justice Civil Rights Division and U.S. Department of Education Office of Civil Rights. (2014). *Joint "Dear Colleague" letter*. Retrieved from: https://www2.ed.gov/about/offices/list/ocr/letters/colleague-201401-title-vi.html

Vander Schee, C. (2008a). Consuming health and youth: Health curricula and the production of a healthy student. In D. Boyles (Ed.), *The corporate assault on youth: Commercialism, exploitation, and the end of innocence* (pp. 1-26). New York, NY: Peter Lang.

Vander Schee, C. (2008b). The politics of health as a school-sponsored ethic: Foucault, neoliberalism, and the unhealthy employee. *Educational Policy, 22*(6), 854-874.

Vander Schee, C. (2009). Fruit, vegetables, fatness, and Foucault: Governing students and their families through school health policy. *Journal of Education Policy, 24*(5), 557-574.

Vander Schee, C., & Gard, M. (2013). Healthy, happy, and ready to teach, or why kids can't learn from fat teachers: The discursive politics of school reform and teacher health. *Critical Public Health, 24*(2), 210-225.

Villanueva, E. (2018). *Decolonizing wealth: Indigenous wisdom to heal divides and restore balance.* Oakland, CA: Berrett-Koehler.

Villarosa, L. (2019). *Myths about physical and racial differences were used to justify slavery—and are still believed by doctors today*. Retrieved from https://www.nytimes.com/interactive/2019/08/14/magazine/racial-differences-doctors.html

Walkerdine, V. (2003). Reclassifying upward mobility: Femininity and the neo-liberal subject. *Gender and Education,* 15(3), 237-248.

Walkerdine, V. (2009). Biopedagogy and beyond. In J. Wright & V. Harwood (Eds.), *Biopolitics and the "obesity epidemic."* London, England: Routledge.

Ward, E. C., & Besson, D. B. (2012). African American men's beliefs about mental illness, perceptions of stigma, and help-seeking barriers. *The Counseling Psychologist, 41*(3), 359-391.

Ward, E. C., & Collins, J. (2010). Depression in African American males. *African American Research Perspectives, 11*, 6–21.

Washington, H. (2006). *Medical apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present.* New York, NY: Harlem Moon.

Washington, H. (2019). *A terrible thing to waste: Environmental racism and its assault on the American mind.* New York, NY: Little, Brown.

Webb, L. & Quennerstedt, M. (2010). Risky bodies: Health surveillance and teachers' embodiment of health. *International Journal of Qualitative Studies in Education, 23*(7), 785-802.

Webb, L., Quennerstedt, M., & Öhman, M. (2008). Healthy bodies: The construction of body and health in physical education. *Sport, Education & Society, 13*(4), 353-372.

Weis, G. (1999) The abject borders of the body image. In G. Weis & H. F. Haber (Eds.), *Perspectives on embodiment: The intersections of nature and culture* (pp. 41-60). New York, NY: Routledge.

Welch, R., McMahon, S., & Wright, J. (2012). The medicalization of food pedagogies in primary schools and popular culture: A case for awakening subjugated knowledges, *Discourse: Studies in the Cultural Politics of Education, 33*(5), 713-728.

Whitehead, D. (2003). Health promotion and health education viewed as symbiotic paradigms: Bridging the theory and practice gap between them. *Journal of Clinical Nursing, 12,* 796-805.

Willgoose, C. E. (2010). Health education as a basic. In J. M. Black, S. Furney, H. M. Graf, & A. E. Nolte (Eds.), *Philosophical foundations of health education.* San Francisco, CA: Jossey-Bass.

Williams, B. J., Hay, P. J., & Macdonald, D. (2011). The outsourcing of health, sport and physical educational work: A state of play. *Physical Education & Sport Pedagogy, 16*(4), 399-415. doi:10.1080/17408989.2011.582492

Winfield, A. G. (2012). Resuscitating bad science: Eugenics past and present. In W. H. Watkins (Ed.), *The assault on public education.* New York, NY: Teachers College Press.

World Health Organization. (2009). *A snapshot of the health of the young people of Europe.* Copenhagen, Denmark: Author.

World Health Organization. (2018). *Mental health: Strengthening our response.* Retrieved from: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

Wright, J. (2004a). Critical inquiry and problem-solving in physical education. In J. Wright, D. Macdonald, & L. Burrows (Eds.), *Critical inquiry and problem-solving in physical education* (pp. 3-15). London, England: Routledge.

Wright, J. (2004b). Post-structural methodologies. In J. Evans, B. Davies, & J. Wright (Eds.), *Body knowledge and control: Studies in the sociology of physical education and health* (pp. 19-30). New York, NY: Routledge.

Wright, J. (2014). Beyond body fascism: The place for health education. In K. Fitzpatrick & R. Tinning (Eds.), *Health education: Critical perspectives* (pp. 233-248). New York, NY: Routledge.

Wright, J., Burrows, L. & Rich, E. (2012). Health imperatives in primary schools across three countries: Intersections of class, culture, and subjectivity. *Discourse: Studies in the Cultural Politics of Education, 33*(5), 673-691.

Wright, J., & Harwood, V. (Eds.). (2009). *Biopolitics and the "obesity epidemic*." London, England: Routledge.

Wu, J. (2015). Mental health: Not just a White people thing. *UWIRE Text.* Retrieved from: https://uwire.com/?s=UWIRE+Text&x=26&y=14&=Go

Yosso, T. J. (2005). Whose culture has capital? A critical race theory discussion of community cultural wealth. *Race, Ethnicity, and Education, 8*(1), 69-91. doi: 10.1080/1361332052000341006

Yosso, T. J., Smith, W. A., Ceja, M., & Solórzano, D. G. (2009). Critical race theory, racial microaggressions, and campus racial climate for Latino/a undergraduates. *Harvard Educational Review, 79*(4), 659 -690.

Appendix A

Teachers College IRB Approval Notification

Teachers College IRB *Expedited Approval Notification*

To: Clare Parks
From: Amy Camilleri
Subject: IRB Approval: 19-271 Protocol
Date: 04/07/2019

Please be informed that as of the date of this letter, the Institutional Review Board for the Protection of Human Subjects at Teachers College, Columbia University has given full approval to your study, entitled "*How do youth imagine a healthy life?*," under **Expedited Review** on 04/07/2019: Category (7) Research on individual or group characteristics or behavior

The IRB Committee must be contacted if there are any changes to the protocol during this period. Under the new IRB regulations, continuing review for this study is not required. If you encounter any problems or issues, please contact the IRB office to discuss. When you have completed the study, please terminate using the "Terminate Protocol" button at the top of the view protocol page in Mentor IRB. The IRB number assigned to your protocol is **19-271**. Feel free to contact the IRB Office (212-678-4105 or accamilleri@gmail.com) if you have any questions.

Please note that your Consent form bears an official IRB authorization stamp and is attached to this email. Copies of this form with the IRB stamp must be used for your research work. Further, all research recruitment materials must include the study's IRB-approved protocol number. You can retrieve a PDF copy of this approval letter and the official stamped consent(s) materials from Mentor IRB.

When your study ends, please visit the IRB Mentor site. Go to the view protocol page and click on the "Terminate Protocol" button at the top.

Best wishes for your research work.

Sincerely,
Amy Camilleri
IRB Administrator
IRB@tc.edu

Attachments:
- CP_Assent_Diss.Pilot_3.2019_Final.pdf
- CP_Informed Consent_Dissertation_4.5.2019_Final.pdf
- _Parental Permission - CP Dissertation_4.5.2019_Final.pdf

Appendix B

Summary Guide for Potential Participants

As a research project required for the EdD degree in Health Education, I will complete a dissertation on the topic “How do young people make meaning of health?” The topic was chosen after I taught health classes at a public charter high school and health workshops at our program, and wondered if my lessons were meeting my students’ wants and needs for health. I have conducted literature reviews on the topic of health education for several years and am particularly interested in youth voices. Since I am interested in descriptions and meanings connected with your experience, I will use qualitative research methods in obtaining the essences of your experience. I will interview 40 to 50 co-researchers and adhere to the ethical principles of human science research.

Appendix C

Parental Consent Form

Protocol Title: How do youth imagine a healthy life?
Subtitle: Interview Consent
Principal Investigator: Clare Parks, Teachers College, 212-289-4838 ext. 207

INTRODUCTION

Your child is being invited to participate in a research study called "How do youth imagine a healthy life?" Your child may qualify to take part in this research study because they are currently enrolled in a health class or have taken a health class during high school. Up to 50 students and alumni will participate in this pilot study and it will take 60 - 90 minutes of your child's time to complete.

WHY IS THIS STUDY BEING DONE?

This study is being done to explore how youth think and feel about health. The researcher is interested in what matters to young people with regards to health, how they navigate health in the current context, and how they imagine a healthy life. The results will be used in the principle investigator's dissertation, to make recommendations for health researchers and educators, and will inform future health programming at [redacted.] This program is unaffiliated with the NYC Department of Education.

WHAT WILL MY CHILD BE ASKED TO DO IF I AGREE THAT MY CHILD CAN TAKE PART IN THIS STUDY?

If you decide to allow your child to take part in this pilot study, your child will be asked for brief demographic information and interviewed by the principal investigator. During the interview they will be asked to discuss their experience learning about health throughout their life. This interview will be audio-recorded. After the recorded interview is written down the original recording will be deleted. If you do not wish your child to be audio-recorded, your child will not be able to participate. The interview will take approximately 60 to 90 minutes. Your child will be given a pseudonym or false name in order to keep their identity confidential.

WHAT POSSIBLE RISKS OR DISCOMFORTS CAN MY CHILD EXPECT FROM TAKING PART IN THIS STUDY?

This is a minimal risk study, which means the harms or discomforts that your child may experience are not greater than your child would ordinarily encounter in daily life while taking a school-based health class or participating in health workshops at [redacted.] Your child might feel embarrassed to discuss their perceptions of sensitive health topics. However, your child does not have to answer any questions or divulge anything they

don't want to talk about. Your child can stop participating in the study at any time without penalty. They will be asked about healthy people in their lives, where they learned the most about health, what they learned in health class at school, and other health-related questions. Students will be adequately informed that they do not have to answer any question they do not feel comfortable answering. The principal investigator is taking precautions to keep your child's information confidential and prevent anyone from discovering what they say or their identity, such as using a pseudonym instead of their name and keeping all information on a password protected computer and locked in a file drawer.

<u>WHAT POSSIBLE BENEFITS CAN MY CHILD EXPECT FROM TAKING PART IN THIS STUDY?</u>

There is no direct benefit to your child for participating in this study.

<u>WILL MY CHILD BE PAID FOR BEING IN THIS STUDY?</u>

Your child will not be paid to participate. There are no costs to you for your child's taking part in this study. All student participants will receive 50 [redacted] bucks, and all alumni participants will receive an item from the [redacted] store. All participants will be entered in a raffle to win a $100 gift card, and you will have a 1 in 50 (or fewer) chance of winning.

<u>WHEN IS THE STUDY OVER? CAN MY CHILD LEAVE THE STUDY BEFORE IT ENDS?</u>

The study is over when your child has completed the interview. However, your child can leave the study at any time even if they haven't finished.

<u>PROTECTION OF YOUR CHILD'S CONFIDENTIALITY</u>

The investigator will keep all written materials locked in a desk drawer in a locked office. Any electronic or digital information (including audio recordings) will be stored on a computer that is password protected. What is on the audio-recording will be written down and the audio-recording will then be destroyed. There will be no record matching your child's real name with their pseudonym. Regulations require data to kept for at least five years after completion for studies involving children.

For quality assurance, the study team, the study sponsor (grant agency), and/or members of the Teachers College Office of Sponsored Programs may review the data collected from you as part of this study. Otherwise, all information obtained from your participation in this study will be held strictly confidential and will be disclosed only with your permission or as required by U.S. or State law.

HOW WILL THE RESULTS BE USED?

The results of this pilot study will be used in the principle investigator's dissertation, to make recommendations for health researchers and educators, and will influence the development of health programming at [redacted]. The results may or may not be published in journals and presented at academic conferences. Your child's name or any identifying information about your child will not be published. This study is being conducted as part of the dissertation of the principal investigator.

CONSENT FOR AUDIO RECORDING

Audio recording is part of this research study. You can choose whether to give permission for your child to be recorded. If you decide that you don't wish your child be recorded, they will not be able to participate in this study.

______I give my consent for my child to be recorded ______________________________
Signature

______I do not consent for my child to be recorded ______________________________
Signature

WHO MAY VIEW MY CHILD'S PARTICIPATION IN THIS STUDY

____I consent to allow my child's written, video and/or audio taped materials viewed at an educational setting or at a conference outside of Teachers College

____
Signature

_____I do not consent to allow my child's written, video and/or audio taped materials viewed outside of Teachers College Columbia University

____
Signature

OPTIONAL CONSENT FOR FUTURE CONTACT

The investigator may wish to contact your child in the future. Please initial the appropriate statements to indicate whether or not you give permission for future contact.

I give permission for my child to be contacted in the future for research purposes:

Yes _________________________ Initial

No_________________________ Initial

I give permission for my child to be contacted in the future for information relating to this study:

Yes _________________________ Initial

No_________________________ Initial

WHO CAN ANSWER MY QUESTIONS ABOUT THIS STUDY?

If you have any questions about the study or your child's taking part in this research study, you should contact the principal investigator, Clare Parks, 212-289-4838 ext. 207. If you have questions or concerns about your child's rights as a research subject, you should contact the Institutional Review Board (IRB) at 212-678-4105 or email IRB@tc.edu. Or you can write to the IRB at Teachers College, Columbia University, 525 W. 120th Street, New York, NY 10027, box 151. The IRB is the committee that oversees human research protection at Teachers College, Columbia University.

PARTICIPANT'S RIGHTS

- I have read and discussed the informed consent with the investigator. I have had ample opportunity to ask questions about the purposes, procedures, risks and benefits regarding this research study.
- I understand that my child's participation is voluntary. I may refuse to allow my child to participate or withdraw participation at any time without penalty to future services that my child would otherwise receive. I understand that my child may refuse to participate without penalty.
- The investigator may withdraw my child from the research under the conditions that your child expresses or demonstrates discomfort in participation.
- If, during the course of the study, significant new information that has been developed becomes available which may relate to my willingness to allow my child to continue participation, the investigator will provide this information to me.
- Any information derived from the research study that personally identifies my child will not be voluntarily released or disclosed without my separate consent, except as specifically required by law.
- De-identifiable data may be used for future research studies.
- I should receive a copy of the Informed Consent document.

My signature means that I agree to allow my child participate in this study

Child's name: ____

Print Parent or guardian's name: _______________________________

Parent or guardian's signature: ________________________________

Date: ____________________

Appendix D

Assent Form for Minors

Teachers College, Columbia University
525 West 120th Street
New York NY 10027
212 678 3000

Assent Form for Minors

Protocol Title: How do youth imagine a healthy life?
Principal Investigator: Clare Parks, M.A., Teachers College, 212-289-4838

This study is being conducted to explore how youth think and feel about health. The results will be used to make recommendations for health educators and researchers, and will inform future health programming at and beyond [redacted]. You qualify to take part in this research study because you are in 11th or 12th grade, and you have taken at least one semester of a school-based health education class. Up to 50 current students and alumni will participate in this pilot study and it will take 60 to 90 minutes of your time to complete.

I________________________ (student's name) agree to be in this study, titled, "How do youth imagine a healthy life?"

What I am being asked to do has been explained to me by ______________________________.

I understand what I am being asked to do and I know that if I have any questions, I can ask _____________________ at any time. I know that I can quit this study whenever I want to and it is perfectly OK to do so. It won't be a problem for anyone if I decide to quit.

Name: ____

Signature: ____

Witness: ____Date: _______________

DEMOGRAPHIC INFORMATION:

What is your race or ethnicity? _____________________________________

What is your country of origin? _____________________________________

What is your gender identity? _____________________________________

What is your age? _____________________________________

Appendix E

Informed Consent

Protocol Title: How do youth imagine a healthy life?
Subtitle: Interview Consent
Principal Investigator: Clare Parks, Teachers College, 212-289-4838 ext. 207

INTRODUCTION

You are being invited to participate in a research study called "How do youth imagine a healthy life?" You may qualify to take part in this research study because you are currently enrolled in a health class or have taken a health class during high school. Up to fifty current students and alumni of the program will participate in this study and it will take 60 to 90 minutes of your time to complete.

WHY IS THIS STUDY BEING DONE?

This study is being done to explore how youth think and feel about health. The researcher is interested in what matters to young people with regards to health, how they navigate health in the current context, and how they imagine a healthy life. The results will be used to make recommendations for health researchers and educators, and will inform future health programming at and beyond [redacted]. This program is unaffiliated with the NYC Department of Education.

WHAT WILL I BE ASKED TO DO IF I AGREE TO TAKE PART IN THIS STUDY?

If you decide to take part in this study, you will be interviewed by the principal investigator. During the interview you will be asked to discuss your experience learning about health throughout your life. This interview will be audio-recorded. After the recorded interview is written down the original recording will be deleted. If you do not wish to be audio-recorded, you will not be able to participate. The interview will take approximately 60 to 90 minutes. You will be given a pseudonym or false name in order to keep your identity confidential. 12th grade students who are over 18 and have participated in the interview on or before May 3rd, who have also checked that they are willing to be contacted in the future for this study will be asked if they are interested in co-presenting this information at the [redacted] Conference at [redacted] on Saturday, May 4th. Students who are interested will be prepared with the document titled "Additional Modification Document_4.29". In order to present at the conference, students will be asked to disclose their participation in the study and self-identify at the conference.

WHAT POSSIBLE RISKS OR DISCOMFORTS CAN I EXPECT FROM TAKING PART IN THIS STUDY?

This is a minimal risk study, which means the harms or discomforts that you may experience are not greater than you would ordinarily encounter in daily life while taking a school-based health class or participating in health workshops at [redacted.] You might feel embarrassed to discuss your understanding of sensitive health topics. However, you do not have to answer any questions or divulge anything you don't want to talk about. You can stop participating in the study at any time without penalty. You do not have to

answer any question you do not feel comfortable answering. The principal investigator is taking precautions to keep your information confidential and prevent anyone from discovering what you say or your identity, such as using a pseudonym instead of your name and keeping all information on a password protected computer and locked in a file drawer.

WHAT POSSIBLE BENEFITS CAN I EXPECT FROM TAKING PART IN THIS STUDY?
There is no direct benefit to you for participating in this study.

WILL I BE PAID FOR BEING IN THIS STUDY?
You will not be paid to participate. There are no costs to you for taking part in this study. All student participants will receive 50 [redacted] bucks, and all alumni participants will receive an item from the [redacted] store. All participants will be entered in a raffle to win a $100 gift card, and you will have a 1 in 50 (or fewer) chance of winning.

WHEN IS THE STUDY OVER? CAN I LEAVE THE STUDY BEFORE IT ENDS?
The study is over when you have completed the interview. However, you can leave the study at any time even if you haven't finished.

PROTECTION OF YOUR CONFIDENTIALITY
The investigator will keep all written materials locked in a desk drawer in a locked office. Any electronic or digital information (including audio recordings) will be stored on a computer that is password protected. What is on the audio-recording will be transcribed and the audio-recording will then be destroyed. There will be no record matching your real name with your pseudonym.
For quality assurance, the study team, the study sponsor (grant agency), and/or members of the Teachers College Office of Sponsored Programs may review the data collected from you as part of this study. Otherwise, all information obtained from your participation in this study will be held strictly confidential and will be disclosed only with your permission or as required by U.S. or State law. Regulations require data to be kept at least three years after the completion of the study.

HOW WILL THE RESULTS BE USED?
The results of this study will be used in the principle investigator's dissertation, and will influence the development of health programming at [redacted]. The results may or may not be published in journals and presented at academic conferences. Your name or any identifying information about you will not be published.

CONSENT FOR AUDIO RECORDING AND TRANSCRIPTION
Audio recording is part of this research study. You can choose whether to give permission to be recorded. Following audio recording, the audio will be transcribed by a third party using your assigned pseudonym. If you decide that you don't wish to be recorded, you will not be able to participate in this study.

OPTIONAL CONSENT FOR FUTURE CONTACT

The investigator may wish to contact you in the future. Please initial the appropriate statements to indicate whether or not you give permission for future contact.

I give permission to be contacted in the future for research purposes:

Yes ________________________ No________________________
Initial Initial

I give permission to be contacted in the future for information relating to this study:

Yes ________________________ No________________________
Initial Initial

WHO CAN ANSWER MY QUESTIONS ABOUT THIS STUDY?

If you have any questions about taking part in this research study, you should contact the principal investigator, Clare Parks, 212-289-4838 ext. 207.

If you have questions or concerns about your rights as a research subject, you should contact the Institutional Review Board (IRB) (the human research ethics committee) at 212-678-4105 or email IRB@tc.edu. Or you can write to the IRB at Teachers College, Columbia University, 525 W. 120th Street, New York, NY 1002. The IRB is the committee that oversees human research protection for Teachers College, Columbia University.

PARTICIPANT'S RIGHTS

- I have read and discussed the informed consent with the researcher. I have had ample opportunity to ask questions about the purposes, procedures, risks and benefits regarding this research study.
- I understand that my participation is voluntary. I may refuse to participate or withdraw participation at any time without penalty to future services that I would otherwise receive.
- The researcher may withdraw me from the research at his or her professional discretion under the conditions that you express or demonstrate discomfort in participation.
- If, during the course of the study, significant new information that has been developed becomes available which may relate to my willingness to continue my participation, the investigator will provide this information to me.
- Any information derived from the research study that personally identifies me will not be voluntarily released or disclosed without my separate consent, except as specifically required by law.

- De-identifiable data may be used for future research studies, or distributed to another investigator for future research without additional informed consent from the subject or the representative.
- I should receive a copy of the Informed Consent document.

CONSENT FOR AUDIO RECORDING AND TRANSCRIPTION

______I give my consent to be recorded and transcribed by a third party

Signature : ____

______I do not consent to be recorded and transcribed by a third party

Signature: ____

WHO MAY VIEW MY PARTICIPATION IN THIS STUDY

___I consent to allow written and/or audio taped materials viewed at an educational setting or at a conference outside of Teachers College

Signature: ____

___I do not consent to allow written and/or audio taped materials viewed outside of Teachers College Columbia University

Signature: ____

My signature means that I agree to participate in this study.

Print name: ____

Date: _______________________

Signature: ____

DEMOGRAPHIC INFORMATION:

What is your race or ethnicity? ____

What is your country of origin? ____

What is your gender identity? ____

What is your age? ____

Appendix F

Recruitment Email for Alumni

Dear ________,

As you may know, I am working towards completing my doctoral degree in health education at Teachers College, Columbia University, and I am currently working on my dissertation. My study is focused on understanding how youth imagine a healthy life. The results will be used for my dissertation, and to improve how we talk about health at and beyond [redacted.]

If you choose to participate, you will be asked to complete one in-person interview with me that will take 60 to 90 minutes. Attached to this email is the informed consent form that details the study research design/methodology, recruitment processes, participant burden, confidentiality/anonymity, risks/benefits and uses of the data, for your reference.

All alumni participants will be offered an item from the [redacted] store of their choice and entered in a raffle for a $100 gift card and there will be a one in 50 chance of winning. If you are interested or have further questions, please reply to this email and I will follow up with you about next steps. Thank you in advance for your help!

Many thanks,
Clare

Appendix G

Interview Protocol

Thanks for taking the time to interview with me. I want to know what kids think about health and health-related topics. Do you have any questions for me before we get started?

Probes throughout the interview include: what do you mean by that? Can you tell me a story about that? Would it be different if you were a boy or girl? Do you think it's like that everywhere / for everyone?

1. (R1) Who is the healthiest person you know?
    - Probe: What makes them so healthy?
    - Probe: Why is that?
    - Probe: How'd they get that way?
    - Probe: what are their relationships like? What are their moods like? Do they have a spiritual aspect of their life?
2. (R1 + R2) Tell me a little bit about your friends. Do some take better care of themselves than others?
    - Probe: Can you tell me a little bit about that?
    - (R4) Probe: Do you think there's such a thing as a healthy community?
        - Probe: Tell me why / Why do you feel that way?
        - Probe: Is there anything missing? What do you like most? Could it be better?
3. (R2) Where or from who have you learned the most about health?
    - Give them an opportunity to answer before you list: (social media? YouTube? movies? music? friends? health class? older family members?)
    - (R2) Probe: How did you learn how to take care of yourself?
        - Probe: Can you tell me a little bit more about that?

4. (Background) I know you have to have a health credit for graduation. I'm really interested in health class - I've had some interesting experiences in them. What are some of your experiences in health class - at school or here / some other after-school? Tell me a story about it.
    - Probe: Is there anything you remember about what your health teachers did or said that made their messages stick with you?
    - Probe: Was there anything they did or said that had a negative impact on you? A positive impact?
    - Probe: Do you think there is any difference in how students receive information about health depending on who it's coming from?
    - Probe: Does the teachers' identity make a difference? Explain.
5. If you were teaching a health class, what are the topics you would need to cover? What are the most important things to teach young people about health?
    - Probe: How would you teach it?
6. (R3) What is one message you would give a younger sibling or family member about taking care of themselves?
    - (R3) Probe: How do you think that best happens?
        - Probe: Do you think that works?
        - Probe: Whose responsibility is it? Family? School? Community?
7. (R2) How do you think of yourself? Are you healthy?
    - (R1 + R2) Probe: What were the key factors or experiences that helped you define your health? Who or what had the greatest impact on how you've come to understand health?
    - (R4) Probe, if not: What do you want or need to get there?

Thank you so much for your time today and for your honesty. I have learned so much already. Do you have anything else you would like to share about your imagination of health? Is there anything else I should know?

Appendix H

Pilot Study Interview Protocol

Interview Protocol: Applying Seidman's (2013) in-depth, phenomenological three-interview series design, the study specifically aims to address the following research question: how do high school students make meaning of health messages in formal and informal settings?

All interviews are open-ended and this guide should be used not to manipulate participants to respond to every question, but to ask questions that reflect areas of interest to the study in an open and direct way. They may include follow-up questions such as, "What was that like for you?" or, "Would you talk more about that?" Lastly, interviewer may follow up with "Tell me a story about one of those times."

Interview One: Focused Life History

1. Tell me as much as possible about yourself and how you've defined health throughout your life up to the present.
2. Tell me as much as possible about all of the messages you received about any health topic when you were growing up, up until now.
    - Nutrition
    - Drugs / Alcohol
    - Sexuality
    - Mental Health
    - Physical activity
3. Tell me as much as possible about your relationship to health up to the present.

Interview Two: The Details of the Experience

1. Tell me the details of your health class at school.
    a. Middle school
    b. High School

2. Tell me the details of any health classes or workshops you've taken outside of school.
3. Do you remember any conversations you have had with a parent about any health topic? Tell me about those.
4. Do you remember any conversations you have had with friends about any health topic? Tell me about those.
    a. Nutrition
    b. Drugs / Alcohol
    c. Sexuality
    d. Mental Health
    e. Physical activity
5. Reconstruct any health messages you've received from any forms of media - social media, billboards, ads on the train, ads on TV, ads online, etc.
6. Do you remember any conversations you have had with adults outside of your family about any health topic? Tell me about those.
7. What health topics do you think high school students should learn about? How (in what format) should they learn about these?

Interview Three: Reflection on the Meaning

1. Given what you have shared about your experiences with health and health messages up until now, how do you understand the role that health has in your life?

2. How do you understand the way “healthy lifestyles” have been communicated to you?
    a. From school?
    b. After-school?
    c. From caregivers / family?
    d. From social media?
    e. From other forms of media?
    f. From society at large?
3. If I were your younger sibling, what would you want to tell me about health?
    a. Nutrition
    b. Drugs / Alcohol
    c. Sexuality
    d. Mental Health
    e. Physical activity

Appendix I

Reflective Notes Form

Interview no:	Date:	Location:
Time:	Participant:	

Time	Transcript	Reflective Notes[1] (methodological, theoretical, personal connections)

[1] (McCall, 2014)