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# Tracing discourses of health and the body: exploring pre-service primary teachers' constructions of 'healthy' bodies

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## **Tracing discourses of health and the body: Exploring pre-service primary teachers' constructions of 'healthy' bodies**

Contemporary notions of childhood overweight and obesity have become increasingly influential in curriculum and pedagogy in school-based Health and Physical Education (HPE). Teachers' delivery of HPE subject matter and related school practices are likely to have a considerable impact on the attitudes and beliefs of the children they teach, particularly in the primary school. It thus becomes important to consider the ways of thinking about and doing health (discourse positions on health) that teachers bring to their teaching of HPE. This paper examines pre-service teachers' positions in relation to the health discourses to better understand what teachers, in this case beginning teachers, bring to their teaching of HPE and interactions with children in primary schools. It draws on a Foucauldian approach to discourse analysis to analyse pre-service teachers' qualitative survey and interview responses to questions about meanings of health. Three key positions emerged, signifying Agreement, Disagreement and Negotiated positions in relation to the dominant discourses of health and the body.

Keywords: pre-service teacher education; healthism; body; obesity discourse; Health and Physical Education; discourse positions, Primary generalist

### **Schooling healthy bodies**

It is now well documented that in recent times there has been an increased focus on Australian school policies and programs to promote physical activity and nutritional practices with the intention of preventing childhood overweight and obesity (Davidson, 2007). One of the major forces driving such programs and initiatives has been government funding, backed by a host of preventative health taskforces, including organizations such as the Heart Foundation (2007) and Obesity Prevention Australia Inc (2010). As part of this approach, school-based physical activity and nutritional pedagogies in the primary (or elementary) school, in the form of Health and Physical Education (henceforth HPE) and school sport, have been called upon as major resources in the crusade against childhood obesity.

Enlisting schools as sites of health promotion and body regulation agendas is not a particularly new phenomenon. Kirk (1998), for example, mapped the emergence of school practices in the nineteenth and early twentieth century that sought to regulate children's bodies to meet the institutional imperatives of school order and a healthy and

productive citizenry. Gard and Kirk (2007) have since re-visited Kirk's initial analysis of physical education as a site for 'schooling bodies' and 'healthy' citizenship to include the more recent concern over an 'obesity crisis' as a contemporary impetus to the many interventionist practices in schools. Despite research that emphasises the complexity of causes for overweight and obesity and the potential negative consequences for children and young people when making a 'healthy' weight a central rationale for contemporary curriculum (see Evans, 2008; Azzarito, 2007; Guthman, 2009), a myriad of adjunct curricular initiatives firmly position physical activity and nutritional education as a 'cure' for excess weight (Azzarito, 2007; Pyle, 2006).

The attention to early prevention of overweight and obesity situates the primary school and its pedagogues as key players in the 'roll out' of interventionist measures. In Australia (as is the case for many other countries), most primary school physical and health education is taught by generalist teachers. While there is considerable debate about whether this is the most desirable model for delivering HPE to children (DeCorby, Halas, Dixon, Wintrup & Janzen, 2005; Morgan, 2008), the issue for this paper is rather what understandings of health, physical activity and bodies primary teachers bring to their teaching and to their interactions with children. From a poststructuralist perspective, the questions then become: from what discourse positions do teachers teach and how are these positions constituted? In this paper these questions have been addressed by research with preservice teachers in the last year of their primary teacher education, that is, the year before they begin to teach in schools.

### **Problematising contemporary ‘schooling of healthy bodies’**

The desire to understand the ways schools, students and teachers engage with discourses of health and the body has attracted a small but growing body of scholarship, due to the leverage such ways of thinking have on constructions of curriculum (Burrows, Wright & Jungersen-Smith, 2002; Leahy & Harrison, 2008; Lee, 2010) and for the effects this has on the way young people come to understand themselves (McShurry, 2009). A poststructuralist perspective drawing on the work of Michel Foucault informs much of this work. This paper follows that tradition by examining how discourses operate to privilege particular subject positions and forms of practice (Weedon, 1987; Wright, 2006). In the case of this paper, the dominant discourses of overweight and obesity are problematised for the ways they favour ‘normalised’ notions of health and the body; that is, the ways they tend to read ‘health’ via the weight and shape of a body. These normalized notions of health and bodies have been characterized as ‘dangerous’, because they promote ways of thinking about the self that can create guilt, shame and self-surveillance (Wright, O’Flynn & Macdonald, 2006). It is argued that these very ways of knowing and being are made possible through a complex intersection of healthism (Crawford, 1980), obesity and neo-liberal discourses (Lupton, 1999; Rose, 1993). The power/knowledge relations that mesh these discourses provide powerful truths as to how individuals should monitor and be actively involved in working on their bodies. From this perspective, a ‘healthy’ person is seen to be one who monitors all aspects of his/her life. These discursive ‘truths’ are made all the more prominent and pervasive by a host of authoritative campaigns which work to create a robust milieu of healthism. Because of this, such ingrained notions of health can become difficult to interrogate, disrupt or even resist (Kline, 2006).

In such a climate particular ways of thinking and teaching about HPE have the potential to deliver unintended effects for young people's sense of health and body knowledge(s). For example, the literature points to the following negative effects on young people's sense of self and wellbeing made possible by contemporary 'healthy' schooling practices: (i) how becoming thin and the ability to control one's body size is normalized within school cultures (see Evans, Rich, Davies, & Allwood, 2008); (ii) how understandings of health emphasise normative weight categories which are then associated with body regulation and monitoring (O'Dea, 2005); (iii) an increase in discrimination and stigma of overweight students (Puhl & Latner, 2007); and (iv) the uptake of disordered relationships with food and the body contingent on virtuous discourses of exercising and minimal caloric intake (Halse, Honey, & Broughtwood, 2007). Other writers have also argued that in such a corporeal based health context, there is a danger for particular health knowledge(s) to be taken up with little or no space for alternative understandings of health, physical activity or food, such as notions of food that are culturally rather than nutritionally based or an understanding of physical activity that is not associated singularly with exercise (Burrows & Wright, 2007; Burrows, et al., 2002). Perhaps the most severe 'effects' of contemporary practices associated with obesity related meanings of health in the school setting is highlighted in Evans and colleagues (2008) book, *Education, Disordered Eating and Obesity Discourse*. They demonstrate how messages of eating less, exercising more and losing weight are interpreted and recontextualised in the school setting. In particular, they show how the young people they interviewed responded to the 'normalising' messages of eating less, exercising more and losing weight, in ways which promoted disordered relationships with food and the body.

Within the aforementioned agendas of contemporary 'healthy schooling', teachers and members of the school community are invited to be central agents to the 'success' of these 'health' pedagogies. Yet, the generalist primary teachers enlisted to teach HPE curriculum often have minimal formalized background and content knowledge of HPE. However, as other research (Burrows & Wright, 2004) has demonstrated, this does not prevent generalist teachers' promotion of 'healthy' messages about the body through formal and informal school programs and initiatives. If, with Verloop and her colleagues (Verloop, Van Driel & Meijer, 2001, p.446), we accept that 'components of knowledge, beliefs, conceptions and intuitions are inextricably intertwined' with teachers' practical knowledge and teacher behaviours, it becomes important to know what graduating primary teachers know and believe about health and the body. Thus pre-service teachers' ideas and values about health (i.e. their discourse positions) require investigation, given the importance ascribed to teacher identity (Whithead & Hendry, 1976) and biographies (Rich, 2004) in informing teachers' pedagogical choices and content knowledge of in/formal curriculum.

Following Foucault's (1972) vision of subjects as created in and through discourse, pre-service teachers' discourse positions in relation to health become central to the ways obesity related power/knowledge is recontextualised in school spaces. We use a notion of 'discourse position' to characterise the system of ideas or standpoint(s) from which subjects participate and evaluate discourse. According to Jager and Maier (2009), '[s]ubjects develop a discourse position because they are enmeshed in various discourses. They are exposed to discourses and work them into a specific ideological position or worldview in the course of their life' (p. 49). They argue that

[w]ithin a dominant discourse, discourse positions are fairly homogenous, which itself is already an effect of dominant discourse. Dissenting discourse positions often belong to complete counter-discourses... However, these counter-discourses can pick up arguments from dominant discourse and subvert their meaning (Jager & Maier, 2009, p. 50).

Discourse positions can be identified through an analysis of language, written or spoken as subjects/individuals draw on particular patterns of language (discourses) to constitute their speaking positions. The notion of 'discourse position' thus allows for an analysis of the ways pre-service primary teachers' take up, resist or 'traverse' dominant discourses of health and the body.

### **Methodology**

Discourse analysis involves the identification of patterns of language use in written or spoken texts. For the study reported in this paper the texts took the form of qualitative answers to survey questions and to interviews conducted with pre-service teachers from two universities, from herein named 'site A' and 'site B'. At both sites A and B, the participating students were in the final years of their primary teacher education degrees and enrolled in either a Bachelor or Postgraduate course. In most cases participants from the Bachelor degrees were younger in age and often completing their first degree, whereas the Postgraduate education students had already completed at least one degree from outside the education field. By recruiting these various groups, the participant base covered most of the options for completing a primary degree in Australia.

The project gained ethics approval and all participants consented to participating in the study. As a preliminary stage to the recruitment of participants from both institutions and the online survey, semi-structured interviews were conducted with six

pre-service primary teachers from site A. These participants were recruited in lecture time and interviews took place on campus. The participants were aged between 20 and 27 and have been assigned pseudonyms. Questions relevant to this paper that were asked in the interviews include: ‘What does health mean to you?’ and ‘Can you tell if someone is healthy?’ The interviews were recorded and then transcribed with initial impressions of the texts noted.

The survey took place after the preliminary interviews and was designed to extend the scope of the study to a larger and more diverse population of students. It was conducted online and students were invited to participate through an email sent via their institutional server. The survey was completed by a total of 130 pre-service primary teachers: site A (n=77) and site B (n=53). The survey involved a spread of questions covering: meanings of health; sources of health knowledge; obesity related content in coursework; previous schooling experiences and professional experiences. Likert scales were used to elicit responses to attitudinal questions such as, ‘Do you think someone’s size or shape has anything to do with their health?’ Open-ended short answer questions that asked the respondents to explain their Likert ratings were also included to provide data for a discourse analysis of participants’ responses. The participants responded in detail to most of the questions providing around two sentences of text.

For the purposes of this paper, the responses for one question from the survey will be used for analysis. This question asked the respondent to: ‘Please explain why you chose your selection to the previous question [do you think someone’s size or shape has anything to do with their health?].’ The participants’ responses were collated and initially read to form an impression of the diversity of responses and then coded for



continuities and patterns of language. These codings began to suggest three positions or ways of talking about health and bodies. The interview texts and particularly those responses to questions about the participants' meanings of health were then read with these positions in mind and coded in QSR NVivo. The language used in the interviews was able to be mapped across these three positions, with considerable consistency in position for each interview. What the interviews also provided were some explanations as to how the students' experiences and education were related to the differences in positions. To take this up is however beyond the scope of this paper.

### **Discourse positions on health and the body**

From the analysis of the survey and interview data, three positions emerged which described the ways the pre-service primary teachers' situated themselves in relation to dominant discourses associated with health and the body. The first of these, which we have named Agreement, was consistent with a discourse position that 'agreed with' and consistently talked about bodies and health in terms of the precepts of the dominant health discourse. The second, Disagreement, could be aligned with a 'counter discourse' of health and included those responses that challenged the role of the physical body as an indicator of health and in doing so looked at other ways to describe bodies. A last set of responses was coded as Negotiation. These responses could not be aligned with any homogenous or fixed discourse position; they drew on ideas from both dominant and counter discourses of health to negotiate what it means to be to be 'healthy' or the role of the physical body in 'health'.

### **A healthism discourse position: Agreement with dominant health discourses**

The responses coded at Agreement, suggest a discourse position that does not question the relationship between health and weight; associates good health with diligent dietary

and exercise practices; and sees a healthy weight or 'fit' appearance as within an individual's reach. The open-ended survey responses coded at Agreement accounted for 45 of the 130 (35%) open-ended responses. The main characteristics of these responses were: (i) language demonstrating a great deal of certainty - the idea that 'this is the way things are' and your body is unquestionably a proxy for 'health'; (ii) the assumption that individual actions alone lead to health outcomes; and (iii) the use of medicalised language to describe bodies, such as 'weight', 'overweight' and 'obese'. As the following examples suggest, the responses were often short in length and grammatically in the present tense, adding to the certainty or 'truth' of the position: 'Overweight or underweight greatly affect health', 'If you are fat you are unhealthy' and 'People who exercise stay in shape'.

The language of 'healthism', the belief that individual actions lead to particular types of bodies or 'health' outcomes (Crawford 1980), was a strong pattern across the responses coded at Agreement. These responses often held the individual accountable for their lack of 'healthy' practices. At times blame was assigned to those individuals whose 'choices' contributed to their 'condition'; they were characterized as not taking responsibility for their weight, size and shape and apparent lack of 'health'. For instance: 'Because people have a choice over their selection of food and whether or not they do exercise'; and 'Because I feel that if they are overweight they are not eating healthy or exercising enough'

Other knowledge assemblages common to an Agreement position attributed a lack of 'good' nutrition and physical activity to a whole range of illnesses. Some responses even went on to diagnose the future risks for particular types of bodies, drawing on biomedical language to describe bodies: 'There are lots of physical and mental ailments

associated with being overweight'; 'Being overweight or obese can affect their health, the same as being very underweight'. What is interesting in these texts, and most others coded at Agreement is that they often feature the use of the word 'weight' rather than 'size' or 'shape' to formulate their response. In doing so, weight becomes the focus of critique and justification, rather than size or shape. The conflation of these terms weight, size and shape, then limits what is explored in their response. For example, the medicalised terms, 'overweight' and 'underweight', are drawn on in a diagnostic sense. This contrasts with responses coded elsewhere (Disagreement and Negotiation), where notions of size and shape are used in quite different ways. An Agreement position was also evident in some of the interview texts, with two out of the six interview participants predominantly speaking from this position. For example, in Jimmy's response to the question 'How can you tell if a person was healthy or not?':

Outwardly you can tell if like somebody is obese you can tell um in that sense physically, if someone is obese you can go well they are probably not eating right, they're probably not getting the right sort of exercise um they probably already have or are suffering from some health issues or will in the future...

In the first instance, Jimmy's sense making of an unhealthy person is one who is obese; physical appearance or body size and shape are drawn on to construct his meaning of an unhealthy person. He moves on to make assumptions about their health behaviours and then goes further to offer a prognosis based on the health 'risks' that will follow. In this case, simply physical activity and nutrition are deemed the solution to cure 'excess' weight. This is similar to many of the survey responses grouped at Agreement, where individuals are seen to be 'at risk' of disease, obesity or a shorter life expectancy based on their lack of 'healthy' practices or 'choices'.

An understanding of ‘health’ informed by notions of body appearance makes it difficult to resist or dispute the role of size and shape in ‘health’ and easier to ‘agree’ unequivocally that size and shape are fundamental to what it means to be healthy. The relationship between body appearance and health is a powerful discourse position taken up by these participants; they can write with certainty because their position accords with contemporary ideas about health that have considerable social legitimacy.

### **A counter discourse: Disagreement with dominant health discourses**

The patterns of language in the responses coded at Disagreement were in direct contrast to those coded at Agreement, they proposed a counter discourse position. For example, responses coded for this position: (i) did not associate body size or shape with health; (ii) directly challenged the enunciation of size and shape as constituting a ‘healthy’ body; (iii) described health in ways other than the physical; and (iv) pointed towards the problematic nature of health as indicated by appearance. These types of responses were the least common, with 29 of 130 responses in the open-ended component of the survey coded at this position. The following examples from these responses indicate a belief that different body shapes and sizes can be healthy regardless of their size or shape.

Health has more dimensions than just physical. Someone who looks slim/ toned/ muscly may be physically healthy but may have unhealthy beliefs about food and poor body image. They may have trouble dealing with the pressures of stress of life, or be unable to maintain loving or happy relationships with others

Some people are naturally bigger and whilst eating healthy and doing plenty of exercise may still be bigger than others who don’t

These responses coded at Disagreement refuted the idea that the healthy body is the inevitable outcome of eating or exercise choices. The responses also employed a range of vocabulary to describe different bodies, for example the descriptors of: ‘football players’, ‘muscly’, ‘barrel chests’, ‘big woman’, ‘large and curvy’ and ‘slim’.

Such variety contrasted significantly with words such as ‘weight’, ‘overweight’ or ‘fat’, commonly used in the responses coded at Agreement. The responses grouped at Disagreement also suggest resistance to representations of size and shape as indicators of ‘health’. In contrast to the responses coded at Agreement they draw on other truths to construct health, for example genetic make up and mental and spiritual wellness. However, like the responses at Agreement, the language used often suggests certainty. This certainty, however, was about challenging the ‘truth’ that a person’s health can be read off their body size and shape.

Some people may be thin but not fit. They are just like that genetically or have a fast metabolism. Larger people such as football players, that can be of solid builds and can also be fit and healthy

It really depends on the person and their situation. You could see a big woman and think she’s unhealthy, where in fact she had a baby the week before, or a persons lifestyle requires them to eat a lot, for example a weightlifter. Also the world is filled with individuals who have different shapes. A person may be big on the outside, but on the inside are quite healthy. It’s too hard to judge someone

In these responses, individuals were rarely held accountable or blamed for their size, shape and apparent lack of health. This position was also evident in one of the interview texts. For example, when asked ‘How would you tell if a person is healthy or not, or can you tell if a person is healthy or not?’, Rachel challenged the idea that the appearance of the body was an indicator of health:

I don’t think you can really, because you know you can have the fittest people in the world and they could smoke, or how they actually get to that point is not healthy how they do it, like you know like they don’t have, like they don’t eat, or they eat the wrong sorts of things, and so I don’t really think you can tell by looking at someone if they are healthy.

What is particularly interesting here is how Rachel immediately responds in terms of ‘appearance’ (coded as ‘fittest’), suggesting her recognition of the dominant

discourse. However, she goes on to reject the idea that appearance is indicative of health. On the other hand she does associate health with individual choices and behaviour; a healthy person is one who eats ‘enough’, eats the ‘right’ sorts of foods and doesn’t smoke. Her resistance to a healthism discourse only goes so far.

### **A negotiated position: Traversing discourses of the ‘healthy’ body**

In comparison to the Agreement and Disagreement positions, the third position was far more layered and constituted by elements of different discourses. This position was named ‘Negotiation’ because the responses coded here included those that were not ‘fixed’ in relation to their agreement or disagreement with the dominant health discourse that situated body shape or weight as the objective of health. The characteristics of these responses included: (i) negotiation of what it means to be healthy, often challenging the reduction of ‘health’ to a particular body size, shape or weight for all people, but also acknowledging that the physical body plays some role in health; (ii) use of modal language that indicated less certainty and acknowledged exceptions to discursive truths, for example: ‘yet’, ‘somewhat’, ‘then again’ and ‘on the other hand’; and (iii) drawing on multiple ‘truths’ of a healthy body, sometimes challenging the notion that a ‘healthy body’ is not always ‘fit’, ‘toned’, ‘slim’, and of a ‘normal weight’. The participants traversed, and at times drew on contradictory discourses to formulate what were often longer and more complex responses compared to those coded at the other two positions.

This is indicated in the following quotes:

Sometimes genetics and health problems can effect (sic) body type, but yes in some instances body size or shape can be a direct effect of health choices

Somewhat, this is one component of health, body size and shape (very thin or overweight–obese) can signal other health problems that a person is facing. It is only one indicator of many. For example, body size and shape doesn’t necessarily tell you about the health of a person who has a muscly lean body, steroids could still be destroying their kidneys

Sometimes genetics controls the size you are but within yourself you may be fit and active, eat well etc and it won't change the size that you are. Then again many large people are unhealthy

In these responses there seems to be an attempt to provide a coherent story about size, shape and health, yet this was achieved by traversing various, and at times contradictory discourses. Some of these responses commented on the survey question itself, with comments like, 'its too broad a question', whilst other participants drew on their own experiences to position themselves differently from the status quo, for example:

I think that it can certainly be an indicator of someone's health but it is sometimes misleading. I have always been slim and my weight does not really fluctuate depending on my size. I loose weight when I am overstressed as my appetite decreases proportionally. It is at these times that I would consider myself unhealthy. On the other hand I know people who are vigilant with their exercise and eating habits but they find it very difficult to stay slim

The responses coded at Negotiation were significantly less 'fixed' in nature, opening up multiple possibilities and circumstances. However possibilities were not limitless; many of the responses, while acknowledging exceptions to body size as indicating health, in the end leant towards the dominant discourse position. For example,

Shape isn't as important, unless your shape is putting undue pressure on your joints or increases your risk of disease e.g. large waist and heart disease. However size, being over, within or under your healthy weight range can greatly affect your health

This response is similar in its knowledge production to those coded at Agreement; however, it and other similar responses use some modal language, which suggests less certainty in relation to the discursive truths they were producing. In

contrast, other responses, such as that below, drew on a counter discourse, challenging taken for granted notions of a 'healthy' body:

Because body size or shape is only part of someone's health, although sometimes shape is genetic and does not always signify inner health.

As with the other positions, the Negotiation position was also evident across three of the interview texts. In the following example, Lani refrains from presenting a 'fixed' position on 'a healthy person'; rather she negotiates between different discourses of health and the body when asked 'how would you describe a healthy person, somebody who is healthy?'

Well obviously like a healthy weight its just to me you can sort of just tell if someone's, I think you can still be healthy if you're a bit overweight, just a little bit like you don't have to be all perfect so I think yeah you can still be healthy, some people's bodies are just like a bit bigger or a bit smaller, um I don't know a healthy person is um I don't know, I don't know, I've never really thought about that, but yeah you don't really have to be really skinny or anything to be healthy.

The way in which Lani works through the various possibilities suggests, as she says, that she has not thought about health and appearance much before; it could also suggest that she is negotiating what she believes to be the most 'appropriate' position from her reading of the research. In thinking it through, however, she works her way through the various possibilities: 'you can tell from a person's appearance'; but then again you can be a little bit overweight and still healthy, and some bodies are naturally bigger or smaller and so on. In this text, Lani is still not 'fixed' on one position, her response suggests uncertainty and for the purpose of the discussion to follow, a possible openness to other ways of understanding health.



**Discussion: (Re)producing discourses of ‘healthy’ bodies**

According to Foucault (1977) the discourses available for people to draw upon, provide both a means and limit to what can be known, produced and practiced. Therefore teachers have the potential through their interactions with young people to not only (re)produce dominant ideas of what constitutes a healthy body, but also be productive in challenging or negotiating them. If we are to accept that discourses are positioned within a hierarchy of social currency at a given point in time, these data speak to the power of the dominant health discourse in constituting the pre-service primary teachers’ health knowledge. The majority of the pre-service teachers took up a discourse position which was in accord with the dominant health discourse and did so with a high degree of certainty and consistency. Jager and Maier (2009, p. 50) suggest that discourse positions are ‘homogenous at their core and become more diffuse with regard to less central issues’. However, in the case of health discourses, it is not surprising that the dominant discourse, healthism, has considerable pull to the ‘core’ or centre. It draws on neoliberal discourses of individual responsibility and the obesity crisis, which are re-cited in public education initiatives, the media and schools and has the legitimacy of scientific and medical knowledge. Because of this alternative meanings of health are much more diffuse and have far less ‘airplay’ in the media, schools and we would argue many courses preparing primary physical education teachers. The counter discourse position taken up by a small number of participants in this study were less homogeneous, more likely to draw on personal experience, and draw on some of their certainty from recognising and rejecting the tenets of the dominant discourse position.

Primary teachers work within a complex environment in which in the name of reaching children early primary schools have been encouraged to take on a range of

initiatives designed to improve children's health. This has also been one the key rationales for the inclusion of HPE in the primary curriculum (Davidson, 2007; Gard, 2006; Tinning & McCuaig, 2006). As a consequence much of what the pre-service primary teachers' count as 'healthy' is likely to go unchallenged. However in taking up the challenge of calls in the literature for teachers to 'do no harm' when implementing health education content relating to weight, eating behaviours and body shape (O'Dea, 2005), it is important that teacher education provide spaces for students to begin to 'peel back some of the layers of their social reality' around health and the body (Ovens, 2009: 1130). This is also essential in light of calls for 'quality teaching' where teachers are required to teach in ways that allow learners to engage with knowledge as socially constructed and engage with higher order thinking and problematic knowledge (NSW Department of Education and Training, 2003).

Individual pre-service teachers bring with them complex histories, social and personal experiences that mean it is unlikely that only one discourse will inform their teaching practice. However, whilst some of the participants in this study drew on multiple and complex meanings to constitute the ideas about health and the body, many participants' responses presented only one fixed or certain 'truth' – a singular discourse position. It can then be said that whilst a number of participants challenged totalizing and normative 'healthy body' categories, many discursively reinforced the idea that health could be read off the appearance of bodies and that weight equated with health. In this sense, the physical 'capital' of having a 'slim', 'fit' and 'healthy' body held much purchase across many of the individuals' constructions of what it means to be 'healthy'. This suggests an important role for teacher education in providing students with opportunities to examine the discourse positions they take up and their ideas and values

associated with health and the body. This is a role already taken up by some teacher educators in the field (Dinan-Thompson, 2004; Garrett & Wrench, 2008; Kirk, 1986; Sicilia-Camacho & Fernandez-Balboa, 2009). As Beyer (2001, p. 154) states, 'understanding and analyzing the linkages between day-to-day practices in schools and larger domains and values that are often linked to social and political realities is central to the generation of critical theory for teaching and teacher education'. Most relevant here is an understanding of the way language shapes patterns of power and privilege in the constitution of subjects. In this sense, reflective teacher education would resist providing a blueprint for practice and rather open up spaces for multiple ways of knowing and seeing health and the body (see Macdonald, 2002). As teacher educators, reflecting on our own narratives and discourse positions and assisting our students to do so, might be the medium through which we interrupt or transform hegemonic links between biography and practice. Sparkes (1990) suggests that real change happens at the deep level of the subjective self and encourages life history work as one medium to promote critical reflection in teacher education. However as Tinning (2002) has observed, implementing 'critical' pedagogy is no easy task. While Ovens (2009) points to teacher education as one context that can provide a space for a critical pedagogy and the mobilisation of reflection, he also points to the many other contexts from which preservice teachers draw resources to reflect, including schools, and we would add, the mass media and popular ideas about health and the body circulating in everyday conversations.

We acknowledge that teacher education is just one site where health knowledge, beliefs and attitudes can be promulgated, resisted and engaged with. However we argue that primary HPE teacher education has a responsibility to de-stabilise or interrogate truths pertaining to 'obesity', 'overweight', 'bodies' and 'health'. While we agree that

this is far from a simple task, the diversity of positions, as illustrated in this paper, taken up by the pre-service generalist teachers, suggest that there is considerable potential for other ways of thinking and teaching about health. Pre-service teachers, however, need access to health knowledge that extends upon what they already know and allows them to critically engage with varied truths and literature from the field. The impetus being that as teachers they can move beyond a normative discourse position of health and the body and resist buying into body pedagogies that may limit both their own and young peoples sense of self and health knowledge(s).

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