



“Your body is your business card”: Bodily capital and health authority in the fitness industry



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ABSTRACT

Although scholars have noted the connection between appearance and assumptions of health, the degree to which these assumptions matter for establishing authority in social interaction remains less clear. Using a theoretical framework involving “bodily capital”—that is, the value generated from appearance, attractiveness, and physical ability—I investigate the role of appearance in the U.S. fitness industry. Drawing on data from interviews with 26 personal trainers and 25 clients between 2010 and 2011, I find that a trainer’s fit-appearing physique imbues their interactions with a degree of moral and health authority. This corporeal credibility engenders trust among clients and allows exercise to be understood as a form of health work. The implications for academics and medical practitioners reach beyond the gym setting and extend recent research linking appearance to health, authority, and medical credibility.

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Introduction

As a means of evaluating health, one’s appearance has been taken as a sign of well-being or debility for some time (Haley, 1978; Whorton, 1982). While new methods of illness detection have developed technologically, appearance—particularly one that is considered attractive or “fit”—continues to play a role in medical assessment (Jutel & Buetow, 2007). As Jutel and Buetow (2007) note, “Whilst no heuristic is faultless, it is useful for clinicians to reflect on the assumptions underpinning their recommendations and to acknowledge how appearance influences practice” (p. 432). Accordingly, positive health appraisals may be due in part to the continued connection between appearance and morality (Saguy & Gruys, 2010; Synnott, 1989), suggesting that “good-looking” people possess higher strength of character and willpower (Dion et al., 1972). At the same time, sociologists and social psychologists have catalogued the myriad ways that attractiveness reaps material and symbolic rewards including esteem in interpersonal groups (Anderson et al., 2001), economic advantages (Hamermesh, 2011), and social status (Webster & Driskell, 1983). Thus, scholars have shown that being considered attractive leads to assumptions of health, morality, and competence. However, the degree to which these assumptions matter in social interaction—particularly for establishing authority—remains less clear.

Recent research indicates a strong correlation between body weight, appearance, and physician authority (Bleich et al., 2012; Monaghan, 2010). For example, doctors with a normal Body Mass Index (BMI) often recommended exercise and diet as a means of controlling body weight (Bleich et al., 2012). However, overweight

and obese physicians were more likely to suggest pharmacological treatment for obesity (Bleich et al., 2012). Similarly, a study of online discussions among health care workers reveals that many took the adage of “Physician Heal Thyself!” literally in regards to body weight (Monaghan, 2010). Monaghan (2010) finds that physicians often acquiesced to associations between fatness and stigma as a means of bolstering professional credibility (p. 2). As one contributor in the study said, “A picture is worth thousand words. Doctors and nurses are the walking pictures that patients look up to. Would you go on the operating table when your surgeon gets out of breath while taking 10 steps to the operating theater? Not me” (Monaghan 2010, p. 16). One means of explaining this potential loss of credibility is through the concept of “bodily capital” (Bourdieu, 1984; Wacquant, 1995). As a form of capital, the body has become a symbolic container indicating both moral and social worth (Giddens, 1991; Saguy & Riley, 2005). The investment of time, energy, and resources into one’s body, then, constitutes a way to increase status and may be exchanged for economic, social, or cultural goods (Bourdieu, 1984). Indeed, as the above studies indicate, the authority of physicians—individuals with substantial institutional power—may be jeopardized by low levels of bodily capital. But, is the reverse also true? What types of authority are enabled when individuals possess high levels of bodily capital, but little institutional power?

To explore how bodily capital influences authority and credibility in interpersonal interactions, I utilize data from interviews with 26 personal trainers and 25 clients in the U.S. fitness industry. As locations where one’s appearance is highlighted, health clubs (or gyms) are ideal sites to study the effects of bodily capital. Because

exercising in gyms is often done with the simultaneous goals of improving health *and* appearance, the personal trainer-client relationship provides a useful space to investigate fit-appearing bodies and authority. Within the gym environment, personal trainers may be highly regarded for their physiques. At the same time, they have minimal job security and earning potential. Typically only making \$20-\$25 per hour, trainers must often work long and erratic hours to make even part-time wages. Trainers must also act as salespeople, continually convincing clients to purchase more sessions or risk lowering their income. Structurally-speaking, then, trainers possess little institutional power and often instruct clients with significantly more occupational prestige and income. Yet, as my findings reveal, trainers are able to harness a type of moral authority that emanates from their fit-appearing physiques. This corporeal credibility—or high level of bodily capital—engenders trust among their clients and a belief in their health knowledge. Both trainers and clients discussed exercise in terms of diagnosis and treatment—practices that usually exist outside of a typical “work out” relationship. While neither personal trainers nor clients confused exercise instruction with actual medical practice, the line between the weight room and the doctor’s office is complicated by such activity. This study suggests that possessing a fit-appearing physique—conceptualized in terms of bodily capital—provides a degree of moral authority that lends credibility to interactions in the health and fitness industry. The implications for both academics and medical practitioners, however, reach beyond the gym setting and extend recent research linking appearance to health, authority, and medical credibility (Bleich et al., 2012; Jutel & Buetow, 2007; Monaghan, 2010; Saguy, 2013).

Endorsement of Exercise in the “Epidemic” of Obesity

Fit-appearing physiques alone do not command authority. While they might garner respect or elicit attraction, they have no meaning outside of a social context where they are understood to represent willpower, discipline, or a strong moral fiber. Constructions of fit bodies as valorized, then, rely on understandings of un-fit bodies as stigmatized, such as with over-weight and obese bodies in the current historical moment (DeJong, 1980; Fikkan & Rothblum, 2005; Puhl & Brownell, 2001; Puhl & Heuer, 2009). Although concern with body weight is not a new issue (Brumberg, 1988; Schwartz, 1986), the most recent iteration involving the Body Mass Index (BMI) and stricter, more uniform standards has been an epicenter of debate among scholars. Much of this controversy involves questioning the basis of the “epidemic” and exploring its social construction—particularly around how shifting BMI categories in 1998 re-classified 35.4 million U.S. adults as overweight (Flegal & Kuczmarski, 2000, p. 1078). Accordingly, both critical obesity researchers (Campos et al., 2006; Jutel, 2006) and some epidemiologists (Flegal, 2006) remain skeptical about the status of the phenomenon as an “epidemic.”

Outside of academia, however, individuals remain convinced that obesity is a looming national problem. Television news programs often depict fat bodies in stigmatizing ways (McClure et al., 2011; Saguy & Almeling, 2008), while discussing body weight in predominantly medical terms (Gard & Wright, 2005; Saguy et al., 2010). It is within this context that new “moral entrepreneurs” (Becker, 1963) have arisen to altruistically help people by casting body weight as a social problem. Sometimes these moral entrepreneurs are individuals with medical credentials, such as Dr. Sanjay Gupta on *CNN* or Dr. Nancy Snyderman on *Today*, who regularly speak about the dangers of obesity. In other cases, they are

individuals who have had a transformative experience themselves, often celebrities who advocate diet products or fitness plans (i.e., Kirstie Alley for *Jenny Craig* or Marie Osmond for *Nutrisystem*). Lastly, some moral entrepreneurs have arisen within the health and fitness industry itself. These “obesity epidemic entrepreneurs” (Monaghan et al., 2010) capitalize on widespread fears as individuals begin exercising to combat their growing waistlines. For instance, U.S. celebrity personal trainers such as Jillian Michaels and Bob Harper (from *The Biggest Loser*) have endorsed various weight loss products, becoming spokespeople for the fitness movement. Yet well-known physicians and television stars are not the only individuals advocating exercise.

Physicians also espouse the benefits of working out, and frequently recommend exercise to patients. Researchers at the Centers for Disease Control and Prevention (CDC) found that physician endorsement of exercise has increased from 22.6% in 2000 to 32.4% in 2010, particularly for individuals diagnosed with hypertension, cardiovascular disease, cancer, and diabetes (Barnes & Schoenborn, 2012). Smith et al. (2006) similarly note that direct referral of exercise to heart patients significantly increases the likelihood of exercising. A search of relevant scholarly articles dealing with the topics of “physical activity and exercise” in the *Journal of the American Medical Association* illustrates that scientific discussions about the dangers of a sedentary lifestyle have risen as well. Between 1990 and 1999, only 149 articles appeared discussing the benefits of physical activity for patients. However, this number more than doubled between 2000 and 2009 when 374 articles appeared dealing with the topics of exercise and physical activity. While many of the more recent debates focus on health outcomes, others take up related issues such as the possibility of insurance reimbursements for exercise programs (Pahor, 2011) and the removal of national-brand fast food items from hospital cafeterias (Gorrindo et al., 2013). When coupled with studies regarding physician BMIs (Bleich et al., 2012; Monaghan, 2010), such research suggests that medical practitioners must increasingly meet a corporeal threshold to establish credibility. While doctors often suggest that patients begin exercising to ensure their overall health, physicians may find themselves needing to build up their own bodily capital as well.

Bodily Capital

The concept of “bodily capital” (Bourdieu, 1984; Wacquant, 1995) describes the value attached to people’s appearance, attractiveness, or physical abilities that may be exchanged for other forms of economic, social, or cultural capital. Research has shown that one’s bodily capital is consequential in numerous realms of social life, such as influencing evaluations of students (Ambady & Rosenthal, 1993; Clifford & Walster, 1973), the marriage market (Margolin & White, 1987), and income disparities (Hamermesh, 2011; Judge et al., 2009). Conceptualizing bodily capital as a resource explains why individuals invest time, money, and energy into their bodies with an expectation of a return on those investments. For example, many professions including actors, fashion models (Mears, 2011), athletes, personal trainers (Smith Maguire, 2008), and performers convert their bodily capital into economic and social capital. Even individuals who are not in appearance-related professions benefit from building up their bodily capital, such as when appearance plays a role in politics (Messner, 2007), activism (Saguy & Riley, 2005), work settings (Rhode, 2010), or a doctor’s examination room (Anderson & Wadden, 2004; Jutel, 2008).

In order for bodily capital to function, however, it must be deployed within a pre-determined space where such capital is

valued—what Bourdieu (1984) terms a “field.” Within the health and fitness field, physiques that appear muscular, toned, well-groomed, and normatively thin net higher bodily capital than those that do not. Indeed, bodies understood as either overweight or obese run the risk of discrediting individuals within this field. Such loss of status is illustrated by the case of Jennifer Portnick—an aerobics instructor in San Francisco who was fired for appearing to be too heavy (Kwan & Trautner, 2011). Portnick’s knowledge and ability to carry out the various Jazzercise routines suggests that her fitness level was appropriate to the task of aerobics instruction. Yet, her body weight was taken to signify a lack of fitness, thereby excluding the possibility of being both fat and fit. A growing movement to recognize that “fit” and “fat” are not mutually exclusive categories—the Health at Every Size Movement (HAES)—asserts that a state of health is achievable regardless of body size (Bacon, 2008; Robison, 2005). As some scholars note (Kolata, 2007), reaching an idealized toned or thin body may not be genetically possible, even if a person’s objective measures of health (i.e. blood pressure, cholesterol levels) register in traditionally healthy ranges. While appearance and observation remain important tools at a clinician’s disposal, researchers warn against taking thinness or muscularity as determinants of health (Jutel & Buetow, 2007). It is within this context, then, that personal trainers exist. As participants in the fitness industry, their usually fit-appearing physiques are valued, symbolically representing health. However, their high level of bodily capital also provides a moral authority over clients that is rooted in beliefs about attractiveness, discipline, and knowledge (Dion et al., 1972; Webster & Driskell, 1983). This authority undergirds their interactions with clients and allows exercise to be conceptualized in terms of diagnosis, treatment, and healing.

Methods

Between 2010 and 2011, I collected data for this study through semi-structured, in-depth interviews with 26 personal trainers and 25 clients in the U.S. Interviews allow the researcher to investigate the meanings associated with particular behavior, and were appropriate given that I was interested in how personal trainers and clients understood the work that occurred in gyms. I recruited participants through email, “snowball” sampling, and at local gyms where I posted flyers. To be included in the study, clients needed to be working out with a trainer, or have worked with one recently enough to recall the relationship. Trainers needed to be currently working as trainers. This study met all necessary ethical requirements and was approved by the university’s Institutional Review Board. I obtained informed consent from each participant prior to beginning the interview. When obtaining informed consent, I revealed my own position as a client who was currently working out with a trainer. Each interview took place at a time and location of the individual’s choosing and averaged 1.5 hours in length. Interviews were digitally recorded and transcribed, and all names that appear in the study are pseudonyms. Each interviewee was offered \$20 for their time. I asked questions covering four broad areas: 1) starting a training program/becoming a trainer, 2) exercises and routines, 3) interactions with clients/trainers, 4) and health and appearance. This research was funded through an internal university grant, and the funder had no involvement in the collection or analysis of data.

Participant Information

Most of the interviewees were drawn from the southeastern Michigan (USA) area, although some lived outside of the region and were interviewed via Skype: two from California (San Francisco and

Los Angeles), one from Chicago, one from Milwaukee, and two from the Washington, D.C. area. Demographic information was collected through an instrument that asked for self-reported race, gender, age, sexuality, education, and socio-economic status. The racial composition of the client sample included a majority of individuals who identified as white (17 people, 68%), with additional interviewees identifying as Black (five people, 20%), White/Jewish (one person, 4%), Hawaiian (one person, 4%), and Mexican-American (one person, 4%). Trainers were also predominantly white (25 people, 96%), with one person identifying as Black/Jamaican (4%). Clients’ education levels tended toward higher than trainers, with 44% of clients achieving (or in the process of achieving) a Ph.D., versus only 4% of Trainers. However, 50% of Trainers either had or said they were pursuing a Master’s Degree. The gender composition of my study included more women, both as trainers and clients. Overall, I interviewed six male trainers (23%), 20 female trainers (77%), five male clients (20%), and 20 female clients (80%). Participants’ ages also varied: client’s tended toward older with a range of 18 – 65 and a median age of 41; while trainers were somewhat younger, with an age range of 21 – 56 and a median of 34.

Data Analysis

To organize and code the data, I utilized a software program, *NVivo*, which allowed me to more accurately track and combine codes as the analysis progressed through various phases. Data analysis proceeded in two stages: an initial “open coding” stage that was more inductive, followed by a “focused coding” stage that was more deductive. First, I used a coding technique inspired by “grounded theory” (Strauss & Glaser, 1967) but adapted by Emerson, Fretz, and Shaw (1995) termed “open coding” whereby the data is sorted into general patterns and more formal codes are allowed to materialize from the data itself (p. 150). This technique produces numerous, broad codes that may be composed of entire sentences or strings of words that characterize a particular phenomenon. In this initial phase of coding, I produced approximately 85 “open codes.”

Second, I used these codes to re-engage the data and employed a “focused coding” technique (Emerson et al., 1995, p. 160) that allowed me to break down data into more meaningful sub-codes. For this second phase of analysis, I required two full scans of the data and concluded with 38 stable codes that described themes such as “Doctor and Medical Metaphors,” “Trainers as Experts,” and “Bodily Capital and Authority.” During this second phase of coding, I paid particular attention to instances of contradictory data—as these do not necessarily invalidate established codes, but add nuance to them that allows for more precise analysis. For example, while many clients and trainers discussed exercise in overtly medical terms, there were also moments in the data when lines were drawn between trainers and doctors. These snapshots, then, became important aspects of the analysis and suggested that while much of the activity being conducted in gyms was understood as health work, it was not seen as explicitly medical practice in the eyes of interviewees. Lastly, after delving into the data itself, I stepped back and wrote multiple “integrative memos” (p. 165) where connections between individual codes, broad themes, and the data emerged, becoming the building blocks of the analysis.

Findings

A personal trainer’s bodily capital provides a degree of moral authority that establishes trust with clients and allows their work to be seen in terms of healing and treatment. In the following sections, I first detail the types of interactions that occur between trainers and

clients, as well as how trainers understand their position in the fitness industry. In these relationships, trainers saw themselves as highly specialized experts conducting health work that their clients—even health care professionals and occupational elites—valued. Secondly, I suggest that it is a trainers' bodily capital representing willpower, knowledge, and morality that allow them to carry out this health work successfully.

Health Work and Expertise in the Gym

Exercise is typically extolled for its preventative effects, particularly around mobility and functionality. However, trainers and clients often discussed the healing and restorative powers of exercise and what they hoped to achieve through physical activity. Because of this, the exercise carried out in gyms was often framed in terms of diagnosis and treatment. For example, Rachel (61, white, female, client) explains how her trainer helped her to stop taking medication for hypertension:

He set expectations for me, rather than me for him...he says "Okay, here's the way it's going to be. You're going to do what I tell you to do, and the minimum to start with is three one-hour sessions a week. And we won't be using machines. You're going to learn functionality and basic conditioning. And we're going to fix your knee issues." I told him that I couldn't do this, but he looked at me and said, "Yes, you can." So, we did it his way. Honestly, [laughs]...my legs have never been in better shape...He even got me to wear a heart monitor so that he can keep track of my heart. And I was taking anti-hypertensives, and I'm off of all that medication. For him, that was the biggest accomplishment, you know, seeing me get off those medications.

For Rachel, going off medication was a clear sign that personal training was working, and that her trainer was credible in more areas than just exercise. Similarly, Julia (49, white, female, client) who had experienced joint, wrist, and back pain explains her rehabilitation:

Well, I used to have a lot of trouble with my back and my wrist, so I wouldn't do things that would bother those areas. And my trainer said, "Those are exactly the things that you need to work on." So, she got me doing a lot of wrist exercises, and things with my back. I was sore at first, but now my wrists are much stronger, and I haven't had back problems at all. So, I think she really helped me get over the fact that I shouldn't be protecting those things.

Jill (64, white, female, client), an older client who worried about her irregular heart rhythms and medications, was particularly concerned with her trainer's knowledge. She became very trusting, however, when her trainer not only understood the medical issues, but helped her past them as well:

The first thing about her was that she understood my situation—my previous problems with tachycardia. And she had worked in cardiac rehab. She knew my medications immediately. She understood what it might be like for me to exercise and then ten minutes after that pass out. She was totally understanding and helped me exercise safely and overcome my fear. Because I wasn't allowed to get my heart rate over 110 for many years...she started me on the treadmill, and she showed me how to sense my heart rate more by feeling, rather than watching the numbers. So, I began to feel safer by being able to tell how I felt...And I recall sitting in her office, and I broke into tears because she really understood, and she believed I could exercise.

And I had absolute confidence in her ability to see me through that.

One of Jill's greatest anxieties involved adverse physiological reactions to exercise, but her trainer's experience and slower pace set her mind at ease. Ruth (35, white, female, client) exercised initially to lose weight, but was impressed by her trainer's ability to see her physical ailments and address questions she had while working out:

One thing that impressed me was my very first time with her, she noticed that my left leg turns in, like right away. I mean, it was within like two strides on this elliptical machine and she realized it. I've had issues in the past with exercising and the way my leg turns in making it difficult. So, for her to be that in tune to my form made me trust her. And then, I had some questions, because I like to understand how things work, so when I would ask her questions, she could give me very detailed descriptions of the physiology of the exercises, like how the muscles worked.

Although the exercises were not meant to heal Ruth's leg, she did note that her overall health improved when her trainer understood how to appropriately adjust the workout for her particular comportment.

Trainers also discussed how their work intersected with the health care industry, both directly and indirectly. For example, Cathy (28, white, female, trainer) explains how the link between the doctor's office and gyms typically works:

Well, I wanted to work with people who wanted to change. Because they get referred by their primary care physician, so it's not necessarily like they're seeking out the help themselves. Their doctor has sent them there...so, if somebody had diabetes they were there to try and treat that, you know, with exercise...but I've also trained a guy that had Parkinson's, and he'd talk to me on his computer pad...And then I had a stroke patient...I wasn't even certified at that point, and so I was like "What? I don't know how to handle someone like that." But, I ended up helping him anyway. I would tie him onto the NuStep machine to help him move his arms and legs and so on.

Cathy understood the limits of her knowledge, and speculated that her stroke patient worked out with her because his insurance had stopped covering physical therapy. And although she knew she was unqualified to meet the special needs of stroke patients, she attempted to rehabilitate them regardless. While this does raise valid concerns about the safety of such activity for clients and the potential legal ramifications for trainers (if injury occurs), it clearly illustrates the blurring of lines between the health care and fitness industries. Jacob (26, white, male, trainer) also wanted a full account of medical issues before beginning a workout program:

So, we'll sit down and I'll ask them about their medical limitations. You know, is a doctor okay with this? And if they do have a lot of issues, medical issues, I want a doctor's note, especially if they're older. I ask about joint pain, bone pain, any previous injuries that still give you problems, a big one is any medications that you're on, because a lot of medications raise the heart rate more, so you never know. I mean, I can watch and see your physical issues, like if you're getting red or if you're profusely sweating or if you're breathing heavy or something like that. But some people won't show those, and their heart is just pounding inside, you know, and you're ready for a heart attack.

This concern and desire to help clients worked in tandem for trainers when, like with Rachel above, they were able to improve an individual's daily functioning or health. As Andrew (34, white, male, trainer) explains:

Recently I had a client, I think she's about 65, and she had a degenerative nerve condition, where she couldn't function at all. She went to the doctor, she got the proper treatment, and the doctor told her to try exercising with a trainer. And it was just like a progression. And now she's back to full activity. And actually, her life is really improved. But, you know, it's kind of interesting because she said that her functionality is improved to the point where she can go to the grocery store and she's able to pick up, like a case of water, and put it in her cart. And, before, she could barely stand up. So, to see somebody go from, you know, such a low level to such a high level is very rewarding.

Andrew's efforts resulted in dramatically increased functionality for his client, which he sees as rewarding unto itself. This sentiment was expressed throughout the interviews with trainers, particularly as they reflected on their position within the health industry.

Personal training is not regulated by state or federal policies, or by a single credentialing body. There are numerous national and international agencies that provide certification and have varying reputations among trainers. Despite the variety, all share a relatively standard system: trainers initially pay for instruction and an exam, and they must renew their certifications annually at their own cost. However, the usefulness of these certifications, beyond needing them for employment, trainers felt could be achieved through the experience of training itself. As Chris (21, white, male, trainer) answered when I asked him what he received from his \$300 certification: "I got a little card with my name on it [laughs]...I mean, I already knew how to exercise. You start training and you find your own method and approach. No one can really teach you how to train." Thus, a trainer's authority did not come from their paper credentials, but from their experience and knowledge, which provided the necessary distinction between themselves and their clients—even those with actual medical training.

Indeed, trainers often compared their own position as exercise experts to health care workers who may have very specific knowledge about bodily illness, but know little about diet and exercise. As Matt (25, white, male, trainer) explains:

Sometimes you get these clients who think that their way is better. And you kind of have to remind them that, you know, this is our profession. You have to think of us as doctors in this field...or dentists. When you go to see them, you know, you don't know anything about your own teeth. But most people trust them because that's their profession.

In this example, Matt compares himself and personal trainers to doctors and dentists—other medical professionals who Matt considers deserving of respect. Matt's words convey a sense of similarity in professionalism and specialized knowledge. However, he and other trainers understood that they were not medical doctors, and often mentioned this in the interviews. For example, Dierdre (36, white, female, trainer) explains:

Sometimes they'll ask something that is really basic, like "My leg is really sore" or "How do I stretch this?" or something like that. And I can give them a good hamstring stretch or whatever. But when they say, "Oh, this hurts" or "That hurts"—and some things I'm familiar with and I know—but when things get a little more

involved I always say, "Remember, I'm not a doctor. I'm just saying this because it's what I think"...I mean, I'm married to a lawyer. So, I always tell them "I'm not telling you this to substitute doctor's advice." And it's never usually anything too serious.

As a means of protecting herself legally, Dierdre consciously separated herself from doctors even while offering what she considered to be health advice. Trainers also discussed their work in terms of physical therapy throughout the interviews. In the U.S., many states recognize physical therapy as a health care profession involving rehabilitation through movement and modified exercises. While the educational requirements of physical therapy are not equivalent to medical doctors, physical therapy is offered as a degree at the B.A., Master, and Ph.D. levels, and it remains a state-recognized and accredited profession. Because of this, trainers often contrasted themselves with physical therapists, while relating the similarity of their work. For example, Sandy (56, white, female, trainer) says, "I mean, I'm not a physical therapist, but well, I do see things. You know? And then it's a challenge for me. Like, what am I going to do with this nine-year old to fix this problem?" Although Sandy verbally denied her status as a physical therapist, she simultaneously acknowledged that she attempts to heal her clients. This same dynamic played out around the role of nutrition, and took on a patterned response among trainer interviewees. As Melanie (44, white, female, trainer) explains:

I don't give nutritional advice because it's outside the scope of my certification. As a personal trainer, I understand it so I give basic nutritional advice. Like, I would say, "Make sure you have eaten something"...but I don't prescribe a diet or anything. I mean, I will say, "If you do have a snack, make sure it has some protein and some carbs so that you don't crash." Or I'll say, you know, "You might want to think about eating healthy," but I don't give nutritional advice.

Trainers would often state that they were not nutritionists (and related that this message is emphasized during the certification process), while still having clients construct food logs and critique food choices. This provided some professional maneuverability for trainers to claim a degree of credibility, without incurring potential legal penalties. Of course, such straddling of professional worlds may also have its dangers, particularly for clients who heed the advice of trainers without degrees in physical therapy, exercise science, or nutrition.

Positioning themselves as similar to (but different from) other health care professionals created important legal distance for trainers. Yet, their interactions with clients who were health care professionals reveal tensions between the fields. As Jane (29, white, female, trainer) explains:

Some clients are not knowledgeable at all, and they know that. And some of them actually know what they're talking about. I just trained a girl who, I think she just graduated with her degree in kinesiology, so she knows stuff. But at the same time, she didn't know stuff. Like, because she's right out of college, she doesn't have that exercise base. So, we're doing all these exercises she's never done before. And that's something that you learn at your first training job where you see all these other trainers doing these things, and then you go try it yourself.

In some cases, trainers were exercising with medical doctors and reflected on their position within that relationship. As Andrea (47, white, female, trainer) notes:

I have one client who's really strong. She's a little thing, you know, but ironically, even though she's a heart surgeon, I think her cardio fitness is less than optimal [laughs]. So, we spend the first 10 minutes of every session doing sprints, plyometrics, and running steps. I don't do that with anybody else, but she asked for that, so we incorporate that every time.

Sandy (56, white, female, trainer), who works in a gym that caters to a higher-end clientele, discusses how she feels about training such people:

You know, I have some high-powered clients...So, we've got doctors and people that have very stressful jobs. And to have them say, "Do you know how much I look forward to coming to these sessions?" and "I feel so good when I'm done working out with you"...that makes me feel really good...But, that means that I've got to stay on my toes. I have to read my journals. I have to pay attention to what other people are doing, but hold true to my own values and morals and what I believe is right for my training style...And, you know, I have a skill set that makes somebody who is a transplant surgeon want to come to *me* for help—that makes me feel really good.

Of course, not all trainer-client relationships with power differences worked out as expected, and Sylvia (22, white, female, trainer) explains how she had to let a client go who would not heed her advice:

I just ended a training relationship with a woman who was obese. And she was a dietician. How ironic, huh? She was a binge eater and she knew it. But, I couldn't ever tell her anything because she "knows way more" than I do, but it was right there and so obvious. She was an emotional eater. But really, a dietician who binge eats?!

Davin (23, Black, male, trainer) also comments on the linkages between knowledge, physique, and respect even by clients with degrees and exercise knowledge:

Some of my clients have had degrees in exercise science or kinesiology, but it might have been a while back, so they're not as fresh...When it comes to health and fitness, there are always new breakthroughs...But, it's almost like you get a higher level of respect, so to speak, being a trainer...Now, I personally feel I have a general amount of knowledge and I'm in really good shape. But, I feel like I can learn so much more, and I want to develop my body and fitness more than where it's at now. But for the average client and even some doctors, you know, you're up there, and they look up to you as being in great shape.

In all of the above examples, trainers remarked on their positions as experts with a specialized skill set that clients in typically higher status locations valued. The activity conducted by trainers was understood as a form of health work, and both trainers and clients saw this as a function of what working out could accomplish. However, this acknowledgement then begs the question: what allows personal trainers to harness such health authority in interactions with clients? And importantly, why do clients listen to them?

Bodily Capital, Authority, and Trust

Personal trainers rely on their knowledge, as well as appearance, to make a living through exercising with clients. In this line of work, a trainer's physique comes to represent a commodity that signals their investment in physical fitness and health. It also quite visibly stands as a type of corporeal credibility that allows them to convert their bodily capital into other forms of capital. Throughout the interviews, trainers routinely referred to their physicality in terms of credibility. For example, Jason (42, white, male, trainer) said:

You know, it's like...your body is your business card, and I think you need to present yourself as such. People see me [in the gym] and realize that I do work out a lot, and I do take care of myself...so, you are your own business card, you know what I mean? If you're a fat trainer, I don't think many people are gonna go to you and say "Hey, I wanna look like you."

This notion came up often in the interviews with trainers—the idea that one's physicality determined if trainers successfully recruited and retained clients, as well as the types of clients they might attract. Denise (36, white, female, trainer) reiterated a similar view when saying:

Well yeah, your body is kind of your calling card. And what you look like will, a lot of times, determine who wants to train with you. I might not get the clients who want to look all "beach body," but the middle-aged over-weight women I can really relate to, and they can see how strong and fit I am.

Sylvia (22, white, female, trainer) also understood her appearance as possessing both symbolic and material value:

Oh yes, appearance is important for trainers. I mean, you wouldn't go find a lung doctor who was smoking a cigarette, right? So, you don't want a personal trainer who's out of shape. You want them to walk the walk. And we do have a person or two who is not very fit. And although they don't necessarily get heat from their clients, I know that the people who run the business are not marketing them to clients because of the way they look. And I've heard them say that. You know? ...We want to look at hot people who are in shape. Not necessarily hot, but definitely in shape people.

Sylvia acknowledges that less fit-appearing trainers are structurally disadvantaged in the industry—owners do not market them to clients, thereby reducing their opportunity to support themselves via personal training. In contrast, trainers with higher bodily capital were structurally advantaged and able to more readily convert their bodily capital into additional economic and social capital. Because assumptions about a trainer's knowledge depended on their appearance, trainers felt pressure to invest time and energy into their own physiques to bolster their influence. As Elizabeth (38, white, female, trainer) relates:

It's funny, but I feel like, okay, now that I'm legit and people are coming to me for advice and people are watching me, I better just keep looking good and keep on working out. And now it's a pre-req. It's not just me going to run five miles. It's a pre-requisite to my job. If I can't run five miles and hang with whoever I'm training, then I'm going to be failing at what I need to do. So now, when I get up, it's not like I'm going to run five miles because that's what I do every day. It's like there's no excuse anymore. Like, you can't just pansy out of it. It's part of my job.

According to Elizabeth, both performance and appearance are integral aspects of being a successful trainer. In fact, Elizabeth feels that legitimacy as a trainer depends on her ability to stay fit. This sense of credibility stemming from one's body held true for both male and female trainers alike, as Davin (23, black, male, trainer) explains:

I feel like as a trainer, you...should be the epitome of physical fitness...You *are* fitness. You are a personal fitness trainer, a health coach...If I'm a trainer, I have to market myself. Now how would you feel if I'm outta shape, or fat and sloppy, and I say "Hey, I can train you to get in shape, I can get you right." You would look at me like "What? You can't even get yourself right!" Now don't get me wrong, there's a lot of trainers who are geniuses when it comes to exercise science—they just don't apply it to themselves...They may know way more than I do. But...you have to train, and you have to apply it to yourself and discipline yourself before you can market yourself. Otherwise, I don't trust you to get me in shape because you can't even get yourself in shape...You know, you have to practice what you preach and live that life...If you're gonna be a trainer, *be* a trainer. Let it seep from your pores. Let that be who you are.

Madeline (52, white, female, trainer) succinctly captures this association between bodily capital and authority when commenting: "It's very important for a trainer to 'walk the walk.' I mean, it is. The fitter you look and appear—that's part of your authority. It's a *huge* part of your authority, you know? It's something I'm always working on. I'm never satisfied." Many trainers felt strongly about the embodied requirements of their profession, and these associations were shared by clients as well, especially when discussing what the ideal trainer should, and should not, look like.

For clients, the bodily capital of their trainer was just as important to them, since they often paid significant amounts of money over the course of a training relationship. While the length of time clients trained varied, it was common that individuals met with a trainer at least once per week, and often twice. Because clients recognized personal training as an investment of both time and resources, they had equally high expectations for trainers' appearances. For example, Holly (44, black, female, client) said:

I'm gonna be honest. No disrespect, but I just would not want a fat slob training me. It's just you look at them and wonder "Is her diet good?" I mean really, if you see someone in shape, you know they're doing something right... I feel like, again, it goes back to appearance. The person that you're looking at, if they look healthy, it means they're taking care of themselves...It's like, I know my trainer is gonna get down to business because she cares about herself, and she's gonna want me to take care of myself as well. That's the impression I get from my trainer.

Similarly, Gwen's (18, white, female, client) personal trainer fit her expectations appearance-wise for the type of training she was looking for when she signed up:

He was tall, I'd say like 6'3", and like really, really muscular, like muscular on top, and then muscular all over. He was really fit but he wasn't one of those crazy arms, body-builder types. He was just really fit, something I like—that nice balance, where it's not like "OK, I have the crazy neck muscles." You know?

Gwen's image of a "fit" male trainer included visible musculature—but only to a degree, and she differentiated her fit-appearing trainer

from other male trainers with a stereotypical "steroid look" involving body-builders with "crazy arms." However, she also had opinions about what trainers should *not* look like as well:

I definitely think appearance is important for trainers. Because I mean, my mom brought this up one day...She was like "If you went to a nutritionist and they said you're not eating healthy, and it was an overweight person telling you what to do, would you take that serious?" You know? How can you be giving advice when you're not adhering to the things you're saying? So, I definitely think it's a big factor, like my trainer, he obviously gained his muscle, so he knows what he's doing, so I should listen because I can get something out of him. But...if I walked into a gym and was like "I want muscle training," and the trainer was really skinny, I'd feel like "Okay, what does he know?" You know, he doesn't look like he's worked with dumbbells in two years!

For Gwen, the physical embodiment of trainers suggested, quite literally, what they knew about exercise and if their knowledge could be trusted. Daniel (38, white, male, client) echoed what many personal trainers said when discussing what his trainer's body signified:

Absolutely, trainers need to look fit. You know, it's their reputation. My trainer basically wears his reputation, and I think a lot of personal trainers do that. And you can look at them and say, "OK, this is someone who'd be great for triathlons" or "This is someone who's great for body-building." And they kind of wear that in what they look like.

Robert (41, white, male, client) expresses a similar sentiment when saying: "My trainer is definitely in shape, so yeah that's a very important aspect. I can't imagine going to a personal trainer and paying them to help me get fit if it looked like they were 60 pounds overweight." Tori (26, Black, female, client) also felt strongly about how trainers should look and related it to a more general association of appearance and lifestyle:

I think when a person sees you, they don't know anything about you—your past, your present or what you're doing with your life, they just see *you*. And I think for good or bad, people make an estimate of you as a person. So, if you look like you invest in your appearance they think, "Oh, this person takes pride in themselves, so they're probably doing something with their lives." Because if a person looks like they just rolled out of bed, you're gonna think "Oh, they're not motivated, they don't care"...But when you look like you're healthy, like you're vital, people assume that good things are going on.

Tori suggests that one's appearance extends beyond just looking good, and echoes what many clients felt: that a trainer's appearance indicated something about their lives and well-being. It was their bodily capital, then, that allowed trainers to be successful in their work and to be seen as credible experts.

For both trainers and clients, the physical appearance of the trainer was important for establishing trust in the relationship, which allowed exercise to be seen as health work. Trainers understood their own embodiment as a pre-requisite for employment, and that it broadcast their knowledge of exercise and health. Clients were explicit about not wanting a trainer who looked out-of-shape, as this indicated someone who could not apply their own knowledge, or who perhaps did not have any in the first place. Because of this

requirement for training, it is clear that bodily capital was one of the most important features for a personal trainer when embarking upon a relationship with a client.

Conclusions

The importance of one's appearance in social life has been connected to myriad material and symbolic rewards. Particularly in relation to health, a good-looking or fit-appearing physique is often read as representing willpower, knowledge, and morality. Yet, as my findings indicate, a fit-appearing physique also carries with it a degree of authority and, in certain fields, health authority. As is the case with personal trainers in the fitness industry, whose high levels of bodily capital imbue their interactions with a moral valence and allow them to see exercise in terms of health work. Accordingly, both trainers and clients understood this activity to be a means of treating and correcting pre-existing health issues—from excess body weight to hypertension and diabetes. But, the construction of exercise as health work relied not on a trainer's accreditations and certifications (none of which authorize them for such activity), but on their bodily capital and fit physiques. Personal trainers who did not meet such corporeal criteria found themselves structurally disadvantaged in the fitness industry, and in low demand by clients.

This research extends current studies linking appearance to health (Jutel and Buetow, 2007) by noting the additional dimension of authority in interpersonal interactions. The significance of this study, then, lies in its implications for both the fitness industry and the doctor-patient relationship. First, personal trainers and clients connect exercise and health in important ways that may have consequences individually and legally. Many trainers took it as a point of pride when clients mentioned going off of medication for existing conditions. While this is certainly something to celebrate from a health standpoint, no mention was made of physician involvement in this decision. Patient adherence to prescription medication regimens has been seen as a problem for some time (Bittar, 1995), particularly when individuals begin feeling better. In cases of diabetes or hypertension, while weight loss may reduce the severity of these conditions, weight loss alone may not be sufficient to treat them appropriately. Thus, a personal trainer's accolades of improved mobility, weight loss, and muscle tone may stand in (dangerously) for a proclamation of health. Second, if corporeal credibility has become increasingly tied to health authority, then physicians and other health care professionals may find themselves with new guidelines for medical practice. Indeed, as illustrated by recent research (Bleich et al., 2012; Monaghan, 2010), such expectations may be already operating in many fields. The impact of such embodied expectations, however, has yet to be measured. Will we eventually see cases of weight discrimination against nurses or doctors, or bodily guidelines for health care professionals similar to requirements for police officers or the military? Such questions provide fertile ground for additional studies investigating health, appearance, and authority.

This study faces some limitations in scope and demographics that must be addressed. First, the gender ratio in the sample included more women than men. While this did seem to reflect the general gender composition of trainers and clients in the study area, this may not be the case in other geographical contexts, or more urban environments. Similarly, study participants were predominantly white. Although some racial variation was seen among clients, all but one trainer in the sample was white. Certainly drawing from a different geographic region would yield more diverse results by race, and future studies might consider this when thinking about how

bodily capital, medical authority, and race intersect—particularly since white beauty standards are not idealized in all social contexts (Craig, 2002). Finally, both the client and trainer samples show high levels of education in both groups. While this should not be considered representative, the southeastern Michigan area is home to three, large public universities, and the likelihood of encountering individuals with advanced degrees increases accordingly. Although the gender, race, and educational demographics do limit generalizability, representativeness was not a goal (nor easily achievable with most qualitative methods). Instead, this study focused on the meanings that both trainers and clients associated with fit-appearing physiques and the effects of exercise on the body.

Future studies might concentrate on the trainer-client relationship in more diverse contexts, such as among gay men and lesbian women, African-Americans, or Latinos to determine if these patterns of bodily capital and health authority play out similarly. Also, many questions remain about how appearance operates in medical contexts, and additional research might address this more pointedly. For instance, how does authority intersect with bodily capital for cardiologists or nurses who often have first contact with patients in medical settings? What appearances are understood as "healthy" beyond a trainer's often-idealized physique? Do race and gender play a role in such assessments of health and therefore authority? While interviewees occasionally touched on the gendered nature of establishing authority—particularly female trainers with male clients—future research might investigate how race functions with high and low levels of bodily capital. While the current study was able to capture this dynamic within a particular population, understanding its applicability to other areas of social life requires additional research. For now, this investigation has shed some light on how high levels of bodily capital within the fitness industry imbue personal trainer-client interactions with a moral and health authority.

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