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# "Do you find it normal to be so fat?" Weight stigma in obese gym users

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## Abstract

Weight stigma is a negative social process that involves discrimination against overweight and obese people. Gyms are important environments to promote exercise where weight stigma can be a hindrance for obese exercise practitioners. This critical-oriented study provides evidence-based answers to this question: How do obese users experience weight stigma in gyms? Six obese gym users (BMI >30) participated in semi-structured interviews and provided visual data for photo-elicitation. A thematic analysis enabled the grouping of their experiences around weight stigma into three forms of discrimination: 1) *direct*: negative comments about body weight and body size; 2) *indirect*: internalization of negative stereotypes on weight, ability or appearance; 3) *structural*: explicit or symbolic rejection related with weight-centric exercise, equipment and recommendations implicit in marketing and advertising. The results provide evidence and interpretations of different forms of discrimination and inequality that operate in gyms, and how they affect obese users' experiences. Based on these results, we compile a list of measures to prevent weight stigma and recommendations for exercise professionals to relate with obese users.

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weight bias, fitness culture, physical activity, exercise professionals, self-stigma

## Introduction

Since it was first used in the 1960s, the concept 'weight stigma' has generated abundant literature on the different forms of discrimination suffered by overweight and, particularly, obese persons (Vartanian and Porter, 2016). Weight stigma is now a prevalent problem in western societies. In the USA weight stigma rates in obese adults fluctuate between 19 and 42% of the overweight population, with higher rates belonging to the higher BMI categories (Rubino et al., 2020). Weight stigma has negative effects on the wellbeing and quality of life of the overweight and obese population who suffer from it (Diedrichs and Puhl, 2017; Rubino et al., 2020). They become negatively stereotyped and obese people are often discriminated against and excluded from different social scenarios because of their weight, damaging their social status (Link and Phelan, 2001; Meadows and Calogero, 2018).

Weight stigma research has been built helped by general stigma theories. Stigma theories have evolved from a focus on micro-sociological aspects (attributes, traits and behaviours) (Goffman, 1963), towards the progressive incorporation of macro-social structure analysis, which includes economic, ideological and political factors and their relationship with class, power, oppression and command logics, as the ones represented by Scambler (2009) and Link and Phelan (2001; 2006). In health and health-related behaviours, Scambler's (2009) conception relies on the subject's perception of the stigmatising experiences. He distinguishes between *stigma* and *deviation* to refer to the ontological deficit (the supposed imperfection or malfunction) and moral deficit (the behaviour which is considered wrong), respectively. Obesity (ie., the stigma) is often represented as a result of a deviation: the lack of self-control to stop overeating and/or to do more exercise. Therefore, obesity would epitomize a moral deficit: laziness and heedlessness. On the other hand, in their conceptualization, Link and Phelan (2001) identify four interrelated components of sigma and stigmatization processes: a) *Distinguishing and labeling differences* (oversimplification of differences to create human groups); b) *Associating human differences with negative attributes* (linking differences to stereotypes); c) *Separating "us" from "them"* (when 'them' are seen as a menace to "us", because they are considered to be "immoral, lazy, and predatory" (p.370) and; d) *Status loss and discrimination* (a constructed rationale for devaluing, rejecting, and excluding 'them').

Precisely, Link and Phelan (2001) outline that, although most definitions of stigma do not include discrimination, "the term stigma cannot hold the meaning we commonly assign to it when this aspect [discrimination] is left out" (p.370). These authors distinguish between *individual* and *structural* as basic forms of discrimination. Individual discrimination relates to the attitudes and beliefs of a person "A" labeling and stereotyping of a person "B". Later, Lewis et al. (2011) nuanced two complementary dynamics of individual discrimination, distinguishing between *direct* (explicit attribution of negative personal behaviour or attitude) and *indirect* (internalisation of feelings of fear and rejection generated by negative stereotypes) discriminations. *Structural discrimination* refers

to accumulated institutional practices that work to the disadvantage of stigmatized groups "even in the absence of individual prejudice or discrimination" (p.372). Oppressive representations of overweight and obesity can be considered subtle forms of structural discrimination nurturing modes of address that, in Ellsworth's (1997, 8) words, "can make a difference in power, knowledge, and desire" towards obese populations.

Besides these conceptualizations of stigma, this study is also framed within the contemporary critique of sociocultural constructions of body aesthetics and body size, which has been addressed by scholars from a range of disciplinary perspectives (Hepworth et al., 1991; Lupton, 1995; Shilling, 1993). In this venue, the Weight-Centred Health Paradigm (WCHP) is an essential pillar to understand how weight stigma is constructed and reinforced in western societies. According to O'Hara and Taylor (2018) the WCHP is a conjunction of knowledge dominant in health and medical science, which supports the belief that health depends strongly on the person's body weight control by means of a healthy lifestyle, physical exercise and diet. These authors consider that WCHP contributes to creating *adipophobicogenic* environments, that is, settings that create and sustain fatphobia and oppression, promoting weight stigma. Monaghan (2017) points out that the continuous weakening of the Welfare State and public health systems, as well as unequal access to health services in some countries, has fostered a health model which is based on individual responsibility, one of whose side effects is blaming the patient (obese people in this case). *Healthism,* the liberal ideology behind this health model, turns health into a private consumption object, advertising it as a moral and individual endeavour (Jiménez-Loaisa et al., 2019). As a consequence, overweight and obese subjects are negatively stereotyped as irresponsible, lazy, with little self-control and discipline, as well as a social threat due to economic costs brought about by overweight and obesity. Thence, WCHP strengthens a view of overweight and obesity as a deviation, blaming the subjects for their condition.

Agents responsible for the elaboration, dissemination, commercialisation, training and support for the WCHP have been described as *obesity epidemic entrepreneurs* (Monaghan et al., 2010; O'Hara and Taylor, 2018). According to Monaghan et al. (2010), WCHP agents include *slimmers* –people who are constantly on a diet – the scientific community (health experts in particular), the media, governments and the weight loss industry. Under this perspective, fitness culture acts as a legitimating and opportunist agent, fostering and taking advantage of business opportunities in the exercise market by appealing to health and physical appearance to obtain economic benefits (Monaghan et al., 2010).

Numerous testimonials from obese persons locate experiences of weight stigma within several physical activity environments. Obese people have reported insults and discrimination in PE classes, gyms, swimming pools, university sports classes, team sports clubs, public sports events, and other populated or exposed areas where is possible to exercise (Meadows and Bombak, 2019; Pearl and Puhl, 2018), often resulting in negative experiences, reduced physical activity, low feelings of competence, increased exercise avoidance and, ultimately, self-exclusion from these activities (Thedinga et al., 2021).

Nowadays, gyms have become important spaces for physical activity worldwide (Scheerder et al., 2020). However, to the best of our knowledge, the experiences of obese gym users have not been a central focus in the qualitative research of weight

stigma, although some studies include gyms as a part of other physical activity settings. These studies report a wide range of perceptions and situations lived in gyms, such as instructors and other users making derogatory comments against heavier weight individuals, incidents with equipment, fear of being stared at, body shame feelings, reluctance to be photographed, and weight-centric advertising in physical activity organisations (Lewis et al., 2011; Myre et al., 2020). In line with this, the most specific example of a qualitative study that focuses on weight stigma in a gym is an ethnography by Mansfield (2011) in a women's gym. She identified fat stigma processes, such as a disadvantaged position of power in social relationships due to negative stereotypes of fatness, or body gossip scorning excess of bodyweight and fat. In general, these weight stigma experiences and feelings have been associated with worse attitudes towards the gym, higher self-consciousness, and self-stigma of obese participants (Schvey et al., 2017). In consequence, we consider it important to delve into how weight stigma can be generated and experienced in gyms, as well as to provide understanding to the implicit beliefs and practices related to bodyweight in these environments.

Our approach to these issues is underpinned by a critical design committed to exposing and critiquing the forms of inequality and discrimination that operate in daily life. More specifically, we adopt a position informed by Critical Weight Studies and Fat Studies, two multidisciplinary perspectives that question the WCHP and the dominant discourse on obesity (Cooper, 2010; Monaghan et al., 2011). Despite this common aim, both perspectives also differ on a few points. Relating with the object of our study, Fat Studies reject BMI categories in favour of the subject's self-definition, as they consider BMI intrinsically stigmatising and disrespectful with human diversity, triggering the separation between 'them' from 'us' that generates stigmatization (Link and Phelan, 2001). Cooper (2010) also points out that Fat Studies embrace identity politics, and is particularly critical with the 'obesity science' and the positivist paradigm to define and assess the body. For its part, summarizing, Critical Weight Studies assume the need of bodyweight categories, considering them *the least bad option* to build their critiques (Monaghan et al., 2010, 2011). Against this backdrop, we encompass both perspectives, since Fat Studies offer rich and challenging knowledge about weight stigma, while we also consider it important to approach weight stigma using the language of 'obesity science', in order to further critizise it.

In sum, this study aims to explore, highlight and contribute to preventing situations that are considered and interpreted as stigmatizing for obese gym users. In this regard, knowledge of their experiences is needed to foster transformative actions. Hence, the questions that guide the present study are: How do obese users experience weight stigma in gyms? Can we think of critical, inclusive and weight stigma-free alternatives?

## Methods

### *Participants*

Participant selection followed inclusion and convenience criteria (Sparkes and Smith, 2014). Inclusion criteria were BMI≥30 and having exercised in the gym at least once weekly during the past year. BMI≥30 corresponds to medical discrimination of the

obese, the group most affected by weight stigma (Diedrichs and Puhl, 2017; Rubino et al., 2020). BMI variable builds and defines weight categories across different fields and approaches to weight stigma, including critical research (Monaghan et al., 2010). In our case, the choice of BMI as a criterion mainly responds to ontological (verifiable) and practical (easy calculation) reasons. However, some authors have mentioned that the BMI has important limitations, such as lack of professional agreement in its clinical use, inconclusive relationship with poor health, insufficient measure for clinical health assessment, or inability to differentiate between fat mass, fat-free mass, and fat distribution (O'Hara and Taylor, 2018; Sommer et al., 2020). Regarding convenience, since obese gym users are a minority group it was intended to contact as many participants as possible, for which a research advertisement was posted on social networks and in gyms (with prior consent) between May and August 2019. In addition, a snowball strategy was used after having contacted the first potential participants, with whom all the pre-interview communications, confined strictly to research issues, were made through WhatsApp with their consent.

After applying the selection criteria, six persons finally participated in the study (see Table 1). In general, their gym trajectory was quite long, fluctuating from around six months to 23 years in one case (without continuity). While the research was in progress, all of them attended the gym from twice a week to daily, in one case. Three participants had past sports experience other than the gym (including rugby, boxing, bodybuilding or skating) at a recreational level, or in one case at an elite level.

The study took place in a city in Spain, a city which occupies the fourth position in the number of Spanish private fitness centres, with a total of 28. Private fitness centres are an increasing business in Spain (Llopis-Goig and Sánchez-Martín, 2020) and elsewhere (Scheerder et al., 2020). The participants attended different *premium*, *medium*, or *low-cost* private gyms. These gyms differ not only on their fees, but also on the services offered. Premium and medium gyms provide personalized activities, with a higher rate of employees per member (Llopis-Goig and Sánchez-Martín, 2020).

**Table 1.** Participants.

| Pseudonym of participants | Sex | Weight (kg) | Height (cm) | BMI (kg/m$^2$) | Age | Education | Main occupation |
|---|---|---|---|---|---|---|---|
| Víctor | Male | 86 | 177 | 27,2 | 32 | University degree | Salaried worker |
| Daniel | Male | 142 | 177 | 45,3 | 39 | Professional training | Salaried worker |
| Gastón | Male | 128 | 170 | 44.3 | 19 | High school | Student |
| Jennifer | Female | 87 | 169 | 30,5 | 32 | University degree | Student |
| Martín | Male | 98 | 180 | 30,25 | 23 | Professional training | Salaried worker |
| Rania | Female | 78 | 156 | 32,05 | 30 | University degree | Self-employed worker |

Lastly, weight loss was one of the participants' main motives to exercise in gyms and they also mentioned other motives such as improving strength, health, motor competence, stress management and even their physical appearance without weight loss (inspired by some heavy and muscular athletes). Almost all of them had experienced significant fluctuations in their weight at some time in their lives.

## Data collection and analysis

Data was collected via semi-structured interviews that lasted between 75 and 105 min. The interview script was designed through open-ended questions and organized into eight different themes (weight terminology, general impressions on gym, relation with other gym users, staff, facilities, equipment, dressing, exercise and weight loss). For instance, regarding equipment we asked questions like: *What do you think about the gym equipment? Could you tell us about your experiences with it?* Or, regarding staff: *Did you get along with gym instructors, personal trainers, or other exercise professionals? How did they relate to you?* Following a curiosity-based strategy to expand and verify information of interest (Sparkes and Smith, 2014), during the interview process some participants also contributed with some images that were incorporated as data. All the interviews were transcribed verbatim in parallel with a preliminary analysis, coding and tentative interpretation of the data.

Following Braun et al. (2017), a thematic analysis was carried out to provide sense to the data. These authors describe thematic analysis as an appropriate technique to flexibly capture heterogeneous impressions and open discussion from diverse testimonies about the same reality. Researchers systematically and reiteratively read, reorganised and made descriptive and exploratory comments about the data, highlighting recurrent phrases and ideas as well as key concepts. Based on Lewis et al. (2011), we adopted *direct*, *indirect* and *structural* forms of discrimination as a theoretical/analytical framework to initially organise our thematic analysis. Thereafter, we moved to an inductive orientation, so that the analysis was directed to encapsulate some of the content of the data within this framework. Accordingly, we generated succinct labels (i.e. codes), identifying relevant features of the data that could be used to answer the research question. As the process progressed, these three categories proved to be consistent enough to encompass coding and theme development. Finally, the themes were again checked against the dataset and the theoretical framework for detailed analysis and interpretation.

## Ethics and quality

The research design was assessed and accepted by the Ethics Committee of University of Valencia (Spain). Apart from the requirements of procedural ethics, issues involving *ethics in practice* and *ethics in report* (Palmer, 2016) were also taken into account. In this regard, we were highly concerned about avoiding stigmatizing language by using 'neutral' terminology (e.g. BMI or bodyweight) and the participants' language preference to talk about weight.

The interviewer acted at all times as an active listener inviting the participants to tell their story in their own way and their own words, taking special care not to finalize their

accounts with moral justifications (Sparkes and Smith, 2014). In relation to ethics in report, neutral and biomedical terminology -including BMI or terms like *obesity* and *overweight*- have been used in writing this paper since without them it would not be possible even to consider the weight stigma concept or to identify who are its targets (according to their BMI status). In any case, no pathologizing or medicalising unfounded connotations were intended, since this study forestalls any consideration of the participant's health status, which would be impossible and inappropriate to assess in this context. As an extension to these ethical concerns, and in coherence with its critical design, we follow Burke's (2016) approach to validity, who recommends adopting self-selected and contextually situated criteria to justify and inform about the quality of the findings. In terms of a social, scientific novelty and counter-hegemonic relevance, this research deals with a *worthy topic,* and it is meant to make a *substantial contribution* to the potential improvement of wellbeing and good practices in exercise practices. Its *impact* was translated in the impulse to action that has given rise to research weight stigma from the critical perspective against the dominant weight-centric interests and agents. *Consistency* aimed at finding a valid connection between the pieces of the research process puzzle (literature review, research inquiry, findings, interpretation, paradigms and design), and it was also guaranteed by the figure of critical friends assumed by the researcher team. In relation to *resonance,* which includes transferability and naturalistic generalization, the research findings on weight stigma in gyms and in the fitness culture aimed to delve into beliefs, attitudes and behaviours presenting specific examples of experiences that readers could recognise and relate to their own experiences (Tracy, 2010).

## Results and discussion

### *Direct discrimination*

Direct weight discrimination entails explicit negative attitudes and behaviours against overweight or obese subjects, implying an overt rejection (Lewis et al., 2011; Link and Phelan, 2006). All the participants experienced direct discrimination because of their body weight, although each had different perceptions, reactions and consequences. The majority of these experiences were negative comments about weight and weight loss, physical appearance, health or physical performance. One participant also twice witnessed public humiliation of overweight gym members from both the staff and another user. In coincidence with other studies (Scott-Dixon, 2008; Vartanian et al., 2014), agents or sources of direct discrimination in the gym were the staff, his personal trainer, other users and friends and family members. These results agree with findings in weight stigma research that points to friends, family and strangers as the most prevalent and wellbeing-damaging sources of stigma (Lewis et al., 2011; Lozano-Sufrategui et al., 2016; Scott-Dixon, 2008; Vartanian et al., 2014).

Almost all participants reported events of direct discrimination from gym staff. Mostly, they were an expression of the prejudices about poor health in overweight and obese population, as well as the belief that weight is absolutely controllable and it needs intervention (Donaghue and Allen, 2016; Panza et al., 2018). Martín's experience

with his personal trainer is a good example or that. Essentially, his personal trainer proposed and controlled exercise, diet, weight and physical appearance to an extreme extent which Martín described as military. Once he directed an insulting comment at Martin for his weight, implicitly blaming his weight as a sign of moral deviation (Scambler, 2009):

> 'Do you find it normal to be so fat?' Like that, he [the personal trainer] told me. I didn't take offence at the time, you know. If my self-esteem had been different, I wouldn't have come back [to the gym]. I would have told him, look, I am leaving [laughing]. But no, I took it well. I understood it as if I had to keep on going, it is just another phase and I have to keep going and go through it. I have to go through that *wall*. And with a phrase like this I am not going to be… Nobody is going to get me to… [I have to] Move forward. That's all.

In the interview, Martín recognized that the 'wall' metaphor felt *right*. In fact, his perception was that the exclamation from the personal trainer was coherent with his desire to lose weight. Greenleaf et al. (2019) have documented this kind of verbal aggression in the media. However, verbal aggression from fitness professionals is unusual, although there were no other implicit attitudes and beliefs in the form of cutting remarks and aggressive practices in relation to exercise, diet and body weight (Donaghue and Allen, 2016; Panza et al., 2018).

Daniel reported an experience of being ridiculed by a stranger in the changing room. The first one negatively stereotyped Daniel's body, although it ended up in unsolicited lessons about how Daniel had to work out, with alarmist and reiterative comments about his health and weight.

> A guy started asking me if I had played rugby, because he had been a rugby coach, and [he thought that] that I had a body made for rugby, and that I had to train my legs more, that I had to forget about my upper body, that I had to focus on my lower body. Well, it seemed a cool conversation. But there was a moment when he started insisting too much, like three or four times. 'Being so overweight, you will start having heart conditions. Finally, I said: 'fine, but that is my problem, which is why I go to the gym'. Well, it was quite a scene…

Finally, Martín, Jennifer and Rania told of experiences of direct discrimination with friends and relatives. Jennifer in particular was surprised by a comment about her weight gain and subsequent unsolicited recommendation to go to the gym to lose it:

| | |
|---|---|
| Jennifer: | Then, we were talking and… It is true that when I met him, I was thinner. In the end, he [his friend] told me about my circumstances; 'look at you; you have to go to the gym, if you go the gym…'. |
| Interviewer: | What did he mean by 'look at you'? |
| Jennifer: | [He meant] That I was fatter, as if saying you have put on weight. Then it was simply 'if you want, I mean… go to the gym and it will help you'. |

Episodes of direct discrimination were often followed by negative feelings and emotions, such as humiliation, distrust, disdain of their personal efforts, body self-devaluation, fear, guilt and shame. One participant recalled eating and exercise disorders after receiving constant criticism from significant persons -including gym staff- after breaking his diet and training regimes. Coincidentally, the consequences of weight stigma on health that have been studied and positively correlated in research include depressive symptoms, anxiety, stress, poor self-esteem and weight gain (Pearl and Puhl, 2018).

The specific content of direct discrimination also brought out dynamics of power present in weight stigma. When connected to stigma processes, Link and Phelan (2001; 2006) understand power as a social, political, economic and cultural state that facilitates or obstructs the stigmatized subject's ability to change his/her degree of stigma. As we can see in these experiences, obese participants lack power in comparison to professionals and other gym users who reproduced the dominant obesity discourse in their 'expert' advice and health-alarmist messages. This is possible because they are backed up by the influential political, scientific and popular power that situates the dominant WCHP discourse as the 'true' knowledge (Rail, 2012). Sociocultural, discursive, and political stances blaming the obese population for their condition and highlighting economic costs caused by obesity in the national health systems also act as a backdrop of direct discrimination. (Monaghan et al., 2010). Thence, weight stigma becomes part of an apparatus (concept/process) that Shilling (2007) termed *body pedagogics*:

> …the central pedagogic means through which a culture seeks to transmit its main corporeal techniques, skills, dispositions and beliefs, the embodied experiences typically associated with acquiring or failing to acquire these attributes, and the actual embodied changes resulting from this process (p. 13).

In this regard, weight stigma forms part of the apparatus of the body pedagogics of healthism. The simple rationale is that to *be* a fat body is the reverse of a healthy body. Insofar as healthism put the blame on individuals' behaviors, fat bodies then become a legitimate target of discrimination by those who fulfill body norms.

Insofar as it upholds an idea(l) of a 'fit body' that matches with values of discipline, beauty, optimal health, productivity and individualism (Sassatelli, 2010), the fitness culture also participates in these power dynamics that support direct discrimination. Thus, following Link and Phelan (2001), in this context the obese bodies become the "them": an outgroup category receiving all negative attributes. When *they* lack power, these otherness processes may, ultimately, result in direct discrimination.

## *Indirect discrimination*

Indirect discrimination is not exerted overtly and occasionally, but surreptitiously and steadily. However, the internalization of negative stereotypes on body size indirectly influences exercise experiences, usually situating obese gym users in disadvantage in relation to lighter or slimmer users (Lewis et al., 2011).The following feelings and experiences were identified in research participants as manifestations of indirect discrimination:

stereotype consciousness, feelings and fear of being stared at, being laughed at, and judgments; indifferent or rude treatment and self-stigma.

The negative stereotyping of fat persons in western societies mainly gravitates around a belief in their inability to exert self-control over diet and exercise (Rich and Mansfield, 2019). *Stigma consciousness* refers to the subjects' expectation of being negatively stereotyped regardless of their behaviour (Pinel, 1999). With some divergences, this phenomenon was explicitly referred to by Daniel and Jennifer. Daniel rejected the stereotype due to negative past experiences that involved biased exercise recommendations from gym staff: 'they [gym instructors] had a lot of prejudice about that. I mean, you are fat, so you have to go on a stationary bike, lose weight and when you get thinner you can lift weights'. Jennifer confessed her own stereotyped opinion about overweight and obese gym users, like herself:

Interviewer: If we asked someone their opinion about the relation between fat people and exercise, what do you think they would say?

Jennifer: I guess [they would say the same as] what I think when I see a fat user. This person is not going to last [working out] in the gym [laughs] […]. The [typical] fat girl profile that I have seen is the one who wants to lose weight and that is why she joins the gym, and starts in the running treadmill. And you see her and think that she is going to go [to the gym] for one week and she is not coming back again. And it is usually like that.

These negative attitudes that are related to stereotypes towards obesity are the most common not only among fitness and exercise professionals but also among many other professionals in health-related jobs, who hold the belief that body weight is an absolutely controllable parameter (Diedrichs and Puhl, 2017; Rubino et al., 2020).

Participants also experienced indirect discrimination by means of fear of people gazing at them. The participants' feared being stereotyped as unhealthy, fleshy and abject, particularly in changing rooms. In this respect, discourses of body normalcy present in locker rooms fuel their learnt expectations of rejection and devaluation from others (Fusco, 2006). Fear and shame also worked as an anticipatory mechanism against possible discriminatory situations (Link and Phelan, 2001). Wittels and Mansfield (2019) remark the complexity of negative *and* positive feelings that can intertwine in the experiences of obese exercisers. Exercises that could be hampered by body weight are particularly feared. For instance, Rania described fear and shame dynamics when performing pull-ups, an exercise in which weight notably affect physical performance:

> I know that they [pull-ups] are going to be very hard [for me] and I know that at first, I will not be able to do them. Then I feel shy when I think that people are going to stare at me and they are going to tell me, 'How in the world are you going to lift that weight, dummy? It is impossible for you to lift that.'

The treatment by gym staff was also reported as a cause of distress. As reported in the literature, the participants often received well-meaning unsolicited advice and encouragement to lose weight (Myre et al., 2020; Pickett and Cunningham, 2018). However, Víctor also perceived indifference, rudeness, and unfriendly and unhelpful treatment from the gym staff, receiving less helpful attention than other users who, in his words, better fit the 'fitness body ideal'. Víctor's gym partner also realised this, and told him, 'Sometimes I went training with a friend who ended up agreeing with me. "No, he [the instructor] does not treat you as he treats me". He [his friend] is a firefighter [laughs]'.

> Yes, he [instructor] did not only look at them in a different way, but he even chatted with them and he was there helping them in a thousand things with barbells, dumbbells and so on. He advised each of them. And they used to be a small group of good-looking people. And my friend David still goes to that gym, he hasn't quit precisely for that reason, because the attention is sublime when you are a top person.

Stigma processes, such as stereotyping or exclusion, are often embodied and interiorized, provoking self-discrimination, i.e. learnt self-devaluation and personal insecurity attributed to an excess of weight (Link and Phelan, 2006; Meadows and Higgs, 2019). Rania, Jennifer and Martín in their testimonies explained how self-discrimination affected their participation in the gym. For instance, Martín, who had lost more than 30 kg in the last two years, confessed to being afraid of regaining his previous weight, which had made him feel upset and uncomfortable with his self-image. He ascribed his excessive weight solely to overeating and the negative stereotype of being a glutton.

> Interviewer: Do you think you could train and feel good with your previous weight without focusing on losing weight?
>
> Martín: If I could… [Silence and thinks for a moment]. No, I wouldn't be able to, because I wouldn't feel comfortable with my appearance. I don't know… 130 kilos… That's a lot. And you don't feel comfortable. I believe that I don't think I would feel comfortable working out [with that weight]. In fact, I don't want to weigh so much ever again. Actually, I have learnt a lot now. I have learnt how to eat [properly]. That is good and important. I used to devour [food] like a duck before. Ducks just swallow and that's all, and so did I.

Weight self-stigma is a generalised narrative among overweight and obese physical activity practitioners in a variety of spaces, facilities and contexts (Groven et al., 2011; Pickett and Cunningham, 2018). As seen in the former quote, obese persons' embodied self-concept and self-esteem are rather vulnerable, and ideals of physical appearance and body projects in gyms may foster weight self-stigma (Mansfield, 2011). It is important to highlight that, though fitness professionals do not overtly engage in direct discrimination, their actions and beliefs may have important and pervasive effects as indirect discrimination. In this regard, quantitative research has contributed to shedding light on the

relationship between discrimination and self-stigma, for instance, providing evidence on the effects of implicit anti-fat bias of fitness professionals on obese persons' psychological maladjustments (Carels et al., 2010; Robertson and Vohora, 2008), or the importance of shame-free environments as a consideration for obese persons when selecting a gym (Meadows and Calogero, 2018; Schvey et al., 2017).

### *Structural discrimination*

Structural discrimination is the explicit or symbolic disadvantage originated by institutions and environments that includes a wide range of practices (e.g. architectonic/spatial, selection of practices, processes at work, funding, or exclusive policies) (Link and Phelan, 2001). In the physical activity-related weight stigma literature, some of the most common examples are: inappropriate equipment for their size or weight, lack of adaptation to activities, work discrimination in the fitness industry, physical activity-related weight-centric messages in physical culture and public exercise and health recommendations (Lewis et al., 2011; Myre et al., 2020; Pickett and Cunningham, 2018; Rich and Mansfield, 2019).

The first structural element analysed is the selection of activities in gyms. Despite the wide offer available in gyms, most participants claimed that staff recommended a very few types of exercise (namely cardiovascular exercise) as the *most* appropriate for obese, considering their supposed advantages in weight loss. We will call this *weight-centric exercise*. It could be argued that weight-centric exercise fosters the omnipresent interest in weight-loss as the central motive of exercise (Wittels and Mansfield, 2019). In the following quotes, Jennifer and Daniel relate how they were recommended to use the treadmill, and the problems that running involved for them:

> Jennifer: Since the very beginning they told me that the best thing for me was running. But, of course, me running…! As I get in shape maybe yes, but for the present can't do it. I can't run a lot because my knees can't hold.
>
> Daniel: They [gym staff] always insist that cardio [cardiovascular activities] is the best for me. Well, for example, eh… do treadmill! But I can't run because I destroy my ankles and my knees really screw up. So, in that sense there are things that I don't do directly because I weigh too much.

The predominant prescription by gym staff of weight-centric exercise reinforces the dogma that obese people must exercise for weight-loss reasons, and that bodyweight is effectively controllable through exercise (Donaghue and Allen, 2016). With this regard, weight-centric exercise should be *the* restorative measure offered by gyms to improve bodies, exaggerating the effects of exercise on weight loss (Swift et al., 2018). The automatic prescription of weight-centric exercise for obese persons is associated with body dissatisfaction, a desire for thinness and feelings of self-devaluation and distress, typical of weight stigma (Groven et al., 2011; Pickett and Cunningham, 2018; Pudney et al., 2020).

The dogma of weight-centred exercise is not only found in the beliefs about the goals and motives for training. It can also be seen in the equipment present in gym facilities. In this sense, Rania produced a picture of a running treadmill with a graphic representation of a training program for fat people to become slim (Figure 1). The stigmatising effect of that image is highlighted in her comment: 'If you are fat, as in the picture (because if you are slim, you don't have to, of course), your aim must be to lose weight':

Another stigmatising structural element was accessibility to certain equipment (Lewis et al., 2011). Because of his size, Daniel (the largest participant) experienced regular incidents. Once his thigh got stuck in the pull-down machine and the instructor had to come to help him release it, making Daniel feel embarrassed. Daniel also had several problems with stationary bike seats which did not fit him and caused him gluteus injuries and put him off using them. These humiliating situations often involve micro-aggressions such as derogatory reactions, laughing, looks and jibes (Owen, 2012). According to Owen (2012), constant worrying and evaluation about own size and physical space may lead either to disembodiment or hyper-consciousness of one's own body, which in the end results in negative feelings, anxiety and avoiding social contact.

Images of lean and muscular bodies that can be seen in many gyms have been reported as elements of structural discrimination (Myre et al., 2020). Víctor contributed an advertisement of a weight loss contest in a gym he attended some years ago (see Figure 2), a contest reminiscent of the famous and international weight loss TV shows such as *The Biggest Loser* or *Diet War*. In general terms, some critical qualitative researches have exemplified the potential effects of this kind of TV show in weight stigma processes. This would entail the mocking and trivialising of weight, the restrictive cultural norms of femininity and ethnicity, or the presentation of inaccessible, unrealistic and unhealth weight loss practices, among others (Greenleaf et al., 2019; Thomas et al., 2007)

According to Víctor: 'afterwards they give you a diploma saying, "we have lost 200 kilos altogether. The participant with the biggest weight loss is Puri, who has lost 15 kilos"'. The contest included sessions with a dietician which the participants could consult as a group. Víctor explained it by the following simile: 'they are like Alcoholics Anonymous meetings for fat people'. Víctor finally expressed his rejection towards the contest:

Interviewer: Why didn't you participate in the contest?

Víctor: Because it was absurd. I mean, these weight loss marathons are even offensive. You know, it is a medical issue, which is serious. It is not just the fact of being there… I don't know… As if it were a TV show.

Since Gastón attended the same gym at the time of the interview, he was shown the advertisement of the contest as a photo-elicitation resource. Although he was not aware of the challenge, he gave his negative opinion as he was aware of its potential health risks such as rapid weight loss, malnutrition and eating disorders.

Gastón: But I think it is bad for your health because it may be too much weight to lose in such a short period of time. So, I

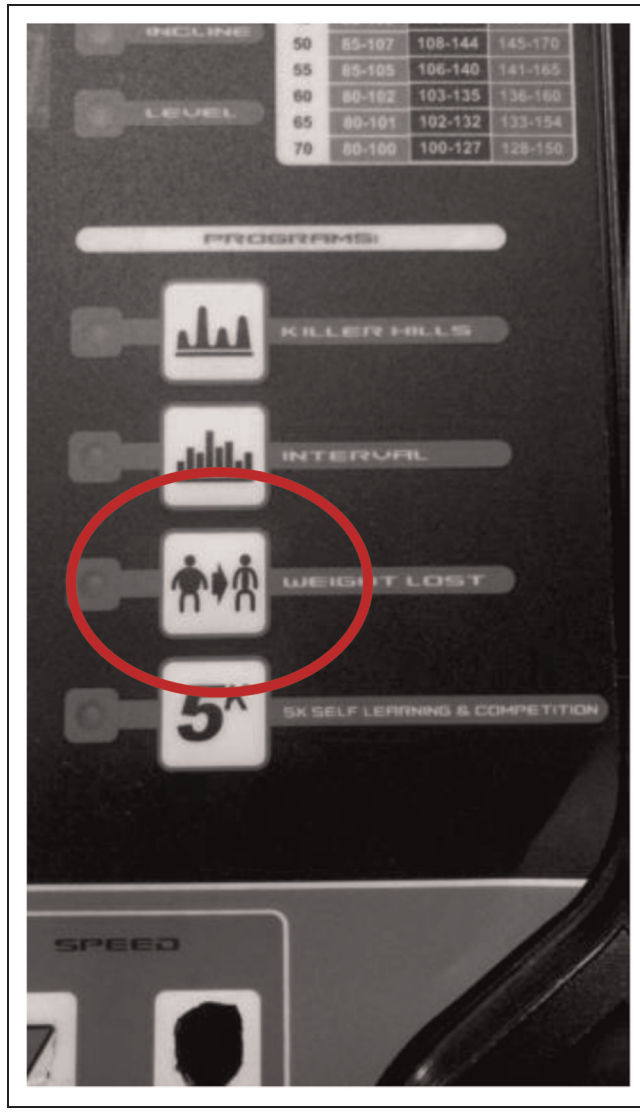


**Figure 1.** Weight-centric Exercise in a running treadmill.

think it is probably the most stupid and toxic thing they could ever have organised.

Interviewer: Why is it toxic?

Gastón: Because it could make someone end up with an eating disorder. It is something like…that participant has lost one kilo more than me this week, so I'll only eat broccoli

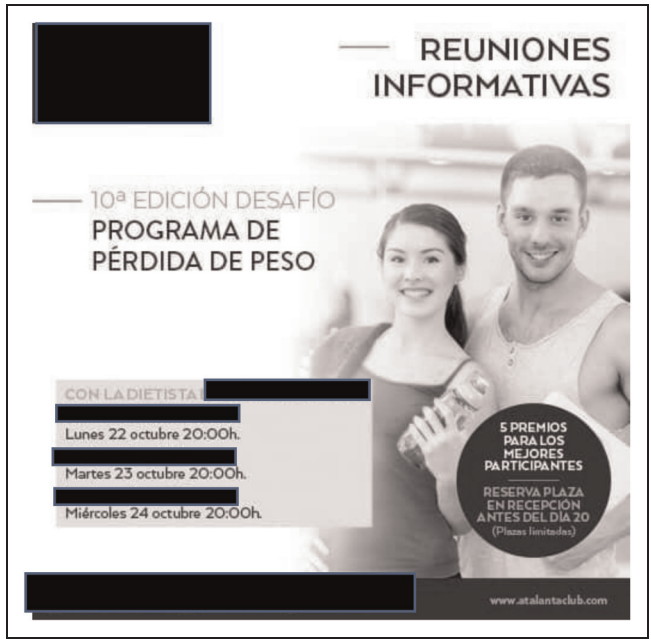


**Figure 2.** Weight loss contest advertisement.

> this week. I don't know, you are driving people to malnutrition. Even if broccoli is nutritious, [the contest] is utterly stupid.

The last structural element to be outlined was mirrors. Mirrors are everywhere in many gyms to the point of making it impossible to avoid seeing your own body. Rania and Víctor in fact indicated body self-devaluation feelings related to self-stigma caused by feeling embarrassed at seeing their reflections. For instance, Rania was very explicit when reporting the negative feelings (e.g. hate, disgust, uselessness and guilt) and the behaviours they brought about:

> Rania: I deeply hate watching me exercising. I can't stand it. It is like all my body is shaking and it is horrible. I hate it. I hate it, hate it, I hate it. And I must say, for example, the whole wall in gym classes is covered in mirrors. It is hard, so I always try to place myself at the back. Firstly, as a way to be less obvious, as always. And secondly, I see myself less if I'm in the middle of a group. Totally. Because I hate seeing myself and I feel that, as I have a lot of body fat, it is more difficult to see my posture [while exercising]. I don't know if I am making myself

clear. It feels as if it is more difficult to see if I am squatting properly or not, if I am doing the exercise properly or not… And I think to myself, 'Agh!' [expresses disgust]; I feel enraged when I can't see it properly or sometimes, I even feel that when you are squatting you descend less, because there is more body fat. Or when you have to jump, I don't like it at all. And when I am lifting weights in the gym, I look at myself once to make sure the form is right, and that's it, I don't look again.

Interviewer: How do these situations make you feel?

Rania: They make me feel guilty. It's like…since you are fat, you have to lose weight.

There has been little research on the use of mirrors in physical activity-related weight stigma, but the available examples found perceptions that showed some people avoided them, did not recognise their own bodies and self-stigma (Groven et al., 2011; Owen, 2012). Nevertheless, it is worth noting that objects such as mirrors currently play a paramount role in body self-evaluation rituals (*mirror checking*) (Cash, 2012). As is the case with fitting rooms in some clothing stores, *skinny mirrors* may be used in gyms because they make people thinner, as has been reported by different media (e.g. fitness forums and blogs) (Carreres, 2016). They work in the same way as mobile phone applications that allow the viewer to *edit* their body image to make it look better, so that it appears to coincide with the normative weight. This particular use could therefore reinforce the fear of gaining weight and body fat as well as becoming overweight or obese.

Synthesising, embedded in the WCHP, structural discrimination represents the foundation of the institutional and political power of weight stigma, which the fitness culture nurtures from. Some elements present in exercise prescriptions, marketing and the materiality of gyms do not only ignore obese population; they normalize weight stigmatizing practices and behaviours, providing a justification for them (O'Hara and Taylor, 2018).

## Conclusions and implications

This study on weight stigma presents evidence and interpretations of different discrimination stances which obese users have experienced at the gym. It provides knowledge on some worthy, essential, impacting and ethical manifestations of direct, indirect and structural discrimination experiences. To some extent, all participants have experienced weight stigma in gyms. Although events of direct discrimination are acute, stigmatization associated with the internalization of body weight stereotypes (i.e. indirect discrimination) is most pervasive, while the conception of weight-centric exercise remains as a concealed though powerful form of structural discrimination wholly affecting obese gym users' experiences. The results reflect how subjective experiences and structural components of weight stigma work in combination. Not surprisingly, obese people are underrepresented in gyms. Thus, this knowledge is important to understand the barriers

faced by obese gym users, as well as to address possible actions towards the promotion of their participation in gyms and, in general, in different exercise environments.

The main contribution of the study to the physical activity and weight stigma literature is, on the one side, a deep and focused examination of gyms as settings in which weight stigma is enacted. Some of the results reinforce and/or extends the knowledge generated in other physical activity settings, while others depict novel issues specifically concerning weight stigma in gyms, such as weight-centric exercise, marketing strategies or the role of certain equipment and facilities. On the other hand, the theoretical/analytical framework enriches a contextualized and interrelated understanding of weight stigma and discrimination as phenomena personally experienced, though connected with macrosocial power dynamics (i.e. scientific, economic and political). The intersection between personal, social, and cultural dynamics traced in this paper facilitates the visibility of social gaps and hidden issues that affect weight stigma, and provides a hint on how the 'arteries of oppression' (Fine et al., 2008, 174) circulate across different levels of direct, indirect and structural discrimination. Finally, the study chiefly contributes to the accumulation of qualitative research in the field of Fat Studies and Critical Weight Studies to gain strength against the WCHP.

However, this study has some limitations which should also be highlighted. As noted in the Methods section, the obese persons that are already gym users may have overcome certain difficulties and hindrances associated with weight stigma, so that their testimonies may not accurately reflect the barriers experienced by obese persons that *may* become gym users. Besides, following an ideal critical design, the study should have included an intervention to reduce weight stigma. These points remain open for future studies.

In any case, the results of the study mainly impact ethic and institutional-managerial issues in gyms and the dominant fitness culture involving professional behaviour. Souza and Ebbeck (2018) highlight education and professional codes of conduct as an important and feasible axis of change to improve attitudes towards obese users in the fitness culture. Hence, fitness professionals must be trained in weight stigma, and consider inadmissible professional attitudes towards overweight and obese users and activities that involve negative, discriminatory, unsafe and fraudulent content. Based on the research findings, a list of specific recommendations is compiled in Table 2.

These recommendations would help to set and adjust particular actions that may foster the prevention of weight stigma in gyms. However, due to the intersectional nature of weight stigma, implications of this study cannot be reduced to a 'fit all' set of policy/pedagogic/practical tips. Thence, the limits of these or any other specific recommendations to address weight stigma are inherent to the complexities of the phenomenon, which involve sociocultural and attributional explanations and processes (Diedrichs and Puhl, 2017). The core message would be that a full socio-cultural shift around the body, its meanings, and a critique of neoliberalist body cultivation practices is required. Thence, it would be necessary to perform a political and economic transformation of the current understandings and policies regarding obesity, health and physical activity, which are predominantly weight-centric, stigmatising and individualistic (Nature Reviews Endocrinology, 2020).

To advance in this global agenda, actions against weight stigma need to join synergies that focus on wealth and income inequality, improvement and general access to national and public health systems, healthy food, as well as accessible and stigma-free

**Table 2.** Recommendations for weight stigma prevention.

| | | |
|---|---|---|
| GYM STAFF | **Code of conduct evaluation** | → Attitudes towards obesity (e. g. beliefs and stereotypes).<br>→ Interest in working with populations with special needs. |
| | **Communication** | → Weight terminology knowledge and knowing customer preferences.<br>→ Avoiding stereotyping in verbal interactions (e. g. about fat excess causes) and no verbal behaviour (e. g. facial expressions).<br>→ Reporting scientific-based weight loss exercise knowledge (e. g. chance of achieving a clinically significant weight loss of 5-10%). |
| | **Appearance** | → Avoid weight discrimination. Evaluating training, knowledge and other (inter) personal skills.<br>→ Loose outfit (no tight clothes). |
| | **Training** | → Providing knowledge about weight stigma (e. g. causes, consequences, discourses, agents, self-stigma, etc.) and weight inclusive health and physical activity perspectives. |
| FITNESS SETTINGS AND INDUSTRY | **Equipment Spaces** | → Enough machines and benches with different sizes, adjustable and with enough load capacity.<br>→ Ensuring enough space between materials.<br>→ Spacious changing rooms and accesses, chair without armrests, etc.<br>→ Mirror-free spaces. |
| | **Techniques** | → Avoiding evaluations without previous consent. Considering risk-benefit before anthropometry assessments involving weight, BMI or body fat. Opting in favour of performance, pain, health and quality of life assessments.<br>→ Considering risk-benefit weight-centric exercise prescriptions. Opting in favour of individualised prescriptions addressing motor performance, personal preferences, safety and positive feelings. |
| | **Images, messages and marketing** | → Promoting body diversity.<br>→ Limiting body and performance appearance ideals and avoiding sexualised attitudes (e. g. Half-naked)<br>→ Banning stigmatising representations of obesity (e. g. insulting, blaming and stereotyping).<br>→ Banning dishonest weight loss messages that share weight and body beliefs such as a total volitional control (e. g. Body ideals attainability) or blaming messages that encourage compensatory exercise. |

fitness programs to improve the population's health and enjoyment of physical exercise (with or without weight loss) (Monaghan et al., 2011; Rail, 2012). Besides, following Link and Phelan (2001; 2006), stigma cannot be effectively prevented without political, economic, cultural, and social power that favour the stigmatized population. In this case, this is only possible by gaining influence and power on scientific, educational, and health structures and institutions towards the configuration of a network of 'critical weight entrepreneurs' to challenge the WCHP (Monaghan, 2017; Monaghan et al., 2010).

Finally, we address a suggestive question risen by a reviewer: how would a stigma-free gym look? As we have shown in the results, there would be fitness facilities and equipment adequate for different sizes and body weights, as well as marketing, policies, and conduct codes that would take into account not only weight stigma, but other forms of embodied discrimination. However, we agree with Souza and Ebbeck (2018) that an alternative weight stigma-free gym would not be exaggeratedly different from the current ones, except for their exercise professionals, who would be aware of, and sensitive to weight stigma and critical weight knowledge, as well as trained in specific exercise techniques and strategies to individualize exercise programs to the obese population. Therefore, a priority is to sensitize the fitness culture, industry and the contexts in which fitness professionals are educated to gain awareness of their potential contribution to improve safety and satisfaction among overweight and obese gym users, thus making it possible for them to have gratifying experiences, as well as affirmative meanings about physical activity, themselves and others.

We believe that gyms and fitness culture (involving activities, environments and staff) can be determinant to improving health and encourage the general population (including obese people) to exercise. However, in doing so they should avoid weight stigma. A respectful, safe and efficient link between gyms and obese population would benefit both. This could be a worthwhile and practical roadmap for future actions.

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