DISABILITY IN THE GYM: PERCEPTIONS AND UNDERSTANDINGS ABOUT INDIVIDUALS WITH DISABILITIES

by

LJUDMILA ZALETELJ

B.A., University of Ljubljana, Slovenia, 2009

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The following individuals certify that they have read, and recommended to the Faculty of Graduate and Postdoctoral Studies for acceptance, the thesis entitled:

Disability in the gym: Perceptions and understandings about individuals with disabilities

Submitted by Ljudmila Zaletelj in partial fulfillment of the requirements for the degree of Master of Arts in Kinesiology

Examiner Committee:

Dr. Andrea Bundon, Kinesiology
Supervisor

Dr. Brian Wilson, Kinesiology
Supervisory Committee Member

Dr. Peter Crocker, Kinesiology
Supervisory Committee Member
Abstract

Obtaining and maintaining health is vitally important to people with disabilities, especially when you consider the fact that they report low standards of health (Carroll et al., 2014; Drum et al., 2005; WHO, 2011). One of the key reasons for their poor health conditions is their lack of engagement in physical activity and exercise (Rimmer et al., 1996; Schoenborn & Barnes, 2002; Washburn et al., 2002). Gyms have been recognized as important environments in which individuals with disabilities can engage in physical activity and exercise and positively influence several aspects of their well-being (Calder et al., 2018; Richardson et al., 2017a, 2017b, 2017c). As trainers and instructors have been recognized as an essential element of supporting positive gym experiences (Martin & Smith, 2002; Richardson et al, 2017c), it is essential to uncover their understanding of disability and individuals with disabilities. Using semi-structured qualitative interviews with 12 trainers and instructors, this research critically explored personal trainers’ and instructors’ understanding of disability and the potential impact of these perceptions and understandings on the experiences of people with disabilities when they visit the gym. The findings revealed that trainers and instructors understood disability as a lack of ability and a deviation from a common norm. Individuals with disabilities were perceived as an anomaly from the desired able-bodied standard. Moreover, the findings highlighted that fear of inability to design and implement adequate and safe training sessions posed a barrier as it discouraged trainers and instructors from working with individuals with disabilities. However, when trainers and instructors did work with clients with disabilities, they did not only have positive experiences but they also felt they developed a more holistic practice as a result of this experience.
Lay Summary

Personal trainers and instructors were interviewed to explore how disability and individuals with disabilities were perceived and understood and how those perceptions and understandings broke down or reinforced barriers for people with disabilities when they visit the gym. The findings revealed that trainers and instructors understood disability as a lack of ability and a divergence from the accepted norm. Additionally, individuals with disabilities were mainly perceived as a deviation from the able-bodied standard. Moreover, the findings illustrated that fear was an important perception that discouraged trainers from working with clients with disabilities. Finally, the findings highlighted the key role experience played in trainers’ perceptions and understandings of disability and explored how being experienced in working with this population developed their general practice.
Preface

This thesis is original, unpublished, independent work by the author, Ljudmila Zaletelj.

This research was approved by the University of British Columbia's Behavioural Research Ethics Board (H18-01842). A version of this work will be submitted for publication.
# Table of Contents

Abstract ........................................................................................................................................ iii
Lay Summary .................................................................................................................................. iv
Preface ........................................................................................................................................ v
Table of Contents ......................................................................................................................... vi
List of Tables ................................................................................................................................. viii
Acknowledgments ......................................................................................................................... ix

## 1. Introduction .............................................................................................................................. 1

## 2. Literature Review .................................................................................................................... 5

### 2.1 Theoretical Approach ........................................................................................................... 5

#### 2.1.1 Symbolic Interactionism ................................................................................................. 5

#### 2.1.2 Biopower ......................................................................................................................... 6

### 2.2 Disability models ................................................................................................................. 7

#### 2.2.1 Medical model of disability .......................................................................................... 7

#### 2.2.2 Social Model of Disability .......................................................................................... 8

#### 2.2.3 Critical Disability Studies ............................................................................................ 12

### 2.3 Concepts in Critical Disability Studies .................................................................................. 14

#### 2.3.1 Ableism ......................................................................................................................... 14

#### 2.3.2 Disablism ....................................................................................................................... 16

#### 2.3.3 Otherness ....................................................................................................................... 17

### 2.4 Benefits of Physical Activity and Exercise for People with Disabilities ......................... 18

### 2.5 Barriers to Physical Activity for People with Disabilities ................................................. 21

#### 2.5.1 Individual Barriers ........................................................................................................ 21

#### 2.5.2 Environmental Barriers ............................................................................................... 22

#### 2.5.3 Social Barriers ............................................................................................................. 22

### 2.6 Gym as an exercise domain for people with disabilities .................................................... 24

#### 2.6.1 Fitness Trainers and Instructors .................................................................................. 26

### 2.7 Gaps in the Existing literature ............................................................................................. 27

## 3. Methodology .......................................................................................................................... 30

### 3.1 Paradigmatic Standpoint ...................................................................................................... 30

### 3.2 Method ................................................................................................................................. 32

#### 3.2.1 Interviews ..................................................................................................................... 33

### 3.3 Sample ................................................................................................................................ 34

#### 3.3.1 Recruitment .................................................................................................................. 37

### 3.4 Data Analysis ...................................................................................................................... 39

### 3.5 Ethical Considerations ......................................................................................................... 41
3.6 Insider Status and Reflexive Journaling ............................................................. 42
   3.6.1 Navigating through difficulties during the research process ..................... 48
4. Findings and Discussion ...................................................................................... 52
  4.1 Participant’s Background and Training Experience ........................................ 53
  4.2 Impairment ...................................................................................................... 55
     4.2.1 Lack of Ability ......................................................................................... 55
     4.2.2 Irregularity .............................................................................................. 58
     4.2.3 Difference ............................................................................................... 60
     4.2.4 Discussion of Theme: Impairment ........................................................... 61
  4.3 Fear .................................................................................................................. 64
     4.3.1 Fear to take on a client ........................................................................... 65
     4.3.2 Fear of Injury ......................................................................................... 69
     4.3.3 Fear of Inability ..................................................................................... 71
     4.3.4 Discussion of Theme: Fear ..................................................................... 72
  4.4 Experience ....................................................................................................... 74
     4.4.1 Personal Experience ............................................................................... 75
     4.4.2 Training Experience ............................................................................... 82
     4.4.3 Discussion of Theme: Experience ............................................................ 90
  4.5 Trainer’s Benefit ............................................................................................. 92
     4.5.1 More Trainable Clients .......................................................................... 93
     4.5.2 Better Trainer ....................................................................................... 98
     4.5.3 Discussion of Theme: Trainer’s Benefit .................................................. 101
5. Conclusion ........................................................................................................ 103
  5.1 Practical Implications ..................................................................................... 106
  5.2 Project Limitations ......................................................................................... 108
  5.3 Future Research Implications ........................................................................ 109
Bibliography .......................................................................................................... 111
Appendices ............................................................................................................. 134
   Appendix A: Letter of Introduction ................................................................. 134
   Appendix B: Consent Form ............................................................................... 136
   Appendix C: Recruitment poster ....................................................................... 138
   Appendix D: Online recruitment poster ............................................................. 139
   Appendix E: Interview guide ............................................................................ 140
   Appendix F: Demographic Information Questionnaire .................................... 143
List of Tables

Table 1: Interview Information ........................................................................................................ 35
Table 2: Participant Demographic Information .................................................................................. 37
Table 3: Themes and subthemes ........................................................................................................ 52
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Dedication

For every individual who has been mistreated because s/he was labelled as being atypical.
1. Introduction

My primary interest in research is the wish to help establish better living conditions for marginalized and oppressed groups, such as people with disabilities\(^1\). In addition, through my work as a personal trainer I was able to recognize the pivotal role trainers assume in the gym milieu. For this reason I decided to embark on the journey presented in this paper. This study explores and analyzes the attitudes, perceptions, and understandings of personal trainers and instructors in regard to disability and people with disabilities. In addition, the study examines if and how these perceptions and understandings break down or reinforce barriers for people with disabilities when they engage in physical activity and exercise in the gym milieu. By drawing on the existing literature on disability and physical activity with a specific focus on disability in the gym environment, this interview-driven qualitative study was undertaken to enhance knowledge of disability in the gym context and attempted to uncover how personal trainers’ and instructors’ perceptions and understandings informed their interactions with clients with disabilities.

The importance of addressing this subject matter becomes apparent with the recognition of disability as a worldwide phenomenon. In 2011, the World Health Organization reported that more than one billion people experience some sort of a disability. Because of the ageing of our population and the global increase in chronic health conditions the number of people with disabilities is on the rise (WHO, 2011). With the growing numbers of individuals with disabilities, the realization that disability is all around us (Garland-Thomson, 2005, 2016),

\(^1\) A note on Language – where possible ‘person first’ terminology (i.e. ‘individuals with disabilities’) was used. Although the term ‘disabled person’ is preferred in certain jurisdictions, I decided to emphasize the person rather than the disability.
and with the understanding of disability as “a social process that intimately involves everyone who has a body and lives in the world of the senses” (Barton, 1993, p. 2), it is significant to explore and uncover how disability is perceived and how those perceptions shape people with disabilities’ everyday lives.

Regular physical activity and a healthy diet are two major components of promotion and maintenance of good health throughout the life span (WHO, 2002). People with disabilities disclose substantially lower standards of health (Altman et al., 2008; Carroll et al., 2014; Chen et al., 2010; Dixon–Ibarra & Horner–Johnson, 2014; Drum et al., 2005; Froehlich-Grobe et al., 2013; Leser et al., 2017; Reichard et al., 2011; Rimmer & Marques, 2012; Valis & Gonzalez, 2017; WHO, 2011). One of the key reasons for poor health conditions of individuals with disabilities is their lack of engagement in physical activity and exercise (Cooper et al., 1999; Rimmer et al., 1996; Schoenborn & Barnes, 2002; Washburn et al., 2002). Additionally, a host of benefits have been recognized in relation to physical activity for this population. Namely, involvement in physical activity and exercise enhances their physical (ICF, 2015), psychological (Allen et al., 2004; Anderson & Heyne, 2010; Blinde & Taub, 1999; Gorgey, 2014; Kosma, et al., 2007; Martin Ginis & Latimer, 2006; Williams et al., 2012) and social (Anderson, 2009; Hansen et al., 2003; Holt & Neely, 2011) health. For those reasons, the need to increase physical activity levels among individuals with disabilities has been acknowledged as a priority (Valis & Gonzalez, 2017).

Despite having identified the problem of physical inactivity among the population of people with disabilities and recognizing the gym as a suitable space for their participation in sport and exercise (Richardson et al., 2017abc), very little research has explored the gym as a
possible exercise domain for this population. Existing research in the context of disability in physical activity and exercise settings has predominantly focused their attention on recognizing various benefits of physical activity (Arbour et al., 2007; French & Hainsworth, 2001; Martin, 2013; Martin Ginis et al., 2012), facilitators, promoting engagement in exercise (Tyrell, 2010; Williams et al., 2014), and barriers individuals with disabilities experience when they participate in physical activity and exercise (Calder et al., 2018; French & Hainsworth, 2001; Martin, 2013; Mulligan et al., 2012; Rimmer et al., 2004b; Rimmer, 2005; Rolfe et al., 2009). Only a single sociological study has examined individuals with disabilities’ experiences of exercising in the gym milieu on their own (Richardson et al., 2017c) or as a part of a group (Richardson et al., 2017a), and highlighted how disabled instructors influence the gym environment (Richardson et al., 2017b). Even though trainers and instructors maintain a significant role in the promotion and adherence to physical activity (De Lyon et al., 2017; Oprescu et al., 2012) and have been acknowledged as a vital element of individuals with disabilities’ positive gym experience (Martin & Smith, 2002; Richardson et al., 2017c), no research to date has focused on gym personnel and their understandings of disability.

Building on previous research, this study aims to add to the existing knowledge about disability in the gym milieu and bring a greater insight into the subject of disability in this context (Chenail et al., 2010). Recognizing this gap, the study not only attempts to add to the literature that has examined disability and physical activity through a sociological lens, but also strives to answer Richardson and colleagues’ (2017c) request for further research on the subject of disability in the gym environment. By acquiring insight into trainers’ and instructors’ perceptions and understandings of disability and people with disabilities, the study highlights
how those perceptions and understandings inform this populations’ experiences when they engage in physical activity and exercise in the gym. Furthermore, analysis of trainers’ experiences of working with clients with disabilities in the gym context also uncovered how trainers can be better educated and supported in order to establish more inclusive gym experiences. In this context, the following research questions were pursued: How do personal trainers and instructors understand disability and people with disabilities? What perceptions or understandings are associated with breaking down or reinforcing barriers for people with disabilities? By exploring personal trainers’ and instructors’ perceptions and understandings of disability and difficulties and obstacles they encounter when going to the gym, this research brings light to the little examined topic. Since individuals with disabilities are an integral part of society, it is important to address the gaps in literature if we wish to improve their exercise experience and add to a greater social inclusion of this growing population.
2. Literature Review

This section represents an overview of the pertinent literature for this research. First, I introduce the theoretical lenses utilized in the study. Second, I turn my attention to critical disability studies and highlight the concepts from this field that are most relevant to this work. Next, I will present the literature on health and physical activity levels of individuals with disabilities with particular attention to the benefits of physical activity and exercise for this population and the barriers that they encounter when trying to be physically active. Lastly, I provide an overview of the research that has explored the gym as an exercise domain for people with disabilities.

2.1 Theoretical Approach

The philosophical assumptions underlying this study draw mainly on the frameworks of symbolic interactionism and biopower. Symbolic interactionism argues that human beings create meaning through social interaction and this process then creates human social reality (Blumer, 1969). Biopower can be understood as having power over one’s body and is a way of achieving the subjugation of bodies and the control of populations (Foucault, 1990).

2.1.1 Symbolic Interactionism

Symbolic interactionism is a theoretical approach for understanding the relationship between human beings and society (Polk, 2017). In accordance with symbolic interactionism, a person is always in interaction with their own self, other people, and their environment (Charon, 1979). Through the process of social interaction human beings create meaning and social reality. Symbolic interactionism attempts to better understand how individuals interact
with one another to create symbolic worlds, and in return, how these worlds shape individual’s behaviors (Blumer, 1969). Furthermore, according to Festinger (1954) all human beings have a need to compare themselves with others, when they equate themselves with either the reference group others or with generalized others.

Symbolic interactionism has been used as a theoretical framework in studies of disability in the past (De Klerk & Ampousah, 2003; Roe et al., 2010). The social construction of reality is highly relevant when considering how people (including personal trainers and instructors) make sense of disability and behave in relation to individuals with disabilities. The theory of symbolic interactionism provides an appropriate framework for studying the aspects of social interaction between individuals with disabilities and their social environment, including their interactions with trainers and instructors in the gym. Additionally, symbolic interactionism also explains trainers’ and instructors’ need to compare people with disabilities with the reference group others (other individuals exercising in the gym).

2.1.2 Biopower

Foucault describes biopower as an array of various techniques for subjugation of bodies and control of populations (Foucault, 1990). He writes that there has been a shift from the power of discipline to the power of biopolitics, namely from a right to ‘take life or let live’ to the power to “foster life or disallow it to the point of death” (Foucault, 1978, p. 138). Biopower does not deal with subjects whose ultimate authority is death, but it rather deals with living beings and takes charge of their lives and gains access to their bodies (Foucault, 1978).

Workings of biopower shine through the ways society regulates our notions of proper ways of living and existing, of how we are supposed to take care of our bodies, lead a healthy
lifestyle and generally assume the role of ‘good neoliberal citizens’ (Crawford, 1980). Biopower relates to this widely accepted and proposed lifestyle: be physically active, take care of your health and body, stay fit and make sure your body is strong, muscular and toned (Fusco, 2017). The gym is a space that enables individuals to most directly shape their bodies, a space in which one can best conform to the standards of society. In relation to disability, it has been revealed that able-bodied individuals perceive physically active individuals with disabilities more favourably (Arbour et al., 2007), subjecting them to discriminatory behaviors less often (Tyrell et al., 2010). These positive perceptions of active people with disabilities are a perfect example of how biopower and biopolitics govern and influence our perceptions and understandings of appropriate ways of living.

2.2 Disability models

Disability can be represented and understood in different ways, two of which are important for this study. First I present the beliefs and understandings of disability from the perspective of the medical model of disability. This is followed by the explanation of the positionality and convictions of social perspectives of disability – the social model of disability and critical disability studies.

2.2.1 Medical model of disability

Medical model of disability was the dominant paradigm until relatively recent times (Thomas, 2003). Medical model understands disability as a consequence of illness and impairment, which results in suffering and social deprivation (Thomas, 2004). The central focus of the medical model are individuals’ abilities or deficiencies (Barton, 1993). Furthermore,
one’s functional limitations (impairments) are the fundamental cause of any disadvantages experienced and these disadvantages can thus only be amended by treatment or cure (Crow, 1996; Fitzgerald, 2012). In this way, individuals with disabilities are perceived as tragic victims and their disability is recognized as their defining feature (Fitzgerald, 2012).

Sport and recreation locales are an area in which the medical model’s understanding of disability and individuals with disabilities still dominates (Townsend et al., 2015; Townsend et al., 2017). In sport and exercise settings, people with an impairment are often perceived as ‘broken’ and therefore it is presumed that any physical activity or exercise in which they partake should take place in a therapeutic environment rather than a fitness one (Susman, 1994). Similarly, individuals with disabilities are often recognized as being unable to be physically active if they cannot use certain parts of their bodies (Martin, 2013). The observation has value in that people with disabilities often cannot use their bodies to the full extent and the activities they participate in might have to be adapted or modified. However, the medical model also indicates that having a disability is a deficiency and inherently negative, and the person with a disability should be healed or mended by the medical profession (Martin, 2013). These perceptions were challenged by the views and understandings of the social model of disability and critical disability studies.

2.2.2 Social Model of Disability

Almost half a century ago, the UK saw the inception of the disability movement when the founders of the Union of the Physically Impaired against Segregation (UPIAS) reconceptualised disability. Instead of seeing the individual in need of medical and social intervention, their concept understood disability as a condition caused by a discriminatory
physical, social, political and economic environment (Albrecht, 2010). Their primary objective was to develop conditions in which people with disabilities would be able to work independently, control their lives and be an integral part of society (Oliver, 2013).

The intellectual and political stances of UPIAS influenced and developed the social model of disability, which has essentially been derived from the following perspective:

“In our view, it is society which disables physically impaired people. Disability is something imposed on top of our impairments, by the way we are unnecessarily isolated and excluded from full participation in society. Disabled people are therefore an oppressed group in society” (UPIAS, 1975).

UPIAS’s words uncover two essential elements of the social model of disability, namely the separation of disability (social exclusion) and impairment (physical limitation) and the belief that people with disabilities are a subjugated group (Oliver, 2013).

The social model of disability was based on a gripping critique of the medical model of disability and served as a foundation for the international Disability Rights Movement, inspiring a number of UN declarations that criticize discrimination and acknowledge the human rights of people with disabilities (Albrecht, 2010). The social model of disability has become the key model in disability studies in Britain. It is essentially based on the idea that disabled people are not disabled by their impairments but by the disabling barriers they face in society (Oliver, 2013, Thomas, 2004). The social model understands disability as “the outcome of social barriers that restrict the activities of people with impairments” (Thomas, 2004, p. 570). Disability authors, such as Barton (1993), share the sentiment that disability needs to be understood as a form of oppression as it results in social and economic difficulties and compromises individual’s
self-identity and emotional well-being. Physical and social constraints of the unfavorable and limiting environment are responsible for their dehumanization and isolation. Disability scholars call for an examination and change of this hostile and unfriendly environment (Barton, 1993).

Furthermore, disability studies scholars like Susan Wendell (1996) recognize social models’ convictions that disability is socially constructed during the interaction between biological characteristics and social and cultural factors. Several social factors contribute to the social construction of disability, such as social conditions that cause or fail to prevent damage to people’s bodies, social expectations of ‘normal’ performance, and the organization of societies based on a young, healthy, non-disabled, ‘ideally shaped’ male body (Wendell, 1996). Likewise, physical structure and social organization of society cause disability: “Not only the architecture, but the entire physical and social organization of life tends to assume that we are either strong and healthy and able to do what the average young, non-disabled man can do or that we are completely unable to participate in public life” (Wendell, 1996, p. 37).

As previously mentioned, at the onset of the movement, disability activists mainly emphasized economic concerns and stressed the need for independent living of people with disabilities. Their attention was focused on the identification and critique of various barriers this population experienced while trying to live independently or when participating in the labour market (Meekosha & Shuttleworth, 2017). Types of barriers identified included physical barriers in the built environment and transport systems (Gleeson, 1999; Imrie, 2004; Zarb, 1995), the organizational and attitudinal barriers in education (French & Swain, 2004; Barton, 1996), barriers in the realm of leisure activities (Carr, 2004), and barriers preventing full participation in civic and political structures and processes (Zarb, 1995). Highlighting various
barriers uncovered the fact that people with disabilities were marginalized and excluded from every realm of social life (Thomas, 1999).

According to Shakespeare (2017) the main strengths of the social model of disability are its simplicity, efficiency and significance, all key requirements of a political slogan or ideology. He also states that the social model of disability is easily explained and understood and due to a clear differentiation between enemies and allies it offers a straightforward plan for social change (Shakespeare, 2017). Moreover, the social model has been successfully used for political purposes and has helped build the social movement of disabled people (Owens, 2014). Another strength of the social model is the identification of social barriers that should be removed, in that way it is more of a “practical tool, not a theory, an idea or a concept” (Oliver, 2004, p. 30). As mentioned before, the social model points out that the problems this population faces are a consequence of social oppression and exclusion rather than their individual deficiencies. On account of the understanding that it is not the person with a disability who is to blame, but the society (Shakespeare, 2017), the social model possesses the power to change the perception of people with disabilities. With the realization that society needs to change, we should identify and address the inequalities and social transgressions individuals with disabilities are faced with in their everyday lives (Shakespeare, 2017).

However, the social model has also been criticized. Some disability authors believed that the complexity and fluidity of the postmodern culture and society required an understanding beyond the beliefs of the social model of disability and argued for a conversational relationship between impairment and disability (Corker, 1999). The debate for the most part arose on the account of the social model of disabilities’ argument for a theoretical differentiation between
impairment as a functional limitation and disability as a socially constructed system of discrimination (Goodley, 2017). This binary way of thinking about disability has experienced a great deal of critique from various scholars, which has caused tensions and divisions within the disability studies community, particularly in the United Kingdom (for example, Corker, 1999; Shakespeare & Watson, 2001; Shakespeare, 2006). Hughes and Paterson (1997) for example, contend that the corporeal experience of impairment beyond disability must also be acknowledged when exploring disability, since experiences associated with impairment (such as feelings of fatigue and pain) may in fact add to the experience of disability. Critical disability studies, which is the focus of the next section, answered the call for a broader understanding of disability.

### 2.2.3 Critical Disability Studies

In qualitative research, the term critical signifies an openly ideologically oriented enquiry that encompasses traditions influenced by various forms of critical theory (Sparkes & Smith, 2014). These traditions then inform critical social science whose main objective is to persuade individuals and groups to change contradictions and distortions in their belief systems and social practices. Furthermore, critical social science is oriented towards social and individual transformation by providing knowledge about existing social structures which are essentially oppressive in nature (Schwandt, 1997). A fundamental objective of critical inquiry is to dig below the surface of oppressive social structures in order to induce emancipation and bring about both individual and social change (Sparkes & Smith, 2014).

This study is grounded in the perspectives provided by the theoretical orientations of critical disability studies, which frames disability as a socially constructed phenomenon rather
than a biological or universal reality (Baglieri & Shapiro, 2012; Davis, 2002; Jaffee, 2017; Meekosha & Shuttleworth, 2017). The emergence of critical disability studies has been attributed to the re-evaluation of the past work in the discipline (Meekosha & Shuttleworth, 2017) and presents a challenge to the Marxist/materialist line of disability studies (Vehmas & Watson, 2013). Critical disability studies draws from a social constructivist paradigm and concentrates on various forms of political, economic, social, and cultural oppression that people with impairments experience (Kliewer, 1998; Jaffee, 2017). Furthermore, critical disability studies examines the complex interplay of social power dynamics, normalization, inclusion/exclusion, accessibility, mobility, identity politics, intersectionality and privilege (Titchkosky, 2011) and argues that the concepts of normalcy and disability are heavily shaped by those in positions of power and control (Kliewer, 1998). Finally, critical disability studies revises various understandings of the lived experience of people with disabilities and reviews possible future directions for social, political, and economic change (Pfeiffer, 2002; Meekosha & Shuttleworth, 2017).

A number of factors contributed to the re-examination and the broader and contextual questioning of people with disabilities and their restrictions. First, disability authors appealed for recognition of a relationship between impairment and disability (Corker, 1999; Shakespeare & Watson, 2001; Shakespeare, 2006). Critical disability studies, therefore, represents a move away from the preoccupation with binary understandings of social versus medical model, and disability versus impairment (Meekosha & Shuttleworth, 2017). Second, the utter diversity of people with disabilities and the variety and degrees of their impairments has driven critical disability studies to derive from a wide range of critical theories (Meekosha & Shuttleworth,
Recognizing the diversity residing within the disability community is imperative for a thorough understanding of individuals’ concerns, values and personal experiences with disability (Rolfe et al., 2012). Finally, some disability scholars claim that one’s social location (for example, individuals’ identifications of gender, class, race, sexuality and age) should also be included in the context of disability research (Thomas & Corker, 2002). Therefore, a general understanding has developed where the struggle for social justice continues in a broader scope, one that is also psychological, cultural, and discursive (Meekosha & Shuttleworth, 2017). As a result, critical disability studies embraces a more intricate interpretation of disability oppression and contributes to a broader understanding of people with disabilities’ place in the world (Meekosha & Shuttleworth, 2017).

2.3 Concepts in Critical Disability Studies

In this section I present the concepts of ableism, disablism and otherness, which I then draw on to examine trainers’ and instructors’ perceptions and understandings of disability and individuals with disabilities.

2.3.1 Ableism

Ableism is deeply and subconsciously embedded within the culture, and is defined as a “network of beliefs, processes and practices that produces a particular kind of self and body (the corporeal standard) that is projected as the perfect, species-typical and therefore essential and fully human. Disability, then, is cast as a diminished state of being human” (Kumari Campbell, 2001, p. 42). Through ableism, individuals who do not conform to the strict corporal standards often end up being perceived as less worthy (Loja et al., 2013). Furthermore, ableism
in its common form leads to an “ability-based and ability-justified understanding of oneself, one’s body, one’s relationship with others within one’s species, other species and one’s environment” (Wolbring, 2012, p. 79). Consequently, ableism creates a different ‘kind of people’ (Hacking, 2007), an inferior other species (Hodge & Runswick-Cole, 2013). The functioning and widely desired neoliberal citizen is always able-bodied and able-minded (Goodley, 2017), which excludes people with disabilities from fitting into the world’s ableist demands. Essentially, from the moment a child is born she/he emerges into a world where disability is worth less, a world where disability may be tolerated but in the final instance is inherently negative. Finally, every individual, regardless of their subject position, is shaped and formed by the politics of ableism (Kumari Campbell, 2008), as ableist society always favors a preferred type of species-typical individual (Goodley, 2017).

Physical activity and exercise settings, such as the gym, are excellent examples of environments entrenched with ableism (Richardson et al, 2017a). Gym is a space dedicated to the improvement of physical fitness in a controlled environment with specialized equipment, health and safety regulations and qualified instructors (Hedblom, 2009). A creation and representation of this space is a fit, muscular and perfectly toned body. Whoever does not fit into that category is marginalized (Crossley, 2006), and ableism in the gym leads to restriction and discrimination of people with disabilities (Wolbring, 2008). The bodies of the unfit and the other are allowed into this masculine space, but they exist only as a negation to the idealized and accepted standard of the strong, white, male body (Wendell, 1996). With the differentiation of bodies, the disability/ability system creates individuals and allows for an unequal distribution of resources, status and power (Garland-Thomson, 2016). People with
disabilities are often marginalized and excluded from the gym environment, the discriminatory experiences they are subjected to can additionally be explained through the concept of disablism.

2.3.2 Disablism

Disablism is a form of social oppression, promoting the differential or unequal treatment of people because of their actual or presumed disabilities (Goodley, 2017; Kumari Campbell, 2008). It is built upon the belief that a person’s abilities or characteristics are determined by disability (Linton, 1998) and the socially engendered undermining of their physical health and psychological and subjective well-being (Thomas, 2004a). Furthermore, disablism arises when the relationship between the environment, body and psyche excludes certain individuals from fully participating in the social world (Marks, 1999). Disablism emerges in two forms: structural disablism and psycho-emotional disablism (Reeve, 2012).

Structural disablism refers to the disabling structural barriers which operate at the public level, such as the exclusion from the built environment (Reeve, 2016). In the gym structural disablism becomes apparent even before one enters the building, with the inaccessibly built facilities and the difficult access to the exercise area (Gardner et al, 2007). It is further enhanced with the complicated use of the washroom and changing facilities (French & Hainsworth, 2001), and with the shortage of appropriate exercise equipment (Rimmer et al, 2005). In this way structural barriers negatively affect person’s psychological and emotional well-being, inducing feelings of otherness, isolation and diminished self-worth (Reeve, 2006, 2014).
Psycho-emotional disablism on the contrary functions at the private level and relates to the negative interactions with others (Reeve, 2012). Psycho-emotional disablism is instrumental in revealing how disablism operates and illuminates how people with disabilities are treated and understood by able-bodied individuals and by others with disabilities (Goodley & Lawthom, 2011). In the gym context applying a lens of disablism highlights how structural barriers send out exclusionary messages that individuals with disabilities are out of place and that they do not belong (Kitchin, 1998). Furthermore, people with disabilities experience psycho-emotional disablism when they get stared at and judged by other gym users or have their experiences invalidated by fitness instructors or managers because they do not conform to the publicly accepted standards of beauty and normalcy (Hughes, 1999; Kehn & Krohl, 2009; Richardson et al., 2017c; Rolfe et al., 2009). In this way, through psycho-emotional disablism individuals’ psychological and emotional health, as well as their self-esteem become compromised (Thomas, 2007). What is more, individuals with disabilities’ bodies often contradict the aesthetic values of the gym and this lack of compliancy to the ‘normal’ body can make them feel looked upon and judged (Garland-Thomson, 2009). These oppressive practices cause individuals to feel othered and a number of times that discourages them from being active in this space and deprives them of the multitude of benefits exercising in this environment brings about (Richardson et al., 2017a).

2.3.3 Otherness

Sport and exercise settings offer a wonderful example of how the concept of the other is formed, constructed and utilized. According to Wendell (1996) the concept of the other is formed when we group people together as the objects of our experience rather than regarding
them as subjects with whom we might identify. This enables us to perceive them as something else – usually something we fear and reject. This way, individuals with disabilities are placed in the opposition (made other) to the worshiped individual of our times (Goodley, 2017). People with disabilities represent a problem for the non-disabled society because they disrupt the normative individual (Marks, 1999) and embody imperfection, even more so they remind us of our own weaknesses, pain and eventual death (Wendell, 1996). Otherness often makes people with disabilities feel invisible (except when they are made hypervisible when portrayed as heroes or tragic victims), ultimately causing a cultural gulf between the disabled and the non-disabled (Wendell, 1996). For example, when going to the gym, people with disabilities are often judged by able-bodied gym users, leaving them separated from the able-bodied participants. This ultimately results in them feeling marginalized and negatively affects their psycho-emotional well-being (Richardson et al., 2017b; Rolfe et al., 2009). Such negative encounters and experiences often cause the feelings of otherness, discouraging them from further visits to the gym despite the numerous benefits of physical activity and exercise (Richardson et al, 2017b).

2.4 Benefits of Physical Activity and Exercise for People with Disabilities

Individuals with disabilities report high rates of poor health (Drum et al., 2005; WHO, 2011), including higher levels of obesity (Altman et al., 2008; Chen et al., 2010; Erhart et al., 2012; Froehlich-Grobe et al., 2013; WHO, 2011) and high rates of secondary health conditions such as diabetes, arthritis, hypertension (Carroll et al., 2014; Dixon–Ibarra & Horner–Johnson, 2014; Froehlich-Grobe et al., 2013; Hoffman et al., 1996; Leser et al., 2017; Reichard et al.,
2011; Rimmer & Marques, 2012; Valis & Gonzalez, 2017; WHO, 2011), muscle atrophy (Rimmer, 1999), and muscle degeneration (Stensrud et al. 2015). One of the key reasons for poor health conditions of people with disabilities is their lack of engagement in physical activity and exercise. Namely, the majority of adults with disabilities do not meet the national recommendations for physical activity and dietary intake and consequently do not profit from the corporeal and mental health benefits of regular exercise (Schoenborn & Barnes, 2002). Furthermore, physical inactivity and related health issues have been shown to result in a lower quality of life, limited ability to carry out normal daily activities including work and social interactions, and diminished independence (Brandt et al., 1997; Nosek, 1997; O’Neill, 1991).

Furthermore, a host of benefits have been identified in relation to physical activity for individuals with disabilities. Involvement in physical activity and exercise are beneficial to their physical (IFC, 2015), psychological (Allen et al., 2004; Anderson & Heyne, 2010; Blinde & Taub, 1999; Gorgey, 2014; Kosma, et al., 2007; Martin Ginis & Latimer, 2006; Williams et al., 2012) and social (Anderson, 2009; Hansen et al., 2003; Holt & Neely, 2011) health. With regard to physical benefits, many of the chronic and secondary health conditions (e.g. preventing high blood pressure, diabetes and osteoporosis) can be improved or even eliminated with increased engagement in physical activity (Anderson & Heyne, 2010; Nosek, 2000; Piotrowski & Snell, 2007; Rimmer et al., 1996; Rimmer & Wang, 2005). In addition, participation in physical activity develops strength and endurance, which in turn helps maintain a higher level of independence and enables individuals with disabilities to participate in different aspects of community life (IFC, 2015).
Having a disability often causes psychological difficulties (Tate et al., 2015), for instance cognitive and emotional problems (Anderson & Heyne, 2010; Craig et al., 2009). Many of these shortcomings can be managed through engagement in physical activity and exercise (Anderson & Heyne, 2010; Gorgey, 2014). Moreover, physical activity can reduce stress and depression (Martin Ginis & Latimer, 2006). Additionally, social interactions in exercise settings bring enjoyment and result in some of the main psychological benefits of physical activity, such as enhanced self-perception, increased self-esteem, improved emotional functioning (Allen et al., 2004; Kosma, et al., 2007), and strengthened perceptions of empowerment (Blinde & Taub, 1999). On the whole, participation in physical activity and exercise positively influences individuals’ general psychological well-being (Santiago & Coyle, 2004; Kehn & Kroll, 2009; Rolfe et al., 2009; White et al., 2011; Williams et al., 2012).

Concerning social benefits, taking part in sport and exercise in a group setting can facilitate socialisation (Anderson, 2009) and provides opportunities for social and inter-personal interaction, thus cultivating social skills (Hansen et al., 2003; Holt & Neely, 2011). More so, physical activity has been recognized as a possible panacea to the stigmatization process (Barg et al., 2010; Tyrell et al., 2010), as it has been indicated that participation in physical activity may counteract the negative perceptions directed towards individuals with disabilities (Blinde & McClung, 1997). Finally, studies have shown that involvement in physical activity and exercise improves one’s social status (Arbour et al., 2007) because active individuals with disabilities are generally perceived more favourably and this in turn results in a noticeable decline in discriminatory behaviors from able-bodied individuals (Tyrell et al., 2010).
2.5 Barriers to Physical Activity for People with Disabilities

Despite the widespread understanding of the various benefits associated with physical activity, individuals with disabilities remain the most inactive population in today’s society (Carroll et al., 2014; Martin, 2013; Richardson et al., 2017b). In order to address the activity levels among the population of people with disabilities we should understand the barriers they are faced with when engaging in physical activity and exercise. When people with disabilities participate in physical activity and exercise they most commonly encounter individual, environmental, and social barriers (Martin, 2013).

2.5.1 Individual Barriers

One of the most prevalent individual barriers to physical activity is impairment itself (Gardner, et al., 2007; Kinne et al., 1999; Tasiemski et al., 2006). Other commonly identified barriers are pain, lack of energy and fatigue (Gardner et al., 2007; Goodwin & Compton, 2004; Henderson & Bedini, 1995; Wilber et al., 2002). As much as physical activity relieves feelings of pain and tiredness, it can also cause added fatigue and increase chronic pain (Martin, 2013). Impairment (e.g. being physically unable to use one’s legs; lack of sight), the way it is interpreted by a social model of disability, can be restrictive to physical activity. Impairment, social and environmental barriers can all work simultaneously (Thomas, 2004a; Thomas, 2004b), and both impairment as well as psycho-emotional oppression represent important barriers to people with disabilities’ engagement in physical activity (Martin, 2013).
2.5.2 Environmental Barriers

Environmental barriers and the lack of proper environments for sport and exercise are one of the main reasons for high rates of physical inactivity among individuals with disabilities (Richardson et al., 2017b; Schifflet et al, 1994). Physical inaccessibility within fitness and exercise facilities limits the participation of people with disabilities and often results from a lack of elevators, ramps and kerb cuts, the existence of narrow doorways, inaccessible fitness equipment and changing rooms (Bedini & Henderson, 1994; Figoni et al., 1998; Cardinal & Spaziani, 2003, French & Hainsworth, 2001; Putnam et al., 2003; Rimmer et al., 2004b; Rimmer, 2005; Rolfe et al. 2009). Additional barriers are represented by a limited number of appropriate places and sport and recreation facilities for engagement in physical activity (Gardner et al., 2007; Martin & Smith, 2002; Rimmer et al., 2005; Martin Ginis & Latimer, 2006). Furthermore, sport and exercise facilities are often inconveniently located (Tsai & Fung, 2005), they lack suitable programs, and are equipped with inappropriate fitness equipment (Rimmer et al, 2005; Martin Ginis & Latimer, 2006).

2.5.3 Social Barriers

Social-level barriers to physical activity become apparent at an early age. In sport and recreational settings community personnel are often not familiar with adapting games for children with disabilities (Lieberman & MacVicar, 2003). Additionally, it has been reported that health care professionals often lack knowledge of the benefits of physical activity and at times even believe that exercise may be harmful to individuals with disabilities (Heller et al., 2011). Even more alarming are the actions of medical doctors, who sometimes tacitly provide approval for students and children with disabilities not to engage in Physical Education classes,
furthermore supporting their inactivity (Martin, 2013). For children and adolescents, a lack of peers or friends to play with and engage in leisure time physical activity rated among the highest barriers to physical activity participation (Kang et al., 2007; Lieberman et al., 2006; Levinson et al., 1991). Lack of access to information and resources during rehabilitation, as well as the understatement of physical abilities from rehabilitation and physical therapists have been commonly identified (Scelza et al., 2005).

In the context of gyms and fitness centres social barriers become widely apparent. Within exercise facilities social barriers are often experienced when individuals with disabilities interact with fitness staff members who often lack the knowledge and training required to provide safe and effective exercise instruction to people with disabilities (Henderson & Bedini, 1995; Rauzon, 2002; Rimmer et al., 2004b, Scelza et al., 2005). In addition, fitness trainers’ and instructors’ negative attitudes, lack of work ethic and proper assistance, coupled with liability concerns have also been reported as significant barriers (Martin, 2013). Furthermore, people with disabilities usually disclose having shortage of knowledge about suitable spaces for sport and exercise (Heller et al., 2002). Individuals with disabilities also believe that owners and employees view accessibility in the gyms unnecessary and meaningless (Rimmer et al., 2004b) as the majority of gyms and fitness centres do not have any policies associated with disability (Martin, 2013). All of the above deprive people with disabilities of important and far-ranging benefits of physical activity.
2.6 Gym as an exercise domain for people with disabilities

Numerous studies (Allen et al., 2004; Anderson & Heyne, 2010; Blinde & Taub, 1999; Carroll et al., 2014; Martin, 2013; Williams et al., 2012) have identified the problem of high levels of physical inactivity among people with disabilities. Additionally, a collection of research has explained how the lack of activity impacts this population’s general health and well-being (Altman et al., 2008; Drum et al., 2005; Froelich-Grobe et al., 2013; Martin Ginis et al., 2012). Clearly, participation in physical activity and exercise has benefits for people with disabilities in many realms of life experience (Van Rheenen, 2016).

One of the commonly used environments for engaging in physical activity and exercise is the gym. Gym is a space dedicated to the improvement of physical fitness in a controlled environment with health and safety regulations, and with qualified trainers and instructors (Hedblom, 2009; Sassatelli, 2010). Previous research has identified the gym as an exercise domain in which people with disabilities can improve their physical, social and psychological health and well-being (Calder et al., 2018; Richardson et al., 2017a, 2017b, 2017c). However, only a very small number of individuals with disabilities profit from participation in the gym (Saxton, 2018).

Despite the well-known and overarching benefits of engagement in physical activity and exercise in the gym environment for individuals with disabilities, very little research has explored the gym as a possible exercise domain for this population. To my knowledge the only study directly related to disability in the gym environment is the work of Richardson and colleagues (2017a, 2017b, 2017c). Richardson’s work focused on the experiences of people with
disabilities when they exercised in the gym individually or as part of a peer group (Richardson et al., 2017a, 2017c). Furthermore, the researchers explored how fitness instructors with disabilities impacted the gym environment (Richardson et al., 2017b). Their findings illuminated some predominant accounts of individuals with disabilities’ experiences when exercising in the gym. Individuals with disabilities experienced many benefits through involvement in the gym. In general, the gym was recognized as a space in which this population could improve their physical condition, enhance their social life and psychological well-being, and raise their overall quality of life (Richardson et al., 2017c). Physical advancement most often led to improved function, reduced pain and increased overall fitness, which in turn promoted their independence. Additionally, the gym also represented a social space, where they could interact with other people and make new friends. Furthermore, the study also showed that the gym can present an inclusive environment, which fosters feelings of belonging and heightens perceptions of social acceptance and self-worth. Finally, exercising in the gym awarded individuals with disabilities with psychological benefits. Specifically, an important perceived benefit was a sense of a psychological ‘time-out’ from the stresses associated with having an impairment (Richardson et al., 2017b, Richardson et al., 2017c).

In contrast, many individuals with disabilities experienced the gym environment as a barrier (Richardson et al., 2017c). Not aligning to the accepted and praised physical image of strong, toned and muscular body (Neville & Gorman, 2016) caused people with disabilities to feel out of place and that they did not belong (Johansson, 1996). Anyone who does not fit into the gyms’ perception of good health is marginalized and left out (Crossley, 2006). Furthermore, the limited values and interpretations of health of those in the gym were another barrier. For
example, trainers and instructors understood pain as a necessary part of the training process, whereas in reality for people with disabilities pain most often served as a warning sign of causing harm to their bodies. Fitness trainers and instructors maintain an important role in this populations’ experiences in the gym environment (Richardson, 2017c) and the next section highlights the significance and characteristics of that role.

2.6.1 Fitness Trainers and Instructors

One of the people gym visitors commonly interact with are fitness instructors and trainers. Fitness trainers and instructors are not only responsible for a pleasant gym experience, they actually serve a larger purpose. Given the general agreement that engaging in regular physical activity and exercise across the lifespan has a significant beneficial effect on health and well-being and considering the high levels of physical inactivity today exercise professionals serve as an important health promotion resource (Blair, 2009; Trost et al., 2014). Health promotion is the “science and art of enabling people and communities to have more control over their health and lives” (Oprescu et al., 2012, p. 1). Fitness trainers and instructors have a key role in endorsing and supporting physical activity adherence and are an essential element in the ‘war’ against obesity and inactive lifestyles (De Lyon et al., 2017; Oprescu et al., 2012).

People with disabilities have identified fitness professionals as an important determinant to their participation in the gym (Richardson et al., 2017b) and recognized knowledgeable and empathetic trainers and instructors as an essential factor of a constructive and positive visit to the gym. However, Richardson and colleagues (2017c) discovered that people with disabilities frequently reported poor encounters with trainers and instructors. Studies have shown that trainers and instructors often lack training and knowledge about
disability specific conditions (French & Hainsworth, 2011; Martin Ginis et al., 2016; Mulligan et al., 2012; Rimmer et al., 2004a). More than that, trainers’ shortage of understanding of disability is usually coupled with improper acknowledgement and treatment of clients with disabilities (Richardson et al., 2017c). Negative experiences with trainers and instructors can be understood as a form of direct psycho-emotional disabilism (Richardson et al, 2017b), which occurs when persons’ words or actions exclude or invalidate an individual (Richardson et al., 2017c). Therefore, in order to increase the physical activity levels of people with disabilities and enhance their gym participation, competent and sympathetic trainers and instructors are vital.

As mentioned, fitness trainers and instructors have a key role in the promotion and adherence to physical activity (De Lyon et al., 2017; Oprescu et al., 2012) and have been identified as a crucial part of a positive gym experience of individuals with disabilities (Richardson et al, 2017b). On that premise, I can deduce that the gym can be recognized as an important environment for raising people with disabilities’ levels of activity and I perceive personal trainers and instructors as one of the key figures in that process. Therefore, it is extremely important to explore and uncover trainers’ and instructors’ understanding of disability and people with disabilities, as well as better identify the inequalities this population faces when exercising in the gym. The main objective of this study was to fill the gap in the existing literature and address the issues mentioned above.

2.7 Gaps in the Existing literature

As highlighted above, limited research has examined the gym as a potential exercise realm for individuals with disabilities. Existing research in the context of disability in physical
activity and exercise settings has primarily focused their attention on identifying various benefits of physical activity (Arbour et al., 2007; French & Hainsworth, 2001; Martin, 2013; Martin Ginis et al., 2012), facilitators, promoting engagement in exercise (Tyrell, 2010; Williams et al, 2014), and barriers individuals with disabilities experience when engaging in physical activity and exercise (Calder et al., 2018; French & Hainsworth, 2001; Martin, 2013; Mulligan et al., 2012; Rimmer et al., 2004b; Rimmer, 2005; Rolfe et al. 2009). A single sociological study carried out by a group of researchers in the UK delved into individuals with disabilities’ experiences of exercising in the gym milieu in individual (Richardson et al., 2017c) or group settings (Richardson et al., 2017a), and examined disabled instructors’ impacts on the gym environment (Richardson et al., 2017b). In addition, as there is a shortage of research in this area, it was helpful to also consider the findings of studies that explored coaches’ experiences of training athletes with disabilities (Bush & Silk, 2012; Wareham et al., 2018; Wareham et al., 2019).

To my knowledge, apart from the mentioned study, there have been no other sociological qualitative examinations of disability in the gym environment. Exploring personal trainers’ perceptions and understandings of disability and individuals with disabilities in the gym milieu I hoped to address the gap in the existing research and add to the knowledge of disability in this context (Chenal et al., 2010). Acknowledging this gap, the study not only attempted to add to the literature that has explored disability and physical activity through a sociological lens, but also aspired to answer Richardson et al.’s (2017c) call for more research on the topic of disability in the gym milieu. In this way, I wished to create suggestions and
guidelines on how to better educate and support trainers and instructors, in order to establish more inclusive gym experiences for individuals with disabilities.
3. Methodology

This chapter details the methodology that guided the research process. The chapter first focuses on describing and explaining the chosen paradigmatic standpoint. Second, details are given on the implemented method including the ways in which data was collected and analyzed. Third, the chapter describes the study’s sample and explains the sampling process. Furthermore, the chapter discusses some of the ethical considerations that were implemented throughout the research process. Lastly, attention is given to my insider status and reflexive journaling.

3.1 Paradigmatic Standpoint

The term ‘paradigm’ refers to the constellation of philosophical assumptions which are shaped by members of a given research community (Humphrey, 2011). Every paradigm is based upon its own ontological and epistemological assumptions and positions (Scotland, 2012). For the purpose of this study a critical interpretivist paradigm was adopted.

In an interpretivist paradigm, a researcher attempts to form meanings through interactions with research participants and in various social settings (Collins, 2010). The ontological position of interpretivism is relativism, which views “reality as subjective and differing from person to person” (Guba & Lincoln, 1994, p. 110). All of our realities are influenced by our senses. Subscribing to interpretivism, I make no claim that the knowledge is independent of me nor that it is objectively found. Coming from a relativist ontology, I realize that realities are subjective, multiple, created, and change over time (Smith & McGannon, 2018). From a subjectivist epistemology, I pursued to understand the participants’ subjective
understandings and experiences and the socially constructed contexts that shape their realities (Smith & McGannon, 2019). Furthermore, I recognize that knowledge and reality are socially constructed, and I acknowledge my co-creation of data (Smith & Sparkes, 2016). Participants’ realities are shaped not only by the broader social context, but also by the more specific context of the research process. Participation in the research project and involvement in interview process additionally influenced their expression of their realities and consequently regulated my interpretation of their narratives.

Second, the study was guided by the positionality and understandings of critical disability studies. Critical disability studies is a discipline that critically analyzes the meaning and implications of the social construction of disability and provides a useful framework for a broader understanding of disability-based oppression (Jaffee, 2017). The word ‘critical’ in critical disability studies stands for a reassessment of the current status and further direction of disability studies (Goodley, 2013), revising social, political, and intellectual understandings of the lived experience of people with disabilities and reviewing possible future directions for social, political, and economic change (Meekosha & Shuttleworth, 2017).

The reasoning behind the choice of critical interpretivist paradigm as an approach to view and analyze the data is twofold. First, previous research on the topic of disability in the gym environment has advocated for an interpretivist research paradigm – that is, ontological relativism and epistemological constructionism (Richardson et al., 2017a; Richardson et al., 2017b; Richardson et al., 2017c). As claimed by interpretivism, reality is multiple and subjective, and knowledge is constructed through interactions between individuals and their social and cultural environments (Sparkes & Smith, 2014). Second, the theoretical orientation of the study
was shaped by the aspects of the social model of disability and the positionality of the critical
disability studies. Both the social model of disability and critical disability studies stem from
critical theory and aim to understand the lived experience of people with disabilities and
illuminate potential ways forward for social, political and economic change (Meekosha &
Shuttleworth, 2017). By applying a critical interpretivist paradigm I was able to critically
examine trainers’ perceptions and understandings of disability and individuals with disabilities
and draw conclusions about the current understandings of disability in the gym milieu.
Additionally, by highlighting how such understandings influenced barriers individuals with
disabilities face when engaging in physical activity and exercise in this environment, I was able
to develop multiple recommendations for future practice and improvement of the exercise
experience of this population.

3.2 Method

The study used a qualitative design and inductive reasoning (Sparkes & Smith, 2014).
Qualitative research attempts to understand phenomena in real world settings, where the
studied phenomena unfold naturally (Patton, 2002). In addition, qualitative researchers are
essentially interested in understanding the meaning people have constructed, that is, how
people make sense of their reality and their experiences in the world (Merriam, 2009). The aim
of utilizing qualitative research methods was to bring attention to subjective perceptions and
understandings of each participant and to reveal their experiences (Flick, 2009). Furthermore,
qualitative methods helped unveil nuances and complexities of the studied subject matter
(Anderson, 2010) and presented various perspectives (Flick, 2009) related to participants’
perceptions and understandings of disability and individuals with disabilities.
3.2.1 Interviews

The study utilized semi-structured interviews with open-ended questions, mainly because they allowed for new ideas to be established during the interviews. Semi-structured interviews proved to be an excellent method for collecting in-depth reports of ‘personal experience’ (McArdle et al., 2012). In addition, semi-structured interviews enabled me to lead the conversation into a desired direction, while allowing research participants to share personally relevant stories, experiences and beliefs (Denzin & Lincoln, 2011; Smith & Sparkes, 2016). Moreover, the nature of the semi-structured interview permitted a certain degree of flexibility. During the interviewing process questions were adapted, their order was changed, or additional unplanned questions were asked to explore and clarify the trainers’ responses (Eliot et al, 2016), which helped generate new and additional visions and understandings of disability and individuals with disabilities (Smith & Sparkes, 2016). Interviews were recorded with an audio recorder and transcribed verbatim, to gain a consistent representation of what was said (Smith & Sparkes, 2016). Generally, the interviews were designed for a length of sixty minutes and took place in a location convenient for the participants. Specifically, interviews occurred either at participants’ workplaces or at coffee shops in Vancouver, British Columbia.

Interviews are a social activity in which two or more individuals engage in a conversation. In turn, this interaction, performed through a multitude of senses, creates knowledge about each other and the social world (Sparkes & Smith, 2014). Furthermore, an interview is an invaluable method of obtaining insight into people’s perceptions, experiences and understandings of a certain subject matter on (Frances et al., 2009). During these interviews participants shared stories, reported on and described their perspectives,
observations, insights, experiences, feelings and behaviours in relation to the research questions (Smith & Sparkes, 2016). A interview guide (Appendix 5) was used in order to ask relatively focused but open-ended questions (Smith & Sparkes, 2016) that encouraged trainers and instructors to elaborate on their views of disability and experiences with clients with disabilities. Probes and follow-up questions helped to elaborate and clarify participants’ responses. Topics covered during interviews particularly focused on trainers’ experiences with clients with disabilities, their perceptions of benefits and challenges training clients with disabilities, and their general beliefs and understandings of disability and clients with disabilities.

3.3 Sample

In purposive sampling research participants are selected according to predetermined criteria in line with a specific research objective (Guest et al., 2006). The criteria for this sample were trainers and instructors working in public and private fitness centres in the city of Vancouver, British Columbia. The sample involved 12 trainers and instructors that participated in a face-to-face interview. Details outlining the participants with interview locations and durations are provided in Table 1. Sample size was small enough to manage the material in the proposed time frame and large enough to ensure a new understanding of the subject matter (Sandelowski, 1995). The purpose was to gain a detailed account of participants narratives, where “the greater the depth and richness of each data item (e.g., an interview) the fewer individual items you will need” (Braun et al., 2016, p. 195). A sample of 12 participants provided enough detailed data to answer the research questions and capture themes across cases, where new information did not significantly add to the current research findings.
Table 1: Interview Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Interview Location</th>
<th>Interview Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jacob</td>
<td>Coffee shop</td>
<td>56:39</td>
</tr>
<tr>
<td>Katrin</td>
<td>Coffee shop</td>
<td>67:19</td>
</tr>
<tr>
<td>Melanie</td>
<td>Gym</td>
<td>54:43</td>
</tr>
<tr>
<td>Susanne</td>
<td>Coffee shop</td>
<td>60:39</td>
</tr>
<tr>
<td>Michelle</td>
<td>Gym</td>
<td>52:40</td>
</tr>
<tr>
<td>Luka</td>
<td>Coffee shop</td>
<td>63:18</td>
</tr>
<tr>
<td>Laura</td>
<td>Gym</td>
<td>74:53</td>
</tr>
<tr>
<td>Eva</td>
<td>Gym</td>
<td>56:23</td>
</tr>
<tr>
<td>Alexander</td>
<td>Gym</td>
<td>88:15</td>
</tr>
<tr>
<td>Steve</td>
<td>Researcher’s office</td>
<td>65:13</td>
</tr>
<tr>
<td>Erica</td>
<td>Gym</td>
<td>70:48</td>
</tr>
<tr>
<td>Jennifer</td>
<td>Coffee shop</td>
<td>59:18</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Average 64:11</strong></td>
</tr>
</tbody>
</table>

All names used in the following sections are pseudonyms adopted to ensure participants’ anonymity.

One of the criteria for participation in the study was experience working with clients with disabilities. Including only trainers and instructors with experience training clients with disabilities enabled me to draw conclusions about their perceptions and understandings of disability and individuals with disabilities. Additionally, the study was restricted to trainers and instructors who held a BC Recreation and Parks Association (BCRPA) fitness certificate, which is the most widely recognized and accepted certification in British Columbia. Finally, because of the nature of the job (flexible hours, possibility of carrying out single training sessions in a day) many trainers choose the profession as a part-time supplemental career. Restricting the study to include only trainers and instructors that have taken on personal training as their main
profession and whose majority of the income (more than 50% of their annual income) comes from training and instructing allowed me to include participants with the largest outreach in the community.

The above-mentioned requirements to participate in the study were outlined in the Letter of Introduction (Appendix 1) and in posters (hard copy and digital) (Appendix 2). Each potential participant was sent a letter of introduction, which presented them with a detailed outline of the study and what participation in the study entailed; a consent form, which explained participant’s rights and consent (Appendix 3); and a demographic questionnaire to be completed before the interview (Appendix 6). The demographic questionnaire provided me with information regarding the participant’s level of education, work experience, and the location of their employment. This information not only presented me with valuable background information about participants, but also allowed me to adjust the interview questions in accordance with participant’s personal experiences.

Out of the 12 participants, 8 were female and 4 were male. The sample was homogenously white, mainly able-bodied (one participant had reported to have a disability), mature individuals with the average age of forty-nine. The averaging years of experience working as a fitness professional across the sample was fifteen years. All of the participants came from the Lower Mainland, BC. At the time of the interview they were working in public and private gyms and fitness facilities in Vancouver, BC. A majority of fitness professionals worked at public facilities – City of Vancouver Board of Parks and Recreation facilities and a few of participants worked privately running their own businesses. Having a diverse sample enabled the study to gain a more holistic understanding of how disability and individuals with
disabilities are understood in public and private fitness spheres of the city of Vancouver.

Additionally, recruiting a diverse sample offered a more comprehensive analysis that was able to appropriately answer the study’s underlying research questions. See Table 2 for detailed demographic information about the participants of the study.

Table 2: Participant Demographic Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Gender</th>
<th>Age</th>
<th>Level of Education</th>
<th>Years of Work Experience</th>
<th>Main Gym</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jacob</td>
<td>M</td>
<td>53</td>
<td>Bachelor’s Degree</td>
<td>17</td>
<td>Public</td>
</tr>
<tr>
<td>Katrin</td>
<td>F</td>
<td>46</td>
<td>College</td>
<td>12</td>
<td>Private</td>
</tr>
<tr>
<td>Melanie</td>
<td>F</td>
<td>48</td>
<td>University Certificate</td>
<td>12</td>
<td>Public</td>
</tr>
<tr>
<td>Susanne</td>
<td>F</td>
<td>32</td>
<td>Bachelor’s Degree</td>
<td>8</td>
<td>Private</td>
</tr>
<tr>
<td>Michelle</td>
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3.3.1 Recruitment

A few different ways and strategies of recruitment were used. Because of the study’s main objective of acquiring trainers’ and instructors’ general understanding of disability and people with disabilities the recruitment was focused on all the larger private fitness centres (for example Steve Nash Fitness, Bodyworks, GoodLife Fitness, Innovative Fitness, Gold’s Gym, Club
16 Trevor Linden Fitness, etc.) and one public organization (City of Vancouver Community Centre fitness centres). Recruitment posters (Appendix 3) were hung up on the notification boards of those gyms and emails were sent to the supervisors of those facilities. Two research participants were recruited through this medium. Moreover, the use of social media (Facebook and Twitter) and online platforms such as the School’s research page were used to recruit additional participants. Unfortunately, no participants were recruited this way. One participant agreed to an interview after a conversation with the researcher in the gym that the researcher regularly visited at that time. Most of the participants were recruited through sending an e-mail that contained information about the study, its main objective and the inclusion criteria. E-mail addresses were found on a publicly accessible BCRPA (BC Recreation and Parks Association) registry of fitness professionals. E-mails were sent to the first thirty professionals in the registry and six trainers and instructors responded and agreed to participate in the study. After recruiting the first couple of participants, snowball sampling was used, a research technique in which the researcher first samples a small group of people important for answering the research questions, and these participants then propose other research participants (Bryman, 2015). Specifically, following each interview, I asked all the research participants if they knew of anyone that met the criteria and that would be interested to participate in the study. Snowball sampling in the end proved to be quite successful as I was able to recruit the final three research participants with the help of this research technique. Following the interview, each research participant was compensated for their time with a stipend in the amount of twenty-dollars. The researcher interviewed all the individuals who consented to participate in the study at a time and place that was convenient to them and all interviews were conducted in person.
3.4 Data Analysis

Following the transcription of the collected digital recordings data was analyzed and interpreted using thematic analysis. Thematic analysis (TA) is a method for identifying patterns (themes) in a dataset, and for describing and interpreting the meaning and importance of those (Braun et al., 2016). This approach can analyze people’s experiences in relation to a specific point in question. Thematic analysis is an excellent tool for identifying how people understand their behaviors related to a certain issue, or it brings insight into their views and perspectives on a certain topic (Smith & Sparkes, 2016).

When searching for themes, Ryan and Bernard’s (2003) recommendations were followed, namely I looked for repetitions (topics that arose again and again), metaphors and analogies (if and how participants represented their thoughts in forms of metaphors or analogies), and similarities and differences (similar or different discussions of a topic). Themes were induced from empirical data (Ryan & Bernard, 2003). Induction is defined as a “process of recording a number of individual instances in order to say something general about the given class of instances” (Brinkmann, 2013, p. 53). Inductive approach attempts to create meanings from the data set, recognizing patterns and connections in order to generate a theory. Inductive reasoning is often referred to as a bottom-up approach to knowing, in which the researcher uses observations to describe the studied phenomenon (Lodico et al., 2010). The goal of this approach was to observe patterns, resemblances and differences in trainers’ and instructors’ perceptions and understandings in order to reach conclusions (Neuman, 2003). Since this is novel research the purpose of the study is to get insight into similar and different
perspectives and experiences of personal trainers and instructors, which will contribute to the overall understanding of the topic.

In order to ensure the proper quality of thematic analysis I engaged in a recursive and reflexive process of moving forward and backwards through six phases (familiarization, coding, theme development, refinement, naming, writing up) described by Braun and colleagues (2016). Through each of the phases I became familiar with the content of the data and coded it by applying a label to segments of interest. In order to identify a bigger meaning or a concept they all shared, codes were grouped, and provisional themes were identified. After the identification of provisional themes I reviewed the data, making sure that the analysis fit well with the collected data and that it properly addressed my research questions. Following revision, my focus was on defining the themes and building an abundant analytic narrative, as well as naming each theme. Last phase of TA was the writing it up phase and it was essentially carried out throughout the analytic process. At the end the writing was compiled, developed, edited, and situated within the overall paper (Braun et al., 2016). Throughout the analytical process I made sure that my analysis was in line with and applied to my research questions.

Collection and assessment of data continued until no more patterns were identified and nothing new was generated (O’Reilly & Parker, 2013). Smith & Sparkes (2016) write that the number of interviews depend on the repetition of data and the sufficient number of interviews is reached when little extra understanding is gained from doing more interviews. Participants were continuously sampled until the information found did not substantially add to the current findings and when research questions could be answered. After approximately 6 interviews I noticed patterns and similarities in codes and potential themes across interviews. This is in line
with existing research suggesting that broader themes can start to be formulated after six interviews (Guest et al., 2006). I continued to sample until 12 trainers and instructors were recruited and interviewed once. Furthermore, I found that a sample of 12 participants provided enough detailed data to answer the research questions and capture themes across cases, where new information did not change or significantly add to the current findings.

### 3.5 Ethical Considerations

Regarding ethical considerations, approval was obtained from the Behavioral Research Ethics Board at the University of British Columbia on September 12th, 2018. The research posed minimal risk to the research participants. Concern for the welfare and respect for each participant was addressed by emphasizing the importance of privacy and confidentiality. Before conducting interviews informed consent from research participants was obtained. Through this process participants were notified of the aim of the research, the methods used in the research process, the potential risks and benefits, the ways of presenting the data, and the intended outcomes of the study (Palmer, 2016). Anonymity of the research participants as well as the fitness centres, in which they train and instruct was ensured, and findings were summarized anonymously using pseudonyms. Before the interview all participants were given assurances of confidentiality, freedom to withdraw, and voluntary participation (Hurd Clarke, 2003). Access to the data was restricted to the researcher (Ljudmila Zaletelj) and the graduate supervisor (Dr. Andrea Bundon). Together we reviewed our responsibilities for confidentiality and data storage and identified a locking file cabinet, encrypted computer system, and laboratory procedures for insuring confidentiality at all stages of the research process.
As Bruce MacFarlane (2009) put it in his writings about the pursuit of ethically sound research: “In conducting qualitative research, front-ended ‘ethical approval’ will never capture the uncertainty and unpredictable nature of the research process itself” (p. 25). As a researcher I had to rely on my own personal values and virtues in order to handle ethical issues in the field (MacFarlane, 2009). Taking a virtue ethics perspective enabled me to reiterate ethical decision-making (Palmer, 2016). This positionality facilitated a process of ongoing reflection and consideration of my own values, beliefs, social and ideological positions (Palmer, 2016). For example, when describing their understandings of and experiences with disability a couple of trainers and instructors used language that I considered to be improper and offensive towards people with disabilities. Regardless of instantly becoming aware of the disrespectful remarks, I did not interject the conversation and challenge the participants. In spite of going against my own values and beliefs as a researcher and a person, I did not want to endanger my relationship and rapport with the participants or risk them to withdraw from the study. It was a difficult decision to make, especially in that instant, when there were a number of thoughts running through your head and you have to make up your mind rapidly. I chose to ‘sacrifice’ my personal beliefs for the sake of the research. This conflict illustrates the complexity and of the research process (Macfarlane, 2009) and highlights how easily a researcher can find himself at a crossroads.

3.6 Insider Status and Reflexive Journaling

At the onset of the study I had been working as a personal trainer for about a decade. In that time, I had the opportunity to work in Europe and Canada, which enabled me to gain relevant experience in the fitness industry. Additionally, being immersed in the health and
exercise milieu and working with clients with disabilities, I was able to attain first-hand knowledge and understanding of disability in this context. Lastly, being familiar with the fitness industry in Vancouver, BC put me in a favorable position for recruitment of research participants. Understanding the distinction between the public and private sectors, being familiar with a good number of gyms in the city and knowing where to advertise the study were all benefits that I could attribute to my insider status. Insider status provided me with valuable insider information about some of the best places for recruitment and enabled me to develop relationships with a few trainers and business owners in this field (Thorpe & Olive, 2016).

As much as I have benefitted from being an insider, I also need to acknowledge how being in that role influenced my interpretation of data. When a researcher shares the experience of study participants it means that he is “simultaneously an onlooker in the stalls and a member of the cast” (Shaw, 1999, p. 10). The question then becomes how to use one’s own experience, which offers intimate familiarity and hence potentially a deeper understanding of the phenomenon, and at the same time, not impose researcher’s experience on participants (Pillow, 2003). No research is free of biases, assumptions, and personality of the researcher and one cannot completely separate oneself from the activities in which one is intimately involved (Sword, 1999). Strategies addressing the effects of the researcher’s characteristics have been developed. An important measure used in qualitative research for securing credibility and quality of research by investigating the lens through which the researcher views the phenomenon studied (Scott, 1997) is reflexivity. Reflexivity is the “active acknowledgement by the researcher that her/his own actions and decisions will inevitably impact the meaning and context of the experience under investigation” (Horsburgh, 2003, p. 309).
In order to acknowledge how my experience influenced the interpretation of data and to enable the appropriate quality of my research, I was reflective about my subjectivities at various stages of the research process (Bryman, 2015; Thorpe & Olive, 2016). A reflexive journal and field notes were kept and regularly updated throughout the study process (after each interview and when analyzing data) to ensure reflection was a continuous process. In my research journal and field notes I critically reflected on my biases, assumptions, observations, experiences, and emotions. For example, the entries included thoughts on my perceptions on participants’ responses, the mood and the context of the interview, ideas about possible interpretations of data, and suggestions for improvement of my interviewing skills. The following is an example of my journal entry after the first interview and it highlights suggestions for the betterment of my interviewing skills:

“In general, I think the first interview went well, I was conscientious about the time and the progress of questions. Next time ask more about them in the beginning, let me explain a bit about themselves, where did they go to school, what kind of certificate they have, etc. It will help with transitioning into the conversation and get them a bit more relaxed. Also. Sometimes I need to be more careful to not interrupt the interviewee’s train of thought and remember the question I want to ask after they start answering the question and ask it after they are done. Finally, I should make sure that I do not ask questions in a way that would influence their answer – especially question #12 (What do you understand under the term disability?)” – October 10th, 2018

Additionally, writing reflexive field notes and creating notes on my perceptions and thoughts provided me with supplementary data for analysis (Smith & Sparks, 2016). Composing field notes right after the interviews proved very useful and served as the first interpretation of
data. Below is an excerpt from a reflexive field note that was written after one of the interviews:

“I feel that Katrin is very open to disability and individuals with disabilities, most likely because of her experience with disability in her family. I was amazed by her fearlessness to take on clients with disabilities, she was not discouraged to take on clients with disabilities from the get go, maybe also due to her upbringing (she mentioned facing troubles head on and not avoiding them) and of course her experience with her father who had lived with an impairment for almost 20 years. She appears to have a strong, determined personality, which also adds to her openness to take on clients with disabilities. It is interesting that she believes that education does not (even if there were a separate course on disability in the fitness industry) give you enough resources to be able to successfully take on an individual with disabilities, she thinks it is vital to be quick and have the ability to think fast and modify exercises when you are dealing with the population.” – October 24th, 2018

A few of the research participants invited me to observe and attend their training sessions, which provided me with direct insight into the training process. Observing and participating in training sessions enabled me to gain valuable insight about accessibility, space, equipment, clientele, and the ways the trainers and instructors carried out the training sessions. After all of those training sessions I created field notes, which served as useful additional data for analysis (Smith & Sparks, 2016). For example, this is an excerpt from a reflexive field note after attending one of the training sessions, where I was able to identify the design of the session and training conditions for clients with disabilities:

“I attended a few of Katrin’s outdoor training sessions. The training session was a bit different from how I imagined it to be – the exercise intervals are quite short and there are no breaks between exercises. The training session offers an interesting variety of
strength and cardio workouts. Saturday’s class is dedicated to the whole body, so there are usually 3 sections for upper body, core and stomach, and legs. Each of the sections is separated with a cardio part (a short run around the field) and at the end there is a longer run (either uphill or on the flat section). The amount of space available for each participant varies depending on the number of people that attend the training session. The surface is flat and I would imagine it is pretty safe for an individual with a physical disability. On the other hand, the training does happen outdoors, so it can be quite cold in the winter months, especially when exercises are done on the mats. Since most of the exercises are done with own body weight or dumbbells, the exercises seem to be suitable for individuals with disabilities, and Katrin also offers modifications, if somebody is not able to do the original exercise.” – December 6th, 2018

During one training session I had the opportunity to observe a client with a disability and pay attention to how she navigated through the session and what modifications were set up for her. The information I gathered were again a helpful contribution in the analytical phase of the research process:

“In the second training session that I attended there was an older lady, who had a heart condition. She was apparently slower and could not do all the exercises. I am wondering how much attention can be given to an individual with disabilities when there is a group of over 30 people that an instructor needs to supervise. Just in terms of safety it could be hard to supervise everyone and focus enough attention to the individual with disabilities. Additionally, I am not sure how can an instructor ensure the appropriate level of quality of the training session – for the client with disabilities and the rest of the class. Katrin (the instructor) has mentioned that she does not have any problems with including individuals with disabilities and she never turns anyone away.” – December 13th, 2018

Furthermore, keeping a research journal to reflect on the process of research and practices taken was necessary for the production of rigorous qualitative research (Braun &
Clarke, 2013). In order to do so, reflexive journal and field notes were also utilized during the data analysis phase. Below is an extract from the research journal, which was helpful in the analysis section:

“It was very interesting how older adulthood in Luka’s eyes equals disability. All the questions related to disability were answered from the perspective of training older adults. Also, his understanding of disability was probably the most progressive so far. He does not see disability as hindrance, more as a different ability, as an opportunity to still be able to do things and not so much just focusing on what you cannot do when you have a disability. He has a PhD in Psychology, so that might have contributed to his understanding of disability. Another reason for his perception of disability is probably the fact that his wife has lived with a disability for almost all of her life. And she is also a trainer, so he can directly experience how much a person with a disability is capable to do and accomplish. Luka seems to sincerely respect her achievements in terms of her fitness ability and her coaching successes. I also found that he was very willing to help and talk to me for as long as I wanted to, which might also have to do with the fact that he was once a researcher himself.” – December 3rd, 2018

Lastly, I recognize that the research itself likewise shapes the researchers and influences their judgement (Attia & Edge, 2017). Being aware of the existence of retrospective reflexivity (Edge, 2011) I acknowledged and recorded the changes brought about in myself as a result of the research process and how those changes consequently affected the research process itself (Palaganas et al., 2017). For example, by participating in the research process, specifically by carrying out the interviews, observing a few training sessions and participating in a couple of them shaped my understanding of disability and regulated my perception of individuals with disabilities. In the past, when working as a personal trainer and before the onset of this research study, my perceptions and understandings of disability were often guided by fear of
harming my clients with disabilities. The longer the research process went on, the more immersed I became into the topic, the more I started to notice a shift in my understanding of disability and my attitude towards people with disabilities. Better understanding of the origin of some of my perceptions and beliefs about disability regulated my views and essentially lead to my development of more inclusive understandings of disability and individuals with disabilities.

3.6.1 Navigating through difficulties during the research process

One of the predicaments I encountered during my research was the recruitment of research participants. Participant recruitment for qualitative research is often the most challenging part of the project (White, 2017). With a potentially sensitive topic, or due to the lack of knowledge about the subject of disability, trainers and instructors might have felt discouraged to participate in the study. After conducting the first few interviews I hit a wall and was unable to recruit any more research participants. Trying to navigate through this complex situation I came to realize that trainers’ limited understanding of disability could have contributed to the recruitment difficulties I was facing. My thoughts and assumptions are summarized in this excerpt from my reflective journal:

“After 2 months of intense recruitment (online, private and public gyms, sending out a number of emails, using previous research participants and personal contacts that either work in the industry or know people in the industry), I am coming to realize that the biggest barrier to finding trainers that would be interested in participating in the study has been their understanding of disability. Also, after talking to the first three participants, I am getting a feel for their understanding of disability and it appears that trainers understand disability very narrowly – when they think of disability, they imagine someone in a wheelchair or with a prosthetic leg. Consequently, they feel that they do
not have experience training clients with disabilities, even though in reality they often do. Most of the trainers have trained clients with a limited mobility, clients in post-rehabilitation state, older adults, clients with cognitive disabilities, and clients with hidden disabilities. My impression is that even though they have experience training clients with disabilities, they do not realize it and that is why they do not feel that they qualify for the study. Or they simply do not care. In both cases the question is: Why is that? Is that because of the lack of knowledge and awareness obtained through education and certification? Or does it have to do with the general lack of exposure of disability and IWD in the broader societal sense? Most likely it is a combination of both.”

– November 14th, 2018

Interestingly, a good number (approximately ten) of trainers expressed interest to participate in the study. However, they did not hold a BCRPA certification. In choosing to limit the recruitment to this specific certification I had expected to secure the desired number of research participants. BCRPA is the most often accepted certification both in public and private settings in British Columbia, which was the main reasoning for my decision. Limiting the sample to only trainers and instructors holding a BCRPA certification was necessary for drawing conclusions and formation of future recommendations.

Recruitment was further compromised by a lack of recruited participants through the means of snowball sampling at the beginning of the recruitment process. I had expected to be able to utilize participants’ recommendations for other participants (Bryman, 2015). After conducting the first three interviews it became apparent that it would not be straightforward to recruit participants with the help of snowball sampling. My thoughts are summarized in the reflexive journal entry after six weeks of recruitment:
“Another unexpected turn of events – I am not getting any participants through snowball sampling. After 3 interviews I have expected to get some referrals that could have led to other research participants but so far that has not been the case.” – November 18\(^{\text{th}},\) 2018

Additionally, after conducting the second interview and sharing the difficulties I had been experiencing with the recruitment process, one of the research participants made a valid point. She suggested that one of the possible rationalizations for the recruitment struggles could have been related to the current situation personal trainers and instructors in Vancouver deal with. Due to the increasing cost of housing and life in Vancouver many trainers are forced to take on a second job. Since I limited my sample to only trainers working full-time a lot of trainers did not qualify for the study. The following is an excerpt from my reflexive journal:

“Difficulties with recruitment could also have something to do with what one of the trainers I have interviewed pointed out – a lot of trainers nowadays have to take on other work in order to survive in an expensive city like Vancouver. She mentioned that the situation was not like that even 5 years ago, so that could be another reason for why trainers are not responding to me – I am only recruiting trainers that work full-time.” – October 22\(^{\text{nd}},\) 2018

Finally, gatekeepers could have been partly responsible for difficulties with recruitment. Gatekeepers are individuals or groups who control information and are able to grant entry and access to the setting and participants (Holloway, 1997). Prior to gaining access gatekeepers want to be informed about the purpose of the research and the possible outcomes. Additionally, they will also want to know about any possible benefits or risks to themselves or the organization they are affiliated with (Sparkes & Smith, 2014). At the onset of the research I mainly contacted managers at various fitness centers. Holloway (1997) indicated that
gatekeepers, such as managers, might deny access because there is suspicion and fear of criticism or when sensitive issues are to be investigated. Fitness managers might have feared the findings of the study would bring critique to their establishment. What is more, perceptions of and attitudes towards individuals with disabilities is potentially a sensitive topic, which could have further discouraged managers from allowing access to research participants.

Trying to deal with the recruitment adversity I learned to accept that qualitative research is a time demanding process and it is common to underestimate the time required to complete each stage of the process (Sparkes & Smith, 2014). I envisioned an ‘ideal’ plan for each of the stages of the research process. Experiencing research predicaments early in the process helped me realize that research is unpredictable (Smith & Sparkes, 2016) and delays are a common occurrence in such a complex operation. Furthermore, I was able to use this experience in the subsequent stages of the research process.
4. Findings and Discussion

This chapter outlines themes that were constructed and identified through the process of thematic data analysis. The findings are organized into four themes, which were recognized by the virtue of answering the two research questions: (1) How do personal trainers and instructors understand disability and individuals with disabilities?, and (2) What perceptions or understandings are associated with breaking down and reinforcing the barriers for people with disabilities? All themes and subthemes are listed in Table 3 and are presented in the following sections. Additionally, it was important to gather information and gain understanding about participants’ background and their levels of training experience. To better position the research question and situate the sample, this information is conveyed first.

Table 3: Themes and subthemes

<table>
<thead>
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<th>Themes</th>
<th>Subthemes</th>
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<tr>
<td>Impairment</td>
<td>1) Lack of Ability</td>
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<tr>
<td>‘People are disabled by their impairments or differences’</td>
<td>2) Irregularity</td>
</tr>
<tr>
<td></td>
<td>3) Difference</td>
</tr>
<tr>
<td>Fear</td>
<td>1) Taking on a Client</td>
</tr>
<tr>
<td>‘Disability as the elephant in the room’</td>
<td>2) Injury</td>
</tr>
<tr>
<td></td>
<td>3) Failure</td>
</tr>
<tr>
<td>Experience</td>
<td>1) Personal Experience</td>
</tr>
<tr>
<td>‘Experience can move mountains’</td>
<td>2) Training Experience</td>
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### 4.1 Participant’s Background and Training Experience

Participant’s background and training experience represent valuable information for situating the sample and add to the interpretation of data. Out of the 12 trainers and instructors, 8 were female and 4 were male. The sample included mature individuals with the average age of forty-nine. The averaging years of experience working as a fitness professional across the sample was 15 years, ranging from 4 to 40 years. Seven of the twelve trainers and instructors had more than 10 years of experience and five participants have been working in the profession for over 15 years. In addition, all of the participants had some sort of experience training clients with disabilities. Abundant experience certainly contributed to participants’ perception and understanding of disability and individuals with disabilities. Despite a shortage of research currently available on this subject having experience appears to shape one’s perception and understanding of the subject matter (Martin & Whalen, 2014; Wareham et al., 2017). Sampling experienced trainers allowed for the generation of rich data from a perspective of the ‘experts’ in the field of training and instructing. In this way a broader and more comprehensive understanding of participants’ perceptions and understandings of disability and people with disabilities was gathered.
In addition, trainers and instructors did not necessarily fit the bodily ideal of a fitness professional. Namely, eight participants were over the age of 40 and their bodies in most cases did not reflect the widely recognized and accepted corporeal standard in the gym environment (Schommer-Aikins, 2002). Having a fit, thin and athletic body is particularly relevant in the sports and fitness fields (Frew & McGillivray, 2005; Hutson, 2013), where fitness professionals may be highly regarded for their physiques (Hutson, 2013). Investing time and energy in the body becomes a way of acquiring credibility and corporeal capital – a type of capital that is equated to economic, cultural, and/or social capital (Molnar & Kelly, 2013). Most of the participants did not possess the corporeal capital and their bodies in a way represented a negation to the recognized and universally approved standard in the gym milieu.

Finally, participants were relatively highly educated – all of them had some sort of post-secondary education and six participants held a university degree. In addition, seven participants claimed that training and instructing was their second career, a profession they chose later in life – after having children or commencing retirement. This is not surprising if we consider that fitness professionals often have minimal job security and earning potential (Hutson, 2013).

To sum up, trainers and instructors were mature individuals, with substantial experience in their personal lives and their professional careers. Additionally, they were relatively highly educated, especially when considering that a university degree is often not a requirement for a professional exercise leader or a prerequisite for a successful training and instructing career (Melton et al., 2008). Furthermore, most of the participants did not conform to the bodily standards expected from fitness professionals (Schommer-Aikins, 2002). Finally, the nexus of
experience, education, and corporeal capital additionally shaped participants’ perceptions and understandings of disability and individuals with disabilities.

RQ 1: How do personal trainers and instructors understand disability and individuals with disabilities?

4.2 Impairment

‘People are disabled by their impairments of differences’

In order to answer the overarching research question: How do personal trainers and instructors understand disability and people with disabilities? The theme Impairment was recognized. This theme was further broken down into three subthemes – (1) Lack of Ability, which discusses how participants understand disability and individuals with disabilities as having a shortage of ability, (2) Irregularity, which highlights participants’ perceptions of disability as a deviation from a standard norm, and (3) Difference, which illuminates how participants distinguished between able-bodied clients and clients with disabilities.

4.2.1 Lack of Ability

When asked about their perceptions and understandings of disability a number of participants focused on individuals’ with disabilities shortage of ability. Trainers and instructors clearly differentiated between the functional abilities of the able and disabled body. In addition, people with disabilities were recognized as needing additional help and customized treatment. Debbie, Susanne and Shawn all understood disability as a lack of ability. Debbie highlighted her perceptions about disability essentially as being a lack of ability. Anyone, who departed from
the standard set by society (Garland-Thomson, 2016) was in her eyes considered as having a disability:

“Whatever kind of disability people have, even obesity is a disability because they cannot do a lot of the things that regular weight people can do. It is such a broad definition. So, I guess anybody that is not able to do things that able-bodied people could. I do not know if that is a very good definition.”

Susanne understood individuals with disabilities as having different abilities. She perceived difference as a deficiency, which required a customized approach. Furthermore, Susanne recognized that the majority of available services are designed for the able-bodied population, which reinforces individuals with disabilities’ positionality as a minority:

“Yes, someone who cannot just go on the internet and just easily try and find what they need to train, that is what I would say. So they would be like: ‘Oh, none of these things match what I need’, their abilities are very different, ‘I cannot see or hear or I cannot move this way, I need extra help or someone to find me something customized because I cannot do it with what is available to the majority of the population’. In a way it is a minority kind of thing.”

Finally, Shawn as well understood disability as a shortage of ability, which is apparent from his words:

“Yeah, dis-ability, so you put dis- in front of something, it is a lack of ability, if you just want to define a word by what it means.”

Shawn further explained his views on disability and individuals with disabilities. He postulated that every individual should be born with a certain set of abilities and whoever was not lucky enough to be endowed with those abilities is cast as an individual with a disability:
“Lack of ability is interesting. I meet a lot of people, who are fully able-bodied, who seem to lack ability because they lack the motivation or whatever. So, to me I guess it means that, I don’t know there are maybe certain abilities that a human organism should be capable of doing, like if you have two hands, you should be able to grip things, you have two legs, and you should be able to walk. So, I guess disability means that those basic abilities that we are all naturally endowed with, for whatever reason they don’t have some of those.”

Shawn’s perception of disability again put ability at the forefront of every individuals’ existence. Any ‘normal’ individual possesses the physical abilities awarded at birth. People with disabilities are then recognized as lacking the ‘natural’ abilities they should have been equipped with. In general, trainers’ and instructors’ narratives about their understanding of disability as a lack of ability reflect the notion of ableism. Physical activity environments like the gym are filled with the concept of ableism (Richardson et al., 2017c), which is defined as social bias, beliefs and practices directed against people whose bodies do not function as the universally accepted normal standard (Wendell, 1996; Wolbring, 2008). More than that, ableism does not only represent the negative attitudes towards people with disabilities, it is the ‘trajectory of perfection’ and a ‘deep way of thinking how ‘certain clusters of people are en-abled via valued entitlements’ (Kumari Campbell, 2019, p. 146). Ableism openly operates to institute the norm (Kumari Campbell, 2009) and casts disability as a ‘diminished state of being human’ (Kumari Campbell, 2001, p.44).

Furthermore, in participants’ accounts of disability one can recognize ability-based understandings of oneself, the body and relationships with others (Wolbring, 2012). Ableist perceptions judge the favored neoliberal citizen as always being able-bodied, able-minded (Goodley, 2017), capable, malleable and compliant (Goodley 2004). The bodies of the
commonly desired citizen can be best sculpted in an environment like the gym, in a controlled space and with specialized equipment (Hedblom, 2009). Even though the bodies of the unfit and the other are permitted to enter this environment, they are perceived only as a contradiction of the glorified and generally accepted measure of the strong, white, male body (Wendell, 1996). Consequently, any body and any individual that does not conform to this ableist corporeal standard is marginalized (Crossley, 2006) and discriminated against (Loja et al., 2013; Wolbring, 2008).

4.2.2 Irregularity

Participants further discussed their perceptions and understandings of disability as a deviation from a standard and a restraint that interfered with individuals’ daily activities. A disabled body was perceived as a deviance from the normal or able body (Goodley, 2017). Furthermore, a disabled body was also associated with irregularity. Two of the trainers, Jacob and Eva, envisioned disability through the lens of ‘social deviance’, which positions disability as stepping out of the normal, widely accepted normative ways of existing (Goodley, 2017). Jacobs’ narrative reflects his acknowledgment of disability as an improper way of functioning (Bury, 2000) and a divergence from the accepted ways of being:

“I would say that they are not functioning properly in either physical or mental way. So, they are not functioning, I can’t think of a better way to say it, just functioning in a proper way. From the standard what society would say is normal, I suppose.”

On a similar note, Eva essentially perceived disability as an impairment of function, which prevents one from functioning in an appropriate and generally expected way. In her eyes physical and sensory impairments cast you as being irregular and set you apart from the norm
(Lutz & Bowers, 2005):

“Disability means to me an improper function, you are not functioning like apparently healthy. It could be: ‘I have a sore knee today, I have a disability’, my disability could be: ‘Oh, s***, I can’t read that, I need to put on my reading glasses’. Or it could be hearing, those really subtle things.”

The third participant Laura talked about disability as a functional and mental limitation, which negatively shapes your reality and gets in the way of active ways of living (Crow, 1996; Fitzgerald, 2012):

“I suppose any kind of challenge that gets in the way in that you have to think your way around it: ‘Do I need to sit down right now?’ and psychologically: ‘Have I forgotten what I was supposed to be doing here?’ So, there is such a wide range of things that get in the way of just being able to carry on with your day and nothing to interfere with (laugh). I suppose a disability is anything that is getting into people’s way of active living. It is not an easy one to define.”

In her narrative about her understanding of disability, Katrin did not distinguish between individuals with physical impairments and mental disorders, as they are both eternally bound by their inability to carry out a task. Furthermore, she understands disability as a deviation from the ‘normate’ – ‘the corporeal incarnation of culture’s collective, unmarked, normative characteristics’ (Garland-Thompson, 1997, p.8). Katrin stated:

“I think it means a person that is not able to do something, it could be something like walking, or it could be something that they have to take medication for perhaps. It can be bipolar, different things. It does not necessarily mean handicapped but something that they are not able to do and a regular person might be able to do.”
A handful of participants perceived disability as irregularity and viewed their impairment as all-encompassing and the central and defining characteristic of their lives (Fitzgerald, 2012; Lutz & Bowers, 2005). Through trainers’ and instructors’ narratives it becomes apparent that individuals with disabilities were cast as being irregular and deviant. In addition, due to their impairments they were perceived as being abnormal and inadequate, which devalued them as human beings (Lutz & Bowers, 2012). Furthermore, when human life is perceived merely as its biological components, it diminishes the socially, economically and culturally created human being (Goodley, 2017). In this way people with disabilities get treated as objects instead of architects of their own lives and the compliance to normality becomes emphasized (Linton, 1998; Sherry, 2006), reinforcing the exclusionary societies’ value of certain kinds of individuals over others (Abberley, 1987). Finally, being perceived as objects of one’s experience rather than subjects with whom one might identify casts individuals with disabilities as others (Wendell, 1996) and positions them as a contradiction to the glorified individual of our times (Goodley, 2017).

4.2.3 Difference

Finally, two of the trainers and instructors reported viewing disability and individuals with disabilities as being different from the able-bodied majority. Susanne and Jacob specifically talked about understanding disability as having a different skillset and a dissimilar set of abilities. Furthermore, Susanne acknowledged disability to deviate from her previous training experience:

“It means different abilities, I guess (laugh). So, that is why I think it is. Maybe different abilities, so it is maybe a little bit less common than the different kind of abilities that
In addition to recognizing disability as a different set of skills, Jacob reported that training clients with disabilities required additional thought and consideration:

“So they [individuals with disabilities] have different skills that you do not necessarily see, so you have to really think about what is going on a little bit more than with a typical client. That is what I would say there.”

Participants’ perceptions and understandings of disability as a difference are in keeping with the different categorization and treatment of disability across cultures and societies (Shakespeare & Watson, 2001). Societies have historically established divisions between people with disabilities and others (Davis, 2000) and this separation is apparent from Susanne’s and Jacob’s accounts. A well-established approach to understanding difference in relation to disability is the traditional medical view, which differentiates between individuals on the basis of impairment (Stalker, 2004). Both Jacob and Susanne assigned the difference between their able-bodied clients and clients with disabilities to their different abilities and skillset. In this way, subjects are produced and ranked “within a hierarchy of bodily traits that determines the distribution of privilege, status, and power” (Garland Thomson, 1997, p.6).

4.2.4 Discussion of Theme: Impairment

Three subthemes – Lack of Ability, Irregularity, and Difference highlight participants’ understanding of disability and individuals with disabilities. Most trainers and instructors equated disability with impairment and understood it as being defined by physical and
cognitive differences and limitations. Their conceptualizations of disability as a biological determinant were aligned with the perceptions of the medical model of disability, which primarily understands disability as a pathology, a decreased physical, sensory or cognitive state that hinders the individual and calls for a medical intervention (Goodley, 2017). Disability is further viewed as a condition, located within the individual (Linton, 1998). Viewing disability as a medical problem that resides in the individual is a fundamental understanding of the medical model and the point of departure from the social model’s perception of disability as a socially constructed phenomenon (Olkin, 1999).

In addition, the medical model defines disability as a deviation from structural or functional norms (Bickenbach et al., 1999), reducing individuals’ corporeal identity to abnormality (Zitzelsberger 2005). Essentially, medical model perceives disability as being fundamentally negative (Retief & Letšosa, 2018). What is more, the medical gaze not only invalidates those bodies and individuals as dependent, incapable, inferior and even sub-human (Barton, 1993; Kumari Campbell, 2008), but also acknowledges that some bodies ‘matter more than others: some are, quite frankly, disposable’ (Braidotti, 1996, p. 136). Participants’ narratives symbolize a social world that is uneasy with difference, a world where embodying a variation still inhabits a place defined as exceptional rather than being one of the possibilities (Shildrick, 2012).

Furthermore, since disability is perceived as a deficiency, the medical model stresses the need for correction or normalization (Edwards & Imrie, 2003; Martin, 2013). One of the participants, Jacob, illustrated how important it was to remedy impairment. He was convinced that every individual with a disability desired most to fix their condition and regain full ability
(Oliver, 1990). Jacob understood disability as being something inherently bad and something that one should ameliorate in order to conform to a set of standards recognized as normal and beautiful (Barton, 1993). His words reflect the essence of the convictions of the medical model of disability:

“If you are in a wheelchair, you want to get out of that wheelchair. You can be at a restaurant, eating something nice, going out on the sunny day, looking out of a nice window but really you want to get out of a wheelchair. That is your main goal in life. So, if that is your main goal in life, that should be your main goal and gyms are typically a nice way to get rid of that.”

Especially in the sport and exercise settings people with disabilities get perceived as ‘broken’ (Susman, 1994). Due to their impairment they often lack the ability to perform an activity within the range considered to be normal (Goodley, 2017). Jacob’s narrative recognized the gym environment as a suitable space for this populations’ engagement in physical activity and exercise (Richardson, 2017c), a space in which individuals with disabilities can amend and cure their impairment. Consequently, perceiving disability through the lens of the medical model shifts the responsibility for taking care of the impairment to the individuals (Goodley, 2017), who are then supposed to solve their predicament (Smith & Bundon, 2016). This view of disability does not contest social oppression (Goodley, 2017) and subjects people with disabilities to exclusion and oppression (Thomas, 2007; Wolbring, 2008). These understandings and practices negatively shape individuals’ psychological and emotional health and well-being (Reeve, 2012; Smith, 2013; Thomas, 2007).

By interpreting the findings through the critical lens and taking a disability studies position I do not deny the importance of medical intervention or disagree with the overarching
benefits exercising in the gym brings to this population. However, I am critical of the prioritisation of the medical approaches to the disability problem (Shakespeare, 2006), which appeared to be the dominant perception and understanding of disability in the gym milieu. The lack of social understanding of disability highlights the unbalanced coverage of disability and a neglect of political issues (Shakespeare, 2006). Michael Oliver’s words from his first published sociological paper over four decades ago hold value to this day: “The aim of research should not be to make the legless normal, whatever that might mean, but to create a social environment where to be legless is irrelevant” (Oliver, 1978, quoted in Oliver, 1996, p. 137). Trainers’ and instructors’ perceptions and understandings of disability and individuals with disabilities heavily aligned with the medical models’ recognition of disability as lacking, irregular and abnormal, which needs to be alleviated and cured.

**RQ2: What perceptions or understandings are associated with breaking down or reinforcing the barriers for people with disabilities?**

**4.3 Fear**

*‘Disability as the elephant in the room’*

In order to answer the second research question: *What perceptions or understandings are associated with breaking down or reinforcing the barriers for people with disabilities?* Three themes were identified. A perception that reinforced barriers for people with disabilities in the gym milieu is summarized in the theme *Fear*. Participants exposed different avenues of fear as one of the most prevalent perceptions associated with training clients with disabilities. The theme is additionally divided into three subthemes – *(1) Fear to take on a client*, which
highlights how fear negotiated participants’ perceptions of disability and willingness to take on clients with disabilities, (2) Fear of Injury, which discusses the role fear of causing an injury played during the training process, and (3) Fear of inability, which explains how participants’ fear of lack of ability to work with clients with disabilities shaped their perceptions of disability and how it informed their work with this population.

4.3.1 Fear to take on a client

Several trainers and instructors highlighted how being afraid to take on a client influenced their perception of disability and shaped their relationship with individuals with disabilities. Fear to take on a client with a disability represented a significant barrier to this populations’ participation in the gym. Furthermore, participants described how they navigated through their feelings of fear and revealed some of their reasoning behind their perceptions. Katrin shared a story about a young lady with a pacemaker who struggled to find an exercise professional to take her on as a client. Despite being extremely fit, fear prevented trainers to enroll her into their programs:

“The lady with the pacemaker in their 30s, she told me I was the only person that would take her on. She was a very fit girl, she exercised a lot, she was really keen on the mud runs and one day her heart stopped. Not in my class, this was outside. She literally died and they resuscitated her and she had a pacemaker and had to start back slow, nobody would take her. But I took her because I had CPR training, why do they make you take CPR and First Aid? At least I know what to do.”

Having the appropriate certification (CPR and First Aid certificate) determined Katrin’s perception of the situation and influenced her belief that she is able to handle a potentially dangerous situation. Vicinity to the fire department with medical staff and appropriate
equipment seemed to have a positive impact on her perception of the situation:

“Fear, probably fear of being liable if something happened to her. I am lucky enough that right next door I have the fire department and they have an EED, I had to call them two or three times and they always come right away and they would bring the machine if I did need it.”

Katrin further explained her convictions about the exercise professionals’ logic and their rationale for not taking on that client. She believed that trainers’ apprehension originated in their fear of being liable in case of an injury:

“Fear, probably fear of being liable if something happened to her.”

Another participant, Debbie, explained how she experienced fear before taking on her first client with a disability. Additionally, she explained how she was able to control her fear. Through the process of becoming better acquainted with the client she changed her perception of the individual with a disability:

“Yes, for the most part. I mean, the first one, when I trained the gentleman with schizophrenia, I was terrified. But after you get to know him and you realize ‘oh, yeah, he is a good guy’ and when he was lucid you had very good conversations, ‘oh, he is just a normal guy’ and then he was not. So, you just get used to it, like anything. Well, I think I was very, I was a lot more concerned, what is the word, careful. A lot more careful in what I prescribed.”

Through the course of our conversation Debbie came to the realization that her fear to take on clients with disabilities originated from stigma surrounding disability. Her words reflect this recognition:
“But I think part of it is also ... it is not the exercise, it is the stigma. How do I as a trainer deal with somebody? The exercises are all the same, it does not matter, it is my own mindset, I would be afraid probably to train somebody that is in a wheelchair. If I got the training, perhaps.

In spite of recognizing and understanding the source of her fear as being associated with stigma, Debbie remained reluctant to take on clients with disabilities. In addition, Debbie’s negative perception of disability supports existing reports on the experiences of disability, which reveal that disability often gets stigmatized or remains hidden (Wareham et al., 2017). When a person’s acts or attributes are perceived as negatively different they become deviant, varying from prevalent or valued norms (Goffman, 1963). In turn, many able-bodied individuals seem to be hesitant to interact with individuals with disabilities (Fitzgerald, 2012; Lenney & Sercombe, 2002).

Furthermore, Debbie disclosed that every year all of the trainers and instructors working in the public sector in the city of Vancouver would meet for an educational workshop. One of the years they visited the largest rehabilitation hospital in British Columbia, GF Strong, where they got introduced to specific exercises for a range of impairments. Despite becoming familiar with the training regime and acquiring first-hand experience with training individuals with disabilities Debbie still felt intimidated and out of place:

“So, all the fitness staff in the city will get together once or twice a year. So, we get lunch and then we get to learn about whatever. And so, one of them was going to GF Strong. That must have been last year, it is hard to keep everything straight now. But it was interesting because there were different people with like brain injuries and stuff like that and people with paralysis, they had all these adapted exercises, so you would go and you would push and pull and stuff like that, it was interesting. But it was still intimidating.
Because it is just not having that exposure. You feel like a fish out of water or something like that.”

This speaks to ways in which society tends to comprehend disability (Goodley, 2017). The association of disability with stigma reinforces the notion of disability as a problem, residing in an individual (Barnes, 1991). Individuals with disabilities are stigmatized through the form of societal branding, where individuals violate the norms of values of society (Goffman, 1963). Deeply rooted societal perceptions and understandings of disability regulated Debbie’s relationship and attitudes towards disability, leaving her uneasy at the thought of training a client with a disability.

Susanne was another trainer whose perceptions of disability culminated in fear and guided her willingness to take on a client with a disability. In her narrative, she expressed her feelings before the onset of her work with a client with a disability:

“The person with the exercise induced asthma, when I first heard about it, I researched it and I was kind of worried, I did not want to go there, I did not want her to die.”

Additionally, Susanne discussed how trainers and instructors could be reluctant to take on clients with disabilities because of the unclear legislation of the BCRPA certification. Being unsure about the boundaries between training and rehabilitation culminated in fear of overstepping one’s credentials:

“I feel like that some personal trainers have maybe refused those people in the past because of fear. The BCRPA is pretty strict in saying ‘you know, you are not allowed to do rehabilitation’. Maybe that is also another barrier. That they went to other people before, who were like: ‘oh, I am not sure I am allowed or I do not think that I can help you or whatever’. That is another barrier.”
Susanne’s words reflect the convictions of the medical model of disability. One of the central characteristics of the medical model is the belief that impairment needs to be cured, ameliorated or rehabilitated. Through rehabilitation a person with a disability should be adjusted to their condition and to the environment (Olkin, 1999). Additionally, Susanne’s narrative highlights the perception that impairment should be dealt with medical intervention and with the help of medical professionals (Goodley, 2017).

Fear to take on a client with a disability was a perception that profoundly reinforced the barriers for individuals with disabilities in the gym milieu. Participants were afraid to take on individuals with disabilities for a number of reasons, which can be attributed to stigma (Goffman, 1963) associated with disability.

4.3.2 Fear of Injury

The second perception that reinforced barriers for individuals with disabilities in the gym environment was fear of causing an injury. Participants reported being afraid that a client with a disability would get injured during the training session, which is apparent from Debbie’s narrative:

“And safety, there is a girl that goes to Creekside and she has got a trainer that will help her get onto the treadmill. So, what if she falls off? What are the safety aspects of that? I do not know how to do that. I would not be comfortable doing that. So, I would never take that client.”

Similar to recognizing that her fear to take on a client with a disability essentially originated in stigma and her perceptions of people with disabilities as being wear and fragile, Debbie understood the source of her fear of injury:
“And again, that is probably a stigma that you put on yourself, you are more worried about hurting them because they are disabled when they are probably fine but you are just not sure.”

Luka also acknowledged that he was afraid that his clients with disabilities would get injured during his class:

“You are hugely concerned that they are going to fall in class and hurt their head or break a hip or break a wrist. I mean, I am always worried about those kind of things. Every time I am going into class I am thinking is today the day I am going to have a fall from somebody.”

One of the trainers, Shawn, understood fear of causing an injury as a negative perception. He recognized that many individuals, especially inexperienced trainers, are afraid of hurting their clients:

“I think so because you are worried so much how fragile everyone is. And I noticed this with any new trainer, to be honest with you. Even if they are working with someone who is apparently healthy, there is this fear that human beings were made of glass and we are going to break them.”

Being in the profession for almost two decades has awarded Shawn with a wealth of experience. In turn that experience contributed to his understanding of the strength and robustness of the human body. Through the years, he realized the importance of stress for the body and recognized how adaptable it is. This realization influenced his perception and understanding of individuals with disabilities as them being tougher than most people would expect:
“Over the years I have realized that you are not hurting these people, but the body does need to experience stress. The body is always adapting to whatever forces it experiences the most. So, if it never experiences intense, stressful forces it becomes quite soft and weak and everything else. And muscles atrophy and tissues get weaker. Whereas in my own experience, especially with the gymnastics stuff, a lot of it is tough, even on your skin for instance. The calluses I built up over the last couple of years are incredible but it just shows you that the body has this natural capacity to toughen up. I started playing with kettlebells and I took a 2-day workshop and the kettlebell would hit me in the forearm, it is metal, it hurts and after a while your body just adapts to it to the point now when the metal hits me, I was doing kettlebells last night and the things are smashing into my shoulders and I don’t even notice it. I think I have sort of taken that forward and realized that people are a lot tougher than you think they are, even injured people, people with some issues, they are actually a lot tougher. I think we all need to come to the conclusion that we are a lot tougher than we think we are.”

Participants disclosed being afraid clients with disabilities would get injured during a training session. Fear of injury represented a relevant barrier to this population’s involvement in the fitness environment. Two trainers recognized fear as being inherently negative and described its adverse effects on trainers’ perceptions on the impaired body. Specifically, stereotypes about this population portray their bodies as dependent, incapable, fragile and vulnerable (Barton, 1993), which was heavily associated with participants’ fear of inflicting harm and causing an injury to clients with disabilities.

4.3.3 Fear of Inability

The final perception that reinforced barriers for individuals with disabilities in the gym environment was the fear of being unable and incapable to appropriately design and carry out training sessions for this population. Jacob, for instance, felt that he was not the right person to
work with an individual with autism because he was afraid that he would not be able to cater to his clients’ needs:

“Truthfully, there is the thought that you might fail and the thought that you might not be able to figure anything out. I did not think I was the best person at all for it. In the beginning I was really thinking if I was the right person for this at all.”

In addition, Jacob did not perceive himself as having the necessary traits in order to be successful at training clients with disabilities. In his view a trainer would require certain qualities, such as patience and a nurturing personality:

“In my own case I did not see myself as being a super tolerant person, I did not see myself as a really nurturing person. I was kind of surprised they were asking me to different things but I supposed it worked out in the end. Maybe the employer saw something I didn’t. I didn’t feel like I had any of those qualities but they kept asking and it did work out.”

Another trainer, Steve, shared his accounts on training clients with autism. His experience training this population was largely guided by his fear. Because he was uncertain how to react at times he felt intimidated and overwhelmed to the point of almost quitting:

“Even though I had experience I was pooping my pants, I was always scared, it was even uncomfortable at times because you wouldn’t know what to do. I would be super scared, intimidated or so overwhelmed that I almost quit.”

4.3.4 Discussion of Theme: Fear

Trainers and instructors revealed being afraid to be unable to handle people with disabilities or they were afraid they possessed inappropriate personal characteristics and qualities to successfully train clients with disabilities. Participants’ perceptions can be explained
through the concept of psycho-emotional disablism. As there is a lack of culturally agreed rules of engagement with individuals with disabilities (Keith, 1996), often the ‘fear of doing the wrong thing’ results in avoidance instead of interaction (Reeve, 2006; 2008), which was apparent from participants’ narratives. Fear of the unknown and doubt about their abilities to ‘handle’ the unknown significantly influenced trainers’ perceptions of disability and their willingness to train clients with disabilities (Wareham et al., 2017).

In general, the existence of fear was an important determinant when trainers and instructors contemplated whether or not to take on a client with a disability. The concept of otherness can be applied here in at least two ways. First, because trainers feared becoming disabled themselves they tried to avoid having contact with people who faced that reality. In addition, trainers and instructors did not identify with individuals with disabilities and consequently perceived them as objects that they feared and rejected (Wendell, 1996). Furthermore, not only did people with disabilities disrupt the normative individual (Marks, 1999), they also reminded that individual about their own weaknesses and pain (Wendell, 1996). This way the fear of one’s own impairment got projected onto the people living that life and caused trainers and instructors to be less likely to take on a client with a disability. Second, throughout history individuals with disabilities were often perceived as weak and fragile (Barton, 1993). These perceptions can easily lead to developing a fear of causing an injury, which was reported by a number of trainers. Additionally, participants noted being afraid to push their clients too hard due to a lack of understanding of their impairment (Wareham et al., 2017). Fear not only navigated trainers’ and instructors’ perceptions and understandings of disability and individuals with disabilities to often restrain them from taking on a client with a
disability, but also significantly shaped their ways of designing and carrying out the training sessions.

In conclusion, there is a lack of interaction and integration between able-bodied individuals and people with disabilities in the general social context (Wareham et al., 2017), which is also reflected in the gym milieu. Judgement and separation of individuals with disabilities in this environment can additionally be caused by trainers’ perceptions and understandings of disability. Being afraid to take on clients with disabilities, fearing the unknown aspect of training, or causing an injury can further contribute to the segregation of individuals with disabilities. Consequently, this results in them feeling marginalized, which has a negative effect on their psycho-emotional well-being (Richardson et al., 2017b; Rolfe et al., 2009). Such adverse encounters and experiences often cause the development of feelings of otherness, deterring them from further visits to the gym and depriving them of the various benefits of physical activity and exercise (Richardson et al., 2017b).

4.4 Experience

‘Experience can move mountains’

The first perception that broke down barriers for individuals with disabilities in the gym environment is summarized in the theme Experience. The theme is further divided into two subthemes – (1) Personal Experience, which discusses how having experience with disability in a participants’ own personal life affected their perceptions and understandings of disability, and (2) Training Experience, which highlights how obtaining and possessing experience training
individuals with disabilities shaped participants’ perceptions and understandings of disability and individuals with disabilities.

4.4.1 Personal Experience

Engaging with individuals with disabilities seemed to heavily influence participants’ perceptions and understandings of disability and individuals with disabilities. Participants expressed the importance of acquiring such experience in their personal lives. For instance, being exposed to relatives, friends or neighbours, who experienced disability appeared to have significantly affected participants’ understanding of this population. Having first-hand experience with disability either by personally experiencing disability or by being regularly exposed to individuals with disabilities enabled participants to feel more comfortable and confident once the opportunity to train clients with disabilities presented itself. Participants described attaining experience with disability through three channels – family members, neighbours and their own impairment.

FAMILY

Some participants reported living with family members, who were either born with an impairment or acquired one later in life. Katrin explained how her father’s medical condition resulted in a disability and how that affected her family’s everyday life:

“
My father became disabled, well I was about 20 or 21. He had 9 brain tumors and the last one left him with a stroke and a wheelchair and then that was it. And he passed away when he was 69, so it was quite a while, at least 20 years that he was in that wheelchair.”
Furthermore, Katrin noted that taking care of her father and being exposed to individuals with disabilities in her extended family influenced her perceptions of disability and helped her to become more open and willing to take on clients with disabilities:

“Yes, it made me more open, exactly. I have an aunt and uncle that live in one of the senior’s homes that also have disabilities and I visit them every week. My mom’s sister and brother-in law, it just seems like that is the way it is in the world, not everybody is perfectly abled.”

Similarly, when another participant, Eva, was asked about having concerns or reservations before taking on her first client with a disability, she stressed the value of acquiring experience with disability in her personal life. Eva illustrated how being surrounded with individuals with disabilities essentially prevented her from developing any doubts or concerns at the onset of her involvement in training clients with disabilities:

“No. Because I have such breath of experience through personal life, you know, I also helped my mom with my grandfather when he had dementia and helped take care of my great aunt. From that point of view, no, there is not much that throws me off.”

Shawn grew up with a father with a cognitive disability. As a young boy he came to terms with his father’s cognitive abilities. Shawn accepted his father’s reality and he has never known him to be any different from anyone else, which consequently shaped his perceptions of disability:

“My own personal story is that my dad had brain aneurism when I was 4, so he is now 75, he is retired now, but he basically lived his whole life or a big chunk of his life, mid 40-ies onwards, with a very mild brain injury. I was 4 when that happened, so I have never known him as any different but my mom says he was like a different person pre and post. So, I had experience working with people like my dad who had some cognitive stuff.”
Shawn’s perception of his father is in line with Stalker and Connor’s (2004) findings that highlight children’s perceptions of family members with disabilities as being no different from them. Shawn was aware of his father’s impairment but he did not see him as intrinsically different from himself (Stalker & Connors, 2004). As mentioned, experiencing disability early on in his life shaped Shawn’s perceptions and his understanding of disability and ultimately resulted in him being open and willing to take on clients with disabilities.

NEIGHBOURS & FRIENDS

Living close to individuals with disabilities and having friends with disabilities also proved to form participants’ perceptions and understandings of disability and individuals with disabilities. Three of the participants described how having neighbors with disabilities shaped their understandings of disability. Acquired experience of growing up with peers with disabilities significantly affected trainers’ perceptions of this population. Steve shared his story of living close to a neighbor with autism and how he perceived him as being no different from anybody else.

“I actually had a neighbour across the street, his mom told me that he had autism, but she thought it was very close to the spectrum, almost outside. For me I never noticed it, to me he was a normal individual, everything was fine. But when she said that when they went for testing they told them that it could be on the border. He has been my friend ever since Elementary school and then onto High school ... I kind of grew up with it ... For me it was always something that I just thought: This individual is just who they are, it is not different, it is who they are.”
Similar to Shawn, Steve did not recognize his neighbors’ impairment and perceived him as being like everyone else. In addition, Steve expressed how growing up with his neighbor and obtaining first-hand experience with disability positively influenced his attitude towards individuals with disabilities when he considered training this population:

“Because I have experience with my neighbour I felt pretty comfortable and it is personal training, so I thought it was awesome and wanted to try it out.”

In addition to having a breadth of experience with disability in her familial settings Eva also grew up volunteering for a disability sports association and helped take care of a neighbor with a disability:

“When I was teenager I babysat one of the boys across the street, he was actually the same age as me, who had autism. I also volunteered as a teenager for the organization called the Pacific Riding Club for the Disabled.”

As she mentioned [see above], being profoundly experienced shaped her perceptions of disability and heavily informed her work as a trainer and instructor.

Like Eva, Shawn gained experience with disability both in familial and peer settings. He expressed how he saw and understood one of his clients with a disability that he has known since childhood:

“We have a member, she takes a lot of our classes, and she has done some personal training as well. I have known her since we were both little kids.”

Finally, Debbie shared her reasons for having concerns and reservations before starting to work with clients with disabilities. She was hesitant because of her lack of personal
experience with disability. Specifically, Debbie highlighted her shortage of friends with disabilities:

“Because I am not experienced and I do not have any experience with people with disabilities in my own life. So, I never had any experience with people, I never had disabled friends or whatever.”

OWN IMPAIRMENT

Finally, participants revealed how their own temporary or permanent impairments influenced their understanding of individuals with disabilities and framed their perceptions of the training process in general. Being able to relate to clients’ experiences associated with impairment and having to navigate through their own impairments contributed to participants’ more holistic understanding of disability and individuals with disabilities. Laura shared her story of how she acquired an impairment and how that regulated her daily life:

“When I was three and a half I had polio, so I was paralyzed from the waist down. So, I went through a lot of rehab myself and my mom protected me from doing exercise. So early I was very anti-exercise and also because I was uncoordinated and so on at PE in school it was not something that I did.”

Living with an impairment from a young age regulated Laura’s level of preparedness to take on clients with disabilities. When asked about potential concerns or reservations before taking on clients with disabilities she recognized that her own experience with an impairment informed her view on the matter and allowed her to be relaxed about training this population:

“Not really. No, I mean you have to accept that you do not have all the answers and you are going to make mistakes sometimes but I think working with my own disabilities I can’t be worried about too much.”
In a similar fashion, Shawn elaborated on the importance of having first-hand experience. As a young and inexperienced trainer lack of knowledge and experience with disability and individuals with disabilities represented a significant barrier:

“The lack of knowledge, not knowing what to do, especially as a brand-new trainer in my early 20s. Nothing hurt, you know. So, I was always wondering when clients complained that it hurt: ‘What are they talking about?’ I assumed that they felt like me. The older I got I realized that my tissues are less forgiving, you have to be wiser about what you are doing and things like that.”

Furthermore, Shawn talked about how he matured and advanced through the course of his training career. Experiencing temporary impairment himself helped him better understand clients with disabilities and the experience shaped him into a more all-rounded and essentially better trainer:

“I always say that I think I am a better trainer now in my late 30s than I was before. Even if I was more fit in my 20s or whatever, I don’t think that was necessarily true, to be honest with you. Let’s just say for the sake of the argument that it was, I still think that I am a better trainer as I get older because I have experienced my own aches and pains and my own injuries and my own stuff and I had to deal with it. So, I think because of that I am better now.”

Exposure to and involvement with individuals with disabilities fundamentally shaped participants’ perceptions and understandings of disability and individuals with disabilities. Acquiring experience with disability in their personal lives, for example, growing up with family members, friends or neighbors had a long-lasting impact on their willingness to take on clients with disabilities. Additionally, those participants were also able to better relate to individuals with disabilities and had a broader understanding of disability.
Person-to-person contact has been proven to regulate children’s perception and understanding of disability (Dyson, 2005). A burgeoning body of research has shown that having regular structured or un-structured contact with people with disabilities contributes to children’s and adult’s positive attitudes towards this population (Donaldson, 1980; Esposito & Reed, 1986; Favazza & Odom, 1997; Diamond, 2001; Hong et al., 2014; Tamm & Prellwitz, 2001; Tsakiridou & Polyzopoulou, 2019), which was observed through participant’s narratives. Importantly, such positive attitudes get maintained over time (Dyson, 2005). Personal experience with disability profoundly navigated participant’s perceptions and understandings of disability and their willingness to take on clients with disabilities.

In addition, it has been found that preschool children’s levels of acceptance of classmates with disabilities were related to the frequency of the actual contact with classmates with disabilities: the more frequent the contact, the more positive the attitudes (Okagaki et al., 1998; Diamond, 2001). Furthermore, children today have the opportunity to maintain regular contact with children with disabilities within the inclusive classroom, which has again been associated with their positive attitudes, understandings and acceptance of individuals with disabilities (Diamond, 2001; Diamond et al., 1997; Esposito & Reed, 1986). Children’s early experiences are essential for the development of positive attitudes toward individuals with disabilities later on in life (Diamond, 2001), which was noted in participant’s accounts of growing up with peers with disabilities. Likewise, negative experiences in those settings may lead to the development of prejudice about this population (Stoneman, 1993). Social skills acquired during childhood are predictive of an individual’s later adjustment (Kupersmidt, Coie, & Dodge, 1990; Meyer, Cole, McQuarter, & Reichle, 1990). Being regularly exposed to
individuals with disabilities from an early age therefore facilitates the development of positive perceptions and understandings of disability and individuals with disabilities (Dyson, 2005).

4.4.2 Training Experience

In addition to having personal experience with disability obtaining experience by virtue of the training process proved to be key for a more inclusive understanding of disability. A number of participants shared their stories about how lack of knowledge and experience training this population informed their work. Furthermore, participants expressed their sentiments about the importance of acquiring training experience and how being experienced working with individuals with disabilities impacted their future involvement with this population.

INITIAL LACK OF KNOWLEDGE AND EXPERIENCE

Lacking knowledge about people with disabilities and having a shortage of training experience considerably shaped participants’ perceptions of the work. Eva explained how being inexperienced presented a barrier:

“I think the first time when I got a client with a disability, I think one of them [a barrier when working with clients with disabilities] was maybe knowing where to start, knowing what was appropriate. Once I got the experience there were no more barriers.”

Jeff also talked about how lack of knowledge and experience created doubts and reservations when he considered taking on clients with disabilities:

“I think, I don’t know, just lack of experience maybe. I don’t know why I thought that. Well, it could be lack of knowledge about what to do with them, a lack of philosophical framework.”
Many participants talked about how shortage of knowledge and experience working with individuals with disabilities influenced their work. This reality often made their work difficult, especially because they were not able to relate to their clients’ realities. Jacob illustrated his struggles from his beginnings with training a client with autism. Without previous experience he was unable to understand his clients’ needs and did not know how to navigate through certain circumstances:

“Say you are with someone who is autistic, I did not know what autism was exactly. I knew what it was but I did not necessarily know what was going on. So, if your client is just staring at you in a weird way or he starts screaming, you are kind of like: ‘Oh, why is he doing that?’ So, a lot of it was the knowledge part, I did not know what was going on. You know, like I said, I had people come out of spinal things I suppose and again you read things and you kind of know stuff but you do not really know what is going on with somebody that has spent half of their life in a wheelchair. So, a lot of it is that you do not really know what is going on with them and it is hard to know. If you never worked with someone with that or if you have never worked with a spinal cord injury, if you never worked with someone coming out of a recent heart attack, it is really hard, you can read things but it might take you a while to really kind of see what is going on.”

Another participant talked about relevance of experience. Maria mentioned her non-existent experience with training clients with autism and described how she dealt with that reality:

“Yes, because then I had no background working with people with challenges. I would just have my briefing done with the couple [parents]. Of course, they would brief me and I would go into these meetings and I would kind of get an idea. My first day going to the home that this gentleman lived in, there was a little bit of commotion going on because he had smeared. And I had no idea at that time what smearing was, I definitely learned
what smearing was all about. So, just learning that way and then just going out and working with this gentleman with autism.”

On a similar note, Steve shared his story about how lack of experience lead to his hesitant behavior. During one of the training sessions a client with autism escalated and Steve was uncertain how to handle the situation:

“If a kid [with autism] would just break out and have a certain type of behavior and either start running or screaming that scares you because you are concerned for their safety and the people at the gym’s safety. So, you don’t know how to step in, you don’t want to make it worse but you also don’t want to look like you are useless, so you are stuck between the two lines.”

When trainers and instructors lacked knowledge and experience with disability and people with disabilities that often negatively affected participants’ experiences and perceptions of the training sessions with clients with disabilities. In those instances participants often reported feeling lost, uncertain about the proper ways of handling certain situations, and in general not at ease. Lacking knowledge of disability and experience with individuals with disabilities greatly navigated trainers’ and instructors’ perceptions and understandings of this population. The next section focuses on participants’ stories on the importance of gaining experience when training clients with disabilities.

EXPERIENCE IS KEY – GAINING CONFIDENCE & KNOWLEDGE THROUGH EXPERIENCE

Participants discussed their stories of obtaining experience training and instructing individuals with disabilities. Gaining experience was vital for participants’ perceptions of the training process. Katrin shared how she benefitted from becoming more experienced:
“You learn over the years, at first you are nervous and then over the years you kind of learn what to expect. Over the years it becomes a lot easier, you get more used to it.”

Maria similarly stressed the significance of experience. Like many other participants she also explained how she navigated through the process of learning and attaining experience. Maria appreciated the course of the development of obtaining experience, as it is noticeable from her narrative:

“First, you are like: ‘Oh, my gosh, how am I getting through this or whatever?’ and then you learn that this is what we do, so the propulsion you learn, you have to work those fast twitch muscles, let’s go, let’s get them activated, let’s wake them up. And ha, ha, ta-da we say it because they kicked in. At first it is challenging because it is a little nerve-wracking but you work through it and you learn and then ta-da. It is kind of cool that way.”

Participants also reported how they dealt with their lack of experience. Jacob described the steps he has taken when he navigated through the training sessions with his first client with autism. Through the process of trial and error he was able to use the acquired experience to choose the more appropriate exercises and design a more suitable training program for his client:

“In the beginning I messed up a bit when I think I threw him on machines, I do not throw anyone on machines. After a while I just did not feel right about it, so I just found exercises he could do without a machine. So, say like instead of sitting in a leg press I eventually figured that we could do squats from a bench as long as he starts from the bench and goes up. Or I found the assisted pull up machine, so he could grab the assisted pull up machine and do pull ups that way without having to sit down on something.”
Furthermore, Jacob highlighted the importance of gaining experience training clients with disabilities. Not only did acquired experience positively impact his ongoing training sessions, he was also able to utilize that experience when training another client with a disability:

“Once I worked with a couple of autistic people. Then all of a sudden when you start to think about all the different program changes you have done it all starts to be a lot easier because you start to think: ‘Oh, yeah, with them I did that’. So, let’s say this person has ADD, they are just not paying attention all the time. So, I would say: ‘Ok, maybe I did this for this person, who is autistic and they seem to get better, so maybe I should do this with somebody with ADD’ and all those types of protocols that you might use there.”

After working with individuals with disabilities and getting better acquainted with them, participants were also able to recognize client’s good traits and a pleasant personality. As Debbie explained she appreciated the conversations she shared with one of her clients:

“Yes, for the most part. I mean, the first one, when I trained the gentleman with schizophrenia, I was terrified. But after you get to know him and you realize ‘oh, yeah, he is a good guy’ and when he was lucid you had very good conversations, ‘oh, he is just a normal guy’ and then sometimes he was not. So, you just get used to it, like anything.”

Being young and inexperienced sometimes prevented participants from being able to relate to and understand their clients. Eva shared a story about how she had to learn to adapt her training sessions to better suit her clients’ needs. Learning how to do that through the acquisition of experience again proved to be key in that process:

“Years ago, I think it was in the early 1990s I was part of the research study where I had a group of ladies, who were older and who had never exercised before. I was 26 and I remember teaching a class one day and just feeling really frustrated at their competency
level and I remember having this a-ha moment, it took about a day and I realized that 
the problem was not them, the problem was me. That I did not know how to tone it 
down at that particular point in my life. So, good observational skills can show you when 
you need to change your focus, when you need to change your approach.”

Acquiring experience was essential for participants’ perceptions of training individuals 
with disabilities. Navigating through training sessions, discovering most suitable exercises and 
finding appropriate ways of conveying information positively influenced participants’ 
perceptions of disability and individuals with disabilities. Attaining experience essentially 
shaped participants’ understanding of disability. That in turn led to trainers being more open to 
take on clients with disabilities and broke down barriers for this population in the gym 
environment.

FORMAL TRAINING AND DISABILITY

All of the participants held the Fitness Theory certification, awarded by the BCRPA. 
When asked about the content of the formal BCRPA training in relation to disability, all of the 
participants explained that there was no mention of disability nor was there any direction given 
in relation to training clients with disabilities. Jacob was directly asked if BCRPA covered any 
topics related to disability and his answer was a clear no:

“Not at all. There is zero of that. Not much, I would not think there would be too much in 
there. I would probably say specifically for anyone with a disability, no.”

Susanne also reported not learning about disability and individuals with disabilities during her 
BCRPA Personal Training education:

“I have to be honest, no [laughs].”
When asked if the BCRPA certification provided her with sufficient and appropriate knowledge for training clients with disabilities, Laura clearly stated that that was not the case:

“No [laughter].”

Participants furthermore expressed their opinions about what should be added to the formal BCRPA education. In addition to the main Personal Training certification BCRPA offers a number of additional courses, which every trainer and instructor has the option to choose from. Trainers certified through the BCRPA are required to re-certify every two years and earn a certain number of credits by participating in workshops and attending additional courses. Katrin talked about the supplementary courses offered by the BCRPA and recognized that a separate course for individuals with disabilities would be needed:

“[I] think a workshop or a separate course should be, I do not think there is a course for teaching people with disabilities. There is a course for teaching seniors, for group fitness, weight training, personal training and aqua fit, there is no course to teach people with disabilities. There are workshops, which are helpful, but a separate course would be even more helpful.”

In general, participants did not feel that the formal training they have acquired through the BCRPA Personal Training certification prepared them for training clients with disabilities. Since they lacked formal training trainers and instructors resorted to using other means of education such as using the internet to find the necessary information. Additionally, participants recognized the importance of practical experience, which is highlighted in the following section.

THEORY IS NOT PRACTICE
Finally, participants reported that theoretical knowledge cannot always appropriately address what happens in real life, in practical situations. This discrepancy between theory and practice is noticeable from Steve’s narrative:

“Again, I have not found a real correlation between reading things and what is happening quite often. You know, you can read things, say with a heart attack they should not do this, that, but it does not always seem to correlate. Quite often they can do these things or they could do that or some things that they should not be doing, which literature might say they should do. Because reading things straight out of university is not going to help you with a lot of those things anyway.”

It was perceived that the knowledge a trainer obtains through various forms of education and self-education does not equip you for the physical and mental characteristics of every individual. Every individual is unique and no amount of reading and education can completely prepare trainers for the reality that is presented to them once they meet their client for the first time. Practical, first-hand experience is again an indispensable piece of the puzzle, which is apparent from Debbie’s words:

“Again, I have done some research on it but it is different when you are actually dealing with somebody, the paper says this and then here he is. I mean, you can see it on paper but who knows what is going to walk through the door?”

Having experience with disability obviously broke down barriers for individuals with disabilities in the gym milieu. When participants felt they gained some experience training clients with disabilities, that recognition shaped their perceptions about the training process, individuals with disabilities, and disability in general. On the whole, through the obtainment and development of experience working with individuals with disabilities, trainers and
instructors conveyed a broader understanding of disability and displayed more inclusive practices in relation to individuals with disabilities.

4.4.3 Discussion of Theme: Experience

In line with the findings from this study are the revelations of Wareham and colleagues (2017), who explored coaches’ experience of training elite athletes with disabilities. Trainer-client and coach-athlete interactions and relationships are similar in nature, which is why I believe that coaches’ perceptions of athletes hold relevance for this study. Wareham and colleagues (2017) highlighted that before the onset of the coaching process many coaches expressed their concern about their lack of knowledge and interaction with people with disabilities. Similarly, other research (Martin & Whalen, 2014; Wareham et al., 2018) suggested that insufficient knowledge of or experience with disability greatly reinforce coaches’ reluctance to transition into disability sport. Furthermore, Hanrahan (1998) disclosed that it is common for coaches without previous experience to feel hesitant and reluctant to undertake coaching athletes with disabilities. Lack of knowledge of the physiological aspects of disability and proper ways of behavior are some of the fundamental causes for that occurrence (Wareham et al., 2018). Additionally, coaches were often concerned that they would use inappropriate terminology and language relating to disability or that they would be perceived as being politically incorrect, which is a common phenomenon among able-bodied individuals (Lenney & Sercombe, 2002).

On the other hand, having previous experience and being familiar with disability positively influenced coaches’ perceptions of disability and awarded them with positive expectations about working with athletes with disabilities. Similar to the findings of this study,
living with a disability, working in environments that commonly included individuals with disabilities or having close relationships with people with disabilities all facilitated coaches’ positive preconceptions and understandings of disability (Wareham et al., 2017).

Wendell (1996) highlighted the significance of the public presence of people with disabilities and explained the multitude of benefits it brings to able-bodied individuals. The former may improve their knowledge about disability and develop a better understanding of the realities of living with an impairment. As a consequence of this interaction with individuals with disabilities it would be possible to improve the perceived psycho-emotional disablism in the gym milieu, which has been disclosed as a key barrier for this population when they engage in physical activity and exercise in the gym environment (Richardson et al., 2017c).

Considerable relevance of participants’ lack of experience with individuals with disabilities can be further explained with the help of the concept of otherness. The concept of the other is formed when individuals group people together as the objects of their experience rather than regarding them as subjects with whom they might identify (Wendell, 1996). This enables able-bodied individuals to perceive individuals with disabilities as something else – usually something they fear and reject (Wendell, 1996). The other, somebody essentially different from self, is subjected to anxiety and concern, especially if it threatens to blur the boundaries between one and the other (Douglas, 1969). In line with that, trainers’ and instructors’ narratives revealed that they often viewed people with disabilities as other, especially when they lacked experience with disability. On the other hand, participants highlighted how having experience with disability and being acquainted with people with disabilities shaped their perceptions and understandings of disability and essentially
contributed to their more inclusive practices, which was reflected in their greater willingness to take on clients with disabilities.

Importantly, these fears and anxieties are likely to emerge from and stick to the body (Lupton, 2013). People with disabilities embody imperfection (Wendell, 1996). In the gym environment, the avenue for fit and muscular bodies, the concept of the other is at its strongest. There individuals with disabilities are often criticized and judged, leaving them marginalized, negatively affecting their psycho-emotional well-being and discouraging them from future visits to the gym (Richardson et al., 2017b; Rolfe et al., 2009). Small numbers of individuals with disabilities in the gym milieu then prevent trainers and instructors from gaining experience through direct interaction with this population, which in turn influences their perceptions and understandings of disability, reinforcing the cultural gulf between the two populations.

4.5 Trainer’s Benefit

‘Working with clients with disabilities pays off’

The second perception that broke down barriers for individuals with disabilities in the gym environment is summarized in the theme Trainer’s benefit. Participants highlighted a number of advantages they experienced while engaging with and training clients with disabilities. The theme is further divided into two subthemes – (1) More Trainable Clients, which explains how specific characteristics of clients with disabilities positively influenced trainers’ perceptions and understandings of those clients, and (2) Better Trainer, which discusses how trainers perceived to have benefitted from working with clients with disabilities.
4.5.1 More Trainable Clients

Participants highlighted their experiences with training people with disabilities and how they perceived this clientele as being more trainable than able-bodied individuals. Additionally, trainers and instructors revealed a number of characteristics that influenced their perceptions of clients with disabilities in the training context. Specifically, participants found working with clients with disabilities very rewarding, and this population was recognized as being highly motivated and driven, accountable, thankful, and having an excellent sense of humor.

REWARDING

Training and instructing clients with disabilities was perceived as a rewarding experience. Participants appreciated how they positively impacted their clients’ lives, not only in terms of improving their functional abilities, but also in terms of benefits the clients experienced in a broader sense. The visible physical improvement was in particular more drastic and apparent than in able-bodied clients. Jacob talked about the psychological benefits he experienced because he followed his clients’ physical progress:

“In the end if you take someone who has really say messed up their leg or something then it helps you as a person, you are going to feel a lot better as a person... I think it really benefits you as a person because as a person it really gives you other examples of not just the average, ordinary person. Because maybe the general population they might be, ‘aha, I suppose I feel a little bit better, a little bit’, but if you can see somebody with a broken something or maybe they are in a wheelchair and if they are all of a sudden standing and doing stuff, that is a pretty extreme example of how they came from here to now. All of a sudden they are way over here.”

Maria also recognized the advantages of training clients with disabilities. In her case the
benefits were mostly related to finding the appropriate exercise regime and noticing the progress:

“And that is so rewarding, when you have tapped in and you see that that works. Again, as I shared with you, just seeing that freaking smile on their face, especially with these guys.”

Finally, Luka shared the story about his clients’ abilities to recognize the benefits of training sessions in their everyday lives. His clients were able to transfer the knowledge obtained during training to potentially risky situations, which enabled them to react better and in turn raise their quality of life:

“I mentioned that every now and again you get somebody who says: ‘I was going to fall but because of what we have done in class…’, so those are nice to hear. I have had people also say ‘I feel vertigo when I go up and you have been trying to teach us how to make sure that we have something to hold on to in case we have vertigo but also how to get stronger leg muscles and hopefully boost some of the blood supply back towards the heart and how to time that so that we have less vertigo.’ When they tell you these stories it is kind of anecdotes, but they are rewarding.”

Training and instructing individuals with disabilities proved to be a satisfying and valuable experience. Participants recognized numerous benefits training this clientele brought about.

**MOTIVATION & DRIVE**

Several participants shared their stories about how clients with disabilities radiated high levels of motivation and drive. Katrin shared her observations about people with disabilities and
reported how happy and motivated they were when they attended one of her classes, which is apparent from her narrative:

“The thing I noticed about people with disabilities is that they really, really want to be there and they really just want to do whatever they can do. At first, I would apologize: ‘I am so sorry that you are not getting as good of a workout as everyone else’ and then they kept telling me the same thing: ‘Don’t worry, it is ok, I am going to do what I can do, I am going to sit over here, just do not worry, I am fine’. They are always very happy and very motivated to be there.”

On a similar note Susanne illustrated how her clients with disabilities were often more motivated and excited compared to her able-bodied clients. Additionally, she also offered potential reasons behind their elevated levels of excitement and motivation to participate in physical activity and exercise. She presumed that due to the progressive nature of certain impairments some clients might have felt they had limited time to engage in physical activity, which in turn contributed to their greater enthusiasm and influenced their motivation:

“Usually they are more motivated and they also seem to be more excited about their progress. For some reason I find that people with disabilities are usually more motivated. Some of them because they feel like their time is shorter. Some of them felt like they had to do it now because they have the kind of disability that gets worse over time. For example, with joint hyper mobility as you get older and your muscles get less good at keeping all your joints in place it becomes worse, something like multiple sclerosis, so I think maybe that is why with some people it shortens the time before they get older and become seniors.”

Another participant, Maria, talked about how highly driven most of her clients with disabilities and were how they challenged themselves more than able-bodied individuals:
“I think that in general maybe they do put a bit more into it. Maybe because they really do want to challenge themselves a little bit more: I am freakin’ not giving up, I am gonna do it, no way I am letting this set me back’. I find that they push themselves more than able-bodied individuals.”

Finally, Shawn presented a story of one of his clients with disabilities. He recognized how she did not let her impairment hold her back. Even more so, he perceived this client to be highly motivated, never looking for excuses. Shawn acknowledged that his client with a disability was more motivated and driven than a number of able-bodied individuals:

“We have a member, she is missing a hand and she doesn’t let that hold her back, she has a prosthetic limb and she takes on every challenge. And if there is an exercise that she can’t do because obviously she can’t grip on the inside, she asks for something different: ‘just give me something else for the same muscle’... The fact of the matter is she is willing to go there and not make excuses and then you meet these completely able-bodied people and all they do is make excuses.”

Participants perceived clients with disabilities as highly motivated and driven, often more willing to put in the hard work compared to their able-bodied counterparts. Furthermore, trainers and instructors recognized how their clients’ excitement and strong work ethic benefitted their training practices, their own motivation and love for the job.

ACCOUNTABLE

In addition to having high levels of motivation and drive, clients with disabilities were recognized as taking responsibility for their actions. Susanne expressed how she viewed her clients with disabilities to be more accountable instead of blaming the trainer when they did not achieve the desired result:
“I have this client with joint hyper mobility and she came back to me and I told her ‘go for that much for a run and do that and that exercise’ and she came back and she said she ran a lot more. Then the day after she twisted her ankle, which is one of the recurring injuries that she had from her joint hyper mobility (laugh). And she is like ‘don’t worry, I know it was not like your fault, you did not tell me to do that’. So usually they are also good at not blaming the trainer, which I have heard from other trainers can happen with clients and they would be ‘oh, the trainer gave me this exercise and I did not manage to run or whatever’ but they are more likely to look at the whole picture: ‘this is what you told me, this is what I did, maybe I did too much and maybe these exercises do not work.’ And they take responsibility, they take responsibility for all their actions. They are more willing to take responsibility for their work that they have to do and for the classes.”

SENSE OF HUMOR

Finally, participants highlighted clients’ with disabilities good sense of humor. Maria talked about how she has lots of fun with her clients and she attributed it to their excellent sense of humor:

“Oh, they are all funny. Oh, my god, they have an amazing sense of humor. So, they have a sense of humor, they love having fun [laughs].”

Additionally, Eva recognized how working with clients with disabilities influenced her perception and understanding of clients with disabilities. Gaining experience with this clientele revealed the importance of humor for individuals with disabilities:

“I think it [working with clients with disabilities] impacted my view of people with disabilities, I have a bit more compassion to people who are in pain and people who have challenges and realizing the importance of humor for them.”
Several participants perceived individuals with disabilities to be more trainable than their able-bodied clientele. Personal traits such as high level of motivation, exceptional drive, hard-working nature, accountability, and a great sense of humor made this population more pleasant and easier to work with.

4.5.2 Better Trainer

A number of participants further reported experiencing several benefits from training clients with disabilities. Working with individuals with disabilities challenged trainers and motivated them to be more flexible in their training design, to look for adaptations and modifications, to be more observant, and to think beyond the textbook ideas. Participants recognized how working with this population often pushed them outside of their comfort zone and essentially made them a better trainer. Debbie explained how she perceived to have benefitted from training clients with disabilities and how that in turn shaped her training career:

“But again, I think you also benefit from it, it makes you a better trainer. If you work with people you are comfortable with all the time, nothing ever changes. So, if you are more challenged and you learn and grow as a trainer, dealing with different kinds of people is good. I think you can fall into the trap of always training the same demographics, which is fine, you can do whatever you want as a contract trainer, I can choose not to work with certain people, I can work at certain times, but you want to be comfortable. So, sometimes pushing yourself outside that comfort zone is good.”

In a similar fashion Susanne highlighted how training clients with disabilities positively affected her work. Not only did it make her a more versatile trainer, she also noticed the benefits she could transfer onto her able-bodied clientele:
“And I guess it also influences my work. Before I feel it made me a better trainer as well for all the other clients because now I have a bigger database of exercises. So, if one client says ‘I am bored with this exercise’, what else can I do to work this or stretch this? You can make the exercises more interesting. I like that, it is great.”

Susanne further expanded on the benefits she experienced from working with clients with disabilities. In addition to pushing her to be more creative when designing training sessions, she also recognized how having am impairment was actually an advantage in certain activities:

“So, for the benefits. As I said, it pushes me to always expand my knowledge, it pushes to be more creative, to think outside the box. I learn from them also about some new abilities that I did not know because some disabilities in some sports end up being extra ability, they are actually better at that sport when in their everyday life it is a challenge.”

On a similar note, Laura also talked about developing into a better trainer. She explained that instructing clients with disabilities helped her develop a broader understanding of their abilities and how that regulated the design and implementation of training sessions:

“It made me a better trainer. Partly because you have that ability to think beyond the textbook ideas, so you can have a much broader idea of different things that people can do. But also, an appreciation on the ease with which some people do things and you can take those people and challenge them further because you are trying to find that point where it is hard for them.”

Additionally, Laura expressed her enjoyment for working with individuals with disabilities. She talked about how she found working with that population mentally stimulating and how she enjoyed the challenge. Furthermore, Laura stressed the importance of practical experience when working through some of the challenges while training individuals with disabilities:
“You know what I particularly like is working with people who have health challenges. It challenges me mentally because I am always thinking outside the box, because you do not get answers to your questions in the textbook. And so, I like that it stretches me that way. So, the greater the challenge in terms what should I do with this person, the more I like it.”

Another participant, Eva, shared her perceptions of the benefits she experienced because of training clients with disabilities. Eva acknowledged how this type of work helped her become more observant and she also learned to better progress and modify training sessions:

“Because I mostly deal with just physical disabilities, I would say it benefits me, it makes me a better trainer because I am more observant, it makes me think of better modifications, maybe softer ways to progress things. I know how to modify things if they are having an off day or if they have a temporary injury, I know how to modify, absolutely.”

Finally, Shawn shared his accounts on the perceived benefits of working with clients with disabilities. He described how training a client with a disability influenced his approach to exercises and drove him to become more creative in the design and implementation of training sessions:

“We have a member ... she has a prosthetic limb. And if there is an exercise that she can’t do because obviously she can’t grip on the inside, she asks for something different: ‘just give me something else for the same muscle’ and it has forced me to become much more creative in the way that I approach different exercises.”
4.5.3 Discussion of Theme: Trainer’s Benefit

Many participants acknowledged the positive nature of their experiences with training individuals with disabilities. In addition, there was a pervasive recognition of the various benefits involved with training this clientele. Participants acknowledged how training this population enhanced their knowledge base, raised their versatility in the design of the training sessions and essentially helped them become an all-round trainer and instructor. Previous research (Wareham et al., 2017) directed at coaches’ preconceptions of training athletes with disabilities highlighted coaches’ overwhelmingly positive experiences, where the benefits far outweighed any challenges they encountered during the course of the training process, which very much aligns with the findings of this study.

Additionally, several participants shared their accounts of how training clients with disabilities helped them unravel their innate creativity. Working with this clientele usually compelled participants to think outside the box at the design and implementation stages of the training process. Often they were unable to perform their more standardized training programs, which served as an excellent motivation for delving into research about disability and possible ways of modification of the specific exercises. Participants’ stories aligned with reports from coaches, who also recognized the imagination and resourcefulness training athletes with disabilities elicited (Wareham et al., 2017; 2018).

Participants furthermore explained how they were able to transfer the obtained knowledge and experience to their work with able-bodied populations and how the majority of their clientele benefitted from their broader knowledge base. Wareham and colleagues (2017)
likewise discovered that coaches perceived they were able to apply the knowledge and skills they acquired while coaching athletes with disabilities to create more innovative programs for their able-bodied clients. Trainers and coaches perceived the need to think beyond the limits of uniformity as a valuable profit which ultimately resulted in their recognition of becoming better trainers and coaches (Wareham et al., 2017).

Many participants revealed the psycho-social benefits of training clients with disabilities. Particularly, clients with disabilities were recognized as being highly motivated and driven, accountable, thankful, and with an excellent sense of humor. These numerous positive characteristics heavily informed participants’ perceptions of the work with individuals with disabilities and essentially made their work more pleasant and rewarding. In addition, in line with the findings from Wareham et al. (2017), trainers and instructors reported the favourable feature of the psychological elements of disability as believed that clients’ abilities to overcome adversity in their everyday lives reflected in their strength and determination to overcome obstacles that often presented barriers to able-bodied clients. Numerous participants noted that clients with disabilities were more hardworking, appreciative and driven (Wareham et al., 2017). Finally, the advantages of the relationship between the participant and the client were apparently reciprocal, as the participants found the ability to positively influence their clients’ lives in general, utterly rewarding (Wareham et al., 2017).
5. Conclusion

The final chapter provides an overview of the study’s findings, discusses the practical implications of the findings, describes and addresses project’s limitations and concludes by highlighting some of the possible future research implications.

This thesis explored personal trainers’ and instructors’ perceptions and understandings of disability and individuals with disabilities, and examined if and how these perceptions and understandings broke down or reinforced barriers for this population while engaging in physical activity and exercise in the gym milieu. The incentive for addressing these two areas of inquiry stems from various factors. In spite of the steady increase in numbers of people with disabilities (WHO, 2011) and the recognition of alarmingly high levels physical inactivity among this population (Cooper et al., 1999; Rimmer et al., 1996; Schoenborn & Barnes, 2002; Washburn et al., 2002), very little research has investigated the gym as a possible exercise domain for individuals with disabilities. What is more, the limited research has acknowledged the gym as a suitable space for this population’s participation in physical activity and exercise (Richardson et al., 2017abc) and recognized trainers and instructors as an essential element of individuals with disabilities’ positive gym experience (Martin & Smith, 2002; Richardson et al, 2017c). Regardless of that reality, no research to date has focused on gym personnel and their understandings of disability. This study has built on the existing research about disability in the gym milieu and supplemented the knowledge of disability in this context (Chenail et al., 2010). Finally, analysis of trainers’ experiences of working with clients with disabilities in the gym milieu also uncovered how trainers can be better educated and supported in order to establish more inclusive gym experiences.
In general, the majority of trainers and instructors that participated in the study equated disability with impairment and understood it as physical and cognitive differences and limitations. Disability was often perceived as a shortage of ability and there was a clear distinction between the functional abilities of the able and disabled body. In this way trainers and instructors exhibited ability-based understandings of oneself, the body and relationships with others (Wolbring, 2012). Disability was furthermore understood as a deviation from the universally favored able-bodied standard (Goodley, 2017) and perceived it as a ‘social deviance’, which locates disability as a divergence from the normative ways of existing (Goodley, 2017). In addition, disability was viewed as an irregularity and due to their impairments people with disabilities were regarded as being abnormal and inadequate, which devalued their worth as human beings (Lutz & Bowers, 2012). Finally, individuals with disabilities were recognized as being different from the able-bodied majority, which aligns with the established societal divisions between people with disabilities and others (Davis, 2000; Shakespeare & Watson, 2001).

The findings additionally revealed fear as a central perception that reinforced the barriers for people with disabilities in the gym milieu. Fear was an important consideration when trainers and instructors contemplated whether or not to take on a client with a disability. Specifically, trainers and instructors reported being afraid to take on clients with disabilities, expressed having fear of causing an injury to their clients, and mentioned being afraid to be unable and incapable of appropriately designing and carrying training sessions for this population. Thus, fear added to the separation of individuals with disabilities in the gym environment, which often results in them feeling marginalized, negatively affects their psycho-
emotional well-being (Richardson et al., 2017b; Rolfe et al., 2009) and deters them from further visits to the gym (Richardson et al, 2017b).

On the other hand, trainers’ experience with disability not only proved to be an essential factor in breaking down obstacles people with disabilities encounter in the gym milieu, trainers and instructors also experienced and appreciated a multitude of benefits related to training this population. Having personal experience with disability and possessing experience training individuals with disabilities importantly shaped trainers’ perceptions and understandings of disability and individuals with disabilities. Moreover, being familiar with disability and engaging with this population awarded trainers and instructors with positive expectations regarding the prospect of training individuals with disabilities and enabled trainers to feel more comfortable and confident once the opportunity to train this population arose. In addition, a number of trainers and instructors highlighted the positive nature of their experiences with training individuals with disabilities. Even more so, there was a prevalent acknowledgement of the various benefits involved with training this clientele, which essentially helped them become more versatile trainers and instructors. Finally, many trainers also revealed experiencing numerous psycho-social benefits of training clients with disabilities as this population was perceived to be hardworking, appreciative and driven (Wareham et al., 2017).

In conclusion, trainers’ and instructors’ narratives illustrate a social world that is still dominated by the medical model’s perceptions of disability as a biological determinant (Goodley, 2017) and a deviation from structural or functional norms (Bickenbach et al., 1999). A world, uneasy with difference, a world where embodying a variation still inhabits a place
defined as exceptional rather than being one of the possibilities (Shildrick, 2012). Furthermore, individuals with disabilities are often excluded from relevant areas of social life (Barnes 1991; Goodley, 2017), which results in a shortage of culturally agreed rules of engagement with this population (Keith, 1996). The ‘fear of doing the wrong thing’ culminated in trainers’ avoidance instead of interaction (Reeve, 2006; 2008). However, once trainers and instructors obtained experience with disability and interacted with clients with disabilities they appreciated those relationships and acknowledged the overarching benefits associated with training this population.

5.1 Practical Implications

Guided by the trainers’ and instructors’ narratives a few recommendations were made on how to offer better support and education to trainers and instructors with the purpose of them becoming more willing to take on clients with disabilities and in the long run establish more inclusive gym experiences for individuals with disabilities. Since trainers and instructors have been recognized as paramount to creating a positive gym experience for this population (Richardson et al., 2017c), it appears to be essential to influence their perceptions and understandings of disability and individuals with disabilities. Therefore, trainers and instructors require a greater knowledge and understanding of disability and individuals with disabilities’ experiences in the gym environment. This can be accomplished through education (Richardson et al., 2017c). Since trainers have highlighted the lack of information about disability and direction for design and implementation of training sessions for individuals with disabilities, I believe that a section on disability should be added to the main – Fitness Theory exam. This section does not need to contain all the specific exercises for different types of disabilities as
this is not feasible due to the high number of types of disabilities and the limited space available for additional content. However, it should include a general explanation of the types of disabilities and exercise adaptations and should offer some general guidelines on proper communication and preferred behaviors when working with this clientele. Additionally, a list of websites with quality information on specific types of disabilities and their main characteristics would also be helpful. Furthermore, the BCRPA certification offers a number of Speciality modules such as Group Fitness, Acquatic Fitness, Pilates Fitness, Yoga Fitness, Weight Training, Older Adult, Osteofit and Personal Training. Designing a separate module on Disability would be needed. Lastly, just a sentence or two added to the Fitness Theory certification that would remind the trainers and instructors about this populations existence and would let them know that there are a number of individuals with disabilities, who would want to exercise in either a personal or group setting. Getting this message across, incorporating this idea into their heads and motivating them to think about the possibility of one day training a client with a disability while offering some support would be an important first step to more inclusive practices in the gym environment.

Both the section on disability as well as the Speciality module on Disability should be written from a critical disability perspective. Presenting appropriate exercises and modifications is vital for ensuring a suitable and safe exercise program. However, presenting disability through the lens of critical disability studies would not only introduce the inequalities individuals with disabilities are subjected to in their everyday lives, but it would also present an important step to ensuring trainers’ and instructors more inclusive perceptions and understandings of disability and people with disabilities.
Additionally, a number of participants reported uncertainty in regard to the boundaries between training and rehabilitation. BCRPA certification clearly states that trainers and instructors are not allowed to offer and carry out rehabilitation services. It is difficult to set that boundary and say where one ends and the other one begins. A more specific distinction between training and rehabilitation would be needed, supported with examples.

5.2 Project Limitations

Being a cultural insider helped me throughout the research process, eased the recruitment of research participants and provided me with valuable insider information when I built rapport and interpreted the data. In spite of those benefits, my insider status also presented a limitation during the course of the research process. Since I held some of the similar perceptions and understandings of disability as research participants, it was occasionally difficult to keep the critical distance (Hayward & Cassell, 2018). Even though engagement with subjectivity awards a researcher with rich data and a more nuanced sense of meaning (Hayward & Cassell, 2018), retaining a degree of critical distance is necessary for ensuring the trustworthiness of research findings (Lincoln & Guba, 1989). At times, during interviews I could have been more critical about some of the participant’s accounts and should have pursued to ask additional questions. Sharing some of the participant’s perceptions and beliefs, I ‘settled’ instead of pushing the conversation further, which would have added to a better understanding of the studied topic. In this way, I was able to present myself as a legitimate trainer. However,
throughout various stages of the research process I tried to remain conscious about my subjectivities and attempted to keep a critical distance (Bryman, 2015; Thorpe & Olive, 2016).

Furthermore, after the completion of the interview process I noted that there were some areas of investigation that I could have further explored. Even though participants shared their beliefs regarding possible areas of improvement in the gym environment for individuals with disabilities, I feel that I neglected to ask some additional questions that could have contributed to a richer set of recommendations for enhancement of this population’s gym experiences. While this area should have been further enquired about and explored, I do recognize that in order to ensure the fullest understanding for the most appropriate ways of positive development would require the inclusion of voices of people with disabilities (Bullock & Mahon, 2017).

5.3 Future Research Implications

Considering that disability in the gym environment is a widely under researched area and to date only a single sociological study examined individuals with disabilities’ experiences in this space (Richardson et al., 2017a; 2017b; 2017c), there is lots of room for future research. Specifically, the mentioned study was conducted in the United Kingdom and to my knowledge no research on this topic has been carried out in North America. Further research should therefore focus on individuals with disabilities’ gym experiences in North American gyms, both in the more localized context in Vancouver, BC, as well as in a more global North American environment. Complimenting this study by acquiring an essential view directly from individuals with disabilities would offer a broader understanding of the current situation in the gym milieu.
in the North American context. In addition, this study was limited to only exploring perspectives of the trainers and instructors, who held a BCRPA certification. Even though BCRPA is the most common and widely accepted certification in the province of British Columbia, there are large numbers of trainers who obtained their formal training education through other recognized certifications – CanFitPro, CSEP – CPT (Canadian Society of Exercise Physiology), ACE (American Council on Exercise), NASM (National Academy of Sports Medicine), ACSM (American College of Sports Medicine), to name the few. Adding other trainers with different certifications would bring a broader understanding of disability in this environment and would additionally allow for a comparison between various certifications. Lastly, I would encourage all future research to commit to Richardson and colleague’s (2017c) call for more research on disability in the gym environment. Shedding light upon this overlooked area and gaining insight into the perceptions and understandings of disability in this milieu would highlight the change that is necessary and offer recommendations on how to achieve that transformation.
Bibliography


Eisenberg, Y., Vanderbom, K. A., & Vasudevan, V. (2017). Does the build environment moderate the relationship between having a disability and lower levels of physical activity? A systematic review. *Preventive Medicine, 95*(2017), S75-S84.


about knowledge and knowing (pp. 103–118). Mahwah, NJ: Lawrence Erlbaum Associates.


condition reduction and increased community participation?. *Disability and Health Journal, 4*(2), 129–139.


Appendices

Appendix A: Letter of Introduction

LETTER OF INTRODUCTION
Disability in the Gym: Perceptions and Understandings About Individuals with disabilities

Dr. Andrea Bundon (Principal Investigator)
School of Kinesiology
The University of British Columbia
Contact Number: [REDACTED]
Email: [REDACTED]

Ljudmila Zaletelj, Masters Student (Co-Investigator)
School of Kinesiology
The University of British Columbia
Contact Number: [REDACTED]
Email: [REDACTED]

WHO IS DOING THE RESEARCH?
The principal investigator for this study is Dr. Andrea Bundon, Professor in the School of Kinesiology at the University of British Columbia. Milly Zaletelj is a second year graduate student working under the supervision of Dr. Bundon.

WHAT IS THE RESEARCH ABOUT?
We are interested in learning about how personal trainers understand disability and individuals with disabilities.

WHAT WILL PARTICIPATING IN THE STUDY INVOLVE?
If you agree to participate, you will be invited to take part in one interview (conducted in English) that will be conducted at a place of personal convenience. The interview will be approximately one hour in length. The discussions that take place will be audio-recorded and transcribed (written out word for word) for analysis. Most of the questions are fairly general. Additionally, with your permission, we may contact you for a brief follow-up meeting if required for clarification, elaboration, and/or to discuss the study’s findings.

You do not need to talk about any issues you do not feel comfortable discussing and if you wish to withdraw from the study you may do so at any time without having to give any reason for doing so. There will be no negative consequences to you or anyone else if you chose to withdraw. This study will not subject you to any physical risk. Although we do not expect any psychological risk, in the event you would like to further discuss your feelings regarding the topics discussed in the interviews, accommodations will be made for you. We will accept participants for the study based on order of initial contact with the researcher.
RUMUNERATION
You will be offered a $20 stipend for the interview as compensation for your time and any related travel costs.

WHAT WILL BE DONE WITH THE INFORMATION I PROVIDE?
Any information you provide within this interview will be made anonymous. We will give you a pseudonym (fake name) and all identifying information will be removed. All interview transcripts will be kept in a locked cabinet in the office of the principal investigator and no one other than the researchers associated with this study will have access to this information. The information collected will be written-up for publication in a scholarly journal and/or presented at an academic conference.

WHAT IF I WISH TO WITHDRAW FROM THE STUDY?
Your participation in the research is entirely voluntary and you may withdraw from the study at any time without having to give any reason for doing so and without experiencing any negative consequences.

HOW WILL THE RESEARCH BE USEFUL?
Findings from this study will allow us to gain valuable insight into the way(s) that disability and individuals with disabilities are understood within the gym environment. Moreover, findings from this study will further our understandings of disability within this sporting context and will serve as an important step in creating a more inclusive environment for individuals with disabilities.

If you would like more information about this study or to learn how to become involved, please contact Milly Zaletelj at (e) [redacted] or (c) [redacted]

Thank you!
Appendix B: Consent Form

Disability in the gym: Perceptions and understandings about individuals with disabilities

Andrea Bundon, PhD (Principal Investigator)  Ljudmila Zaletelj, Masters Student (Co-Investigator)
School of Kinesiology  School of Kinesiology
The University of British Columbia  The University of British Columbia
Contact Number: [Redacted]  Contact Number: [Redacted]
Email: [Redacted]  Email: [Redacted]

PURPOSE OF THE STUDY:
The purpose of this study is to explore how personal trainers understand disability and individuals with disabilities. Findings from this study will allow us to gain valuable insights on the way(s) that disability is understood within the Canadian gym culture, and will further our understandings of disability and individuals with disabilities within various sporting contexts.

STUDY PROCEDURES:
You will be interviewed once at a location of your choosing by graduate student, Ljudmila Zaletelj. The interview will take approximately one hour. With your permission, we will digitally record the interviews so that we can concentrate on what you have to say rather than on taking notes. Before the interview begins, we will also request that you complete a basic demographic questionnaire to provide us with a bit of background information about yourself and your involvement in personal training. Additionally, with your permission, we may contact you for a brief follow-up meeting if required. This brief follow-up meeting would be used for clarification, elaboration, and/or to discuss the study’s findings.

CONFIDENTIALITY:
Your identity will be kept strictly private. Only Dr. Bundon and the graduate student (Ljudmila Zaletelj) involved in the project will have access to the digital recordings and study documents, which will be kept in a locked filing cabinet and on a password protected computer. All data will be encrypted. No names or information that might show who you are will be used when the results of the study are reported. The results of this study will be reported in a graduate thesis and may also be published in journal articles and books.

RENUMERATION:
You will be offered a gift card for the interview as compensation for your time.
YOUR RIGHTS:
Your participation in the study is entirely voluntary. You may refuse to answer any question or withdraw from the study at any time without giving a reason.

POTENTIAL RISKS:
This study will not subject you to any physical risk. You can refuse to answer any questions in the questionnaire package and/or withdraw from the study at any time. Although we do not expect any psychological risk, if we feel participating is placing you under undue stress we will discontinue your involvement in the study and direct you to appropriate resources. Any data collected prior to this point will be omitted from the study and destroyed.

WHO TO CONTACT IF YOU HAVE COMPLAINTS OR CONCERNS ABOUT THE STUDY?
If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance email RSIL@ors.ubc.ca or call toll free 1-877-822-8595.

QUESTIONS?
If you have any questions or want further information about the study, please contact Ljudmila Zaletelj by telephone at [phoneNumber] or by email at [emailAddress]

CONSENT

☐ I have read the above and I consent to being part of this study exploring trainers’ understanding of disability in the gym environment.
☐ I have received a copy of this consent form for my own records.

Pseudonym (fake name) to be identified as in the study: ____________________________

Signature: ________________________________________________________________

Printed Name: ____________________________________________________________

Date: ____________________________
Appendix C: Recruitment poster

Are you a personal trainer?

If so, we would love to talk to you!

WHAT IS THE STUDY ABOUT? The purpose of this research is to explore how disability and individuals with disabilities are understood within the gym environment.

YOU CAN PARTICIPATE IN THE STUDY IF:

- You are working as a personal trainer/instructor in Vancouver.
- Personal training is your main profession.
- You hold a BCRPA certification.

WHAT IS INVOLVED? If you agree to participate, you will be interviewed once at a location of your choosing. The interview will take approximately one hour. You will receive a gift card for the interview as compensation for your time.

WHO IS DOING THE RESEARCH? Dr. Andrea Bundon, Professor in the School of Kinesiology at the University of British Columbia and graduate student, Milly Zaletelj.

If you are interested in participating in the study, or would like more information, please email or call Milly at [redacted] or [redacted]. Thank you!
Appendix D: Online recruitment poster

Are you a personal trainer?
If so, we would love to talk to you!

WHAT IS THE STUDY ABOUT? The purpose of this research is to explore how disability and individuals with disabilities are understood within the gym environment.

YOU CAN PARTICIPATE IN THE STUDY IF:

- You are working as a personal trainer/instructor in Vancouver.
- Personal training is your main profession.
- You hold a BCRPA certification.

WHAT IS INVOLVED? If you agree to participate, you will be interviewed once at a location of your choosing. The interview will take approximately one hour. You will receive a gift card for the interview as compensation for your time.

WHO IS DOING THE RESEARCH? Dr. Andrea Bundon, Professor in the School of Kinesiology at the University of British Columbia and graduate student, Milly Zaletelj.

If you are interested in participating in the study, or would like more information, please email or call Milly at: [redacted] or [redacted]. Thank you!
Appendix E: Interview guide

Interview Guide

Disability in the gym: Perceptions and understandings of individuals with disabilities

The following sample interview questions are flexible and may be altered over time as different themes and patterns emerge from the data.

INTRODUCTION

1. Do you have any questions before we begin? Are you OK with me recording the conversation?
2. Can you tell me about your formal education?
3. Can you tell me about your fitness certification? What kind of certification(s) do you have, when did you obtain them?
4. Can you talk about your work as a personal trainer or instructor?
   a) What inspired you to become a personal trainer?
5. What aspects of personal training do you like?
   a) What do you like about the work?
6. Why did you decide to work in this gym (name of the gym they work most often in)?
7. What would you describe as values of this gym? Do these values reflect in your values?
   How so or how not? By values I mean principles of behaviour, moral code, what is important in life.
8. How many clients with disabilities have you worked with and what type of disability and impairment did/do they have?

RESEARCH QUESTION #1: HOW DO PERSONAL TRAINERS UNDERSTAND DISABILITY AND PEOPLE WITH DISABILITIES?

9. What lead you to start working with clients with disabilities? Was there any particular reason for it?
10. How do you experience working with clients with disabilities?
a) Anything in particular that you would point out about that experience?
b) Do you have any anecdotes or interesting stories from working with clients with dis.?
c) If they have experience training clients with physical and intellectual disabilities: is any group harder to train? Why?

11. Did you have any concerns before you took on your first client with a disability?
   a) Can you give me some examples?
   b) Why do you think you had those concerns/reservations?

12. Are there similarities or differences in working with clients with disabilities in comparison with working with able-bodied individuals?
   a) Can you give me some examples of those similarities and/or differences?
   b) How do those potential differences inform your work?

13. How did training clients with disabilities influence your work with able-bodied clients?

14. Did having experience training individuals with disabilities change your perspective on this population? How?

15. What kind of clients do you have in mind when you think about people with disabilities?

16. What do you understand under the term disability? What does disability mean to you?

17. Do you think that BCRPA certificate provided you with sufficient and appropriate knowledge for training clients with disabilities?
   a) If it did not provide you with the knowledge, what do you think was missing?
   b) What would have to be added to the BCRPA training so you would feel more prepared to take on a client with a disability?

RESEARCH QUESTION #2: WHAT PERCEPTIONS OR UNDERSTANDINGS ARE ASSOCIATED WITH BREAKING DOWN OR REINFORCING BARRIERS FOR PEOPLE WITH DISABILITIES?

18. Do you think training individuals with disabilities brings about benefits or challenges to your work?
   a) Why?
   b) How are those benefits, or challenges expressed?
19. What were some of the barriers you encountered when working with clients with disabilities?

20. What would be some of the barriers people with disabilities would encounter when coming to your gym?
   a) Is the gym where you primarily train your clients designed for people with disabilities in terms of proper equipment, space, etc.?
   b) Can you give me some examples of how the gym is suitable to their needs?
   c) Can you give me some examples of how the gym is not suitable to their needs?

21. Do you think people with disabilities should go to the gym? Why? Why not?

22. In an ideal world, what would have to happen so that more people with disabilities would go to the gym?
   a) Do you think more can be done for people with disabilities in the gym environment?
   b) Can you give me some examples?

23. Is there anything that you thought we would talk about and we did not? Is there anything that you would like to add?
Appendix F: Demographic Information Questionnaire

The following questionnaire asks some background information and will be used for research purposes only. All of the provided information is greatly appreciated and will be kept strictly confidential. If you do not feel comfortable providing certain information you may leave those fields blank.

1. NAME: __________________________________________________________

2. DATE OF BIRTH (YYYY/MM/DD): ________________________________

3. GENDER: ______________________________________________________

4. WHERE DO YOU CURRENTLY LIVE (CITY): ________________________

5. HIGHEST LEVEL OF COMPLETED EDUCATION: ______________________

6. FIELD OF STUDY, IF APPLICABLE: ________________________________

7. PLEASE LIST ALL OF YOUR TRAINING CERTIFICATIONS AND FIRST YEAR OF OBTAINMENT:
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

8. NUMBER OF YEARS OF WORK EXPERIENCE AS A PERSONAL TRAINER/INSTRUCTOR (primary source of income): ________________________________

9. NAME AND BRANCH OF THE GYM YOU WORK MOST OF YOUR HOURS IN:
   __________________________________________________________________

10. CONTACT INFORMATION (E-MAIL ADDRESS):
    __________________________________________________________________