Resisting Disablism in the Gym: A Narrative Exploration of the Journey from

Disabled Client to Disabled Instructor

by

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Special thanks are extended to my loved ones, both friends and family. To my friends (particularly handball, archery and friends from the office) thank you for always being there when I needed you, for all the wonderful memories and terrible photos and for exciting adventures we had and will have in later years. To my family, words can't describe how much your support and encouragement has meant through the years and I could not have completed this without you. You are my inspiration always.

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Abstract

It is imperative that people with physical impairments regularly exercise. Exercising regularly can promote well-being through enhancing physical, psychological and social wellness. For example, exercising can alleviate physical symptoms such as pain and muscle spasticity, as well as enhance function and strength. Psychologically, regular exercise has been shown to increase self-confidence, self-esteem and provide respite from daily stresses associated with disability and impairment. Socially, exercising can improve people's social lives, reduce isolation and increase the number of meaningful relationships an individual has. Despite the numerous benefits associated with exercise, people with impairments are among the most sedentary in society. One identified reason for this is the ableism which exists in many fitness establishments. For example, a fitness establishment such as the gym promotes itself as a space where people can improve health and wellness through physical exertion. Unfortunately in this space, health and wellness are constructed through the physical appearance of the body (i.e. the strong, physically aesthetic, muscular body is given value) which can result in disabled people being subject to discriminating treatment from others (e.g. gym instructors) for not aligning to this cultural norm. Consequently, this can have a detrimental effect on disabled people's psycho-emotional well-being and deter them from continuing to exercise in this space, in spite of the potential benefits to be had.

It has been highlighted that more must be done to promote exercise for disabled people and to portray the gym as a more inclusive, accessible space. This is challenging, however, when taking into consideration the various ways the gym marginalizes this population. Ranging from inaccessible environments to disabling interactions, the gym can position disabled individuals as 'other' making this space deemed unsuitable for them to exercise in. It is therefore surprising that an increasing number of disabled individuals desire to become gym instructors and be further integrated into a space which oppresses them.

Accordingly, the purpose of this thesis is to explore these individuals' journey from gym client to gym instructor. To develop a rich, in-depth understanding of this journey, I posited the following research questions:

1) What were participants' experiences of exercising in the gym?

2) What motivated participants to become gym instructors?

3) How did participants make sense of their gym instructor training experiences?

4) What impact did participants perceive they had on the gym environment?

Framed by interpretivism, I applied various qualitative analysis techniques to answer these research questions; specifically inductive thematic analysis, thematic narrative analysis and dialogical narrative analysis (DNA). This thesis has made original contributions to the literature by crafting a deep understanding of disabled people's experiences in the gym and why people enact social missions. For example, in this thesis I contextualized disability in the gym and identified that despite the numerous health benefits disabled people experience by exercising in this space, the psycho-emotional disablism they are subject to acts as a barrier for individuals to exercise here. Importantly, although disablism acted as a barrier to continued exercise it was also a facilitator in their decision to become a gym instructor. Essentially, participants described their own negative gym experiences as fuelling their desires to enact positive change in this space and do social missions in the gym. To be a gym instructor, participants went through a training programme specifically designed to train disabled people to embody this role. At this training, participants initially experienced a sense of validation and belonging through peer group exercise and were able to craft a collective story which allowed them to resist the oppressive disablism they experienced in the gym. However, as training continued and evolved so too did the narratives participants crafted to make sense of their experiences. Instead of one united story, participants crafted two conflicting narratives which redefined their relationship with each other and InstructAbility,

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and ultimately determined why some participants continued their training and others did not. For those who did continue to become fully qualified gym instructors, they felt they had a positive influence in promoting inclusion, exercise and diversity in the gym.

In light of these findings, there are several practical recommendations for exercise practitioners, rehabilitation specialists, gym managers and those prescribing exercise to disabled people. Implications are aimed at improving exercise promotion and experiences of exercise in the gym for disabled people. For example, disabled gym instructors could be a way to bridge the perceived experiential gap between disability and the gym as they exhibit an alternate way of being which is accepted in this space. Through their experiential knowledge of disability and practical knowledge of exercise, these individuals can also relate to disabled clients in a way that non-disabled instructors cannot. Disabled gym instructors, however, can educate non-disabled gym instructors in how to train someone with an impairment. Equally, a more critical attitude to promoting exercise to disabled people is called for. Specifically, to steer away from disabling expectations and narratives of disabled people's motivations to exercise and move towards more realistic, enabling strategies and narratives to facilitate disabled peoples' exercise behaviour.

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Publications and Presentations Arising from this Thesis

Journal Publications

Richardson, E. V., Smith, B., & Papathomas, A. (2016). Disability and the gym: Experiences, barriers and facilitators of gym use for individuals with physical disabilities. *Disability and Rehabilitation,* 39(19), 1950-1957.[1]

Richardson, E. V., Smith, B., & Papathomas, A. (2017). Crossing boundaries: The perceived impacts of disabled fitness instructors in the gym. *Psychology of Sport and Exercise, 24,* 84-92.[2]

Richardson, E. V. Smith, B., & Papathomas, A. (2017). Collective stories and exercise: Investigating the impact of exercising with disabled peers in the gym. *Adapted Physical Activity Quarterly. 34*(3), 276-294.[3]

Conference Presentations

Richardson, E. V., Smith, B., & Papathomas, A. (2016). Disability and the gym: Experiences, barriers and facilitators of gym use for individuals with physical disabilities. DSEP conference, Leeds, UK.

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[1] This paper pertains to chapter 4.
[2] This paper pertains to chapter 9.
[3] This paper pertains to chapter 7.

Chapter One: Introduction

1.0 What is this PhD About?

This PhD considers the role of disabled gym instructors[4] as individuals who can promote diversity and inclusion in the gym. Drawing upon a range of qualitative research methods, I explore the journey of participants from gym client to gym instructor. This journey begins with participants' experiences of exercising in the gym in the capacity of a gym client. From here, the story progresses to investigate why participants wanted to be gym instructors and their experiences receiving gym instructor training with other disabled people. This journey concludes with how participants perceived they impacted the gym environment in the capacity of a gym instructor. Finally, I discuss the many empirical, methodological and practical implications resulting from this research with regards to promoting exercise and inclusion in the gym.

1.1 Background

For individuals with physical impairments, regularly exercising can noticeably improve an individual's health, well-being and quality of life (Martin Ginis, Jorgenson & Stapleton, 2012; Tomasone, Wesch, Martin Ginis, & Noreau, 2013). Physically, health benefits include improved physical function (Martin Ginis et al., 2012) and reduced pain (Norrbrink, Lindberg, Wahman & Bjerkefors, 2012). Psychologically, exercise has been shown to increase independence, enhance perceptions of empowerment (Blinde & Taub, 1999) and allow individuals to craft a more affirmative identity (Kay, Dudfield & Kay, 2010). Socially, participating in regular exercise can reduce isolation (Sporner et al., 2009) and increase perceived social status (Arbour, Latimer, Martin Ginis & Jung, 2007). Problematically, however, these individuals are also among the most sedentary populations in society (Carroll et al., 2014).

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[4] Throughout this thesis, I use UK social model language to describe participants as this terminology (i.e. disabled people) aligns with my position that individuals are disabled by systematic practices of oppression in society and, accordingly, should be accorded a politically social status (Goodley, 2016). In turn, when making reference to a participant's impairment effects, I use the word "impairment".

Gainforth, Latimer-Cheung, Athanasopolous & Martin Ginis (2013) proposed that a key reason why disabled people are one of the most sedentary populations in society is the lack of health promotion directed towards them. Take, for example, the gym. The gym is a space perceived to be dedicated to the improvement of physical fitness through the use of specialized equipment, health and safety legislations, fitness classes and qualified instructors (Sassatelli, 2010). Moreover, as many individuals who acquire their physical impairment undertake a period of rehabilitation in a gym (Williams, Smith & Papathomas, 2014), it is also an exercise space which is familiar to most of this population. Indeed, Day and Wadey (2016) highlighted the gym to be the next stage in long term physical activity adoption for individuals with acquired impairments. Yet, this space is not deemed to promote inclusion of disabled people as the toned, strong, perfectly crafted body has become an image representative of this space (Neville & Gorman, 2016). Individuals who do not align to this idea of fitness, such as many disabled people, feel 'othered' and perceive that they do not belong here (Miller, Parker & Gillinson, 2004). As a result, although fitness institutions such as the gym may promote fit bodies, they also marginalize those that are deemed 'unfit' with regards to the values of the gym (Crossley, 2006).

In response to this marginalization of disability people within a gym setting, a spinal cord injury (SCI) charity in the United Kingdom (UK) (Aspire[5]) designed a programme whereby disabled individuals could train to become gym instructors and work as members of staff in a gym. This thesis focuses on these individuals. Disabled instructors are particularly interesting as they work in and represent the gym but may not embody the physical expectations of a person in this role. As such, disabled gym instructors are worthy of study as, through their difference, they may contribute to a more inclusive gym environment. Moreover, this research contributes to a gap in the literature by focusing on a unique

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[5] Aspire are a spinal cord injury (SCI) charity based in the UK who provide practical support for individuals with a SCI from initial injury through to independent living.

population who have never before been researched with regards to their potential to promote health enhancing behaviours in disabled people. Such a focus also connects with recent calls in sport and exercise psychology to move beyond a simple concern with performance enhancement to also shine a spotlight on under-resourced communities in the field of exercise and health (Whitley, Massey, & Leonetti, 2016). Consequently, this thesis will focus on individuals who have the potential to challenge disablism in the gym and promote exercise to people who are not currently the focus of this fitness institution. To do this, I explore the journey of disabled individuals from gym client to gym instructor.

1.2 Structure of the Thesis

This thesis will unfold as follows. I begin in **chapter two** by reviewing the current literature pertaining to the research context. This includes theoretical and conceptual ideas relating to disability, health and well-being, exercise and the gym. These ideas are imperative for generating understandings and interpretations of results. Following this, in **chapter three** I discuss the methodological and paradigmatic underpinnings of the research in conjunction with methods used to collect and analyse data. The demographic background of participants involved in this research, ethical considerations, representational genres and suggestions of how to judge qualitative research will also be presented. Following this, I present my empirical findings from **chapter four** to **chapter eight**.

In **chapter four**, I begin the story of this thesis by exploring participants' experiences exercising in the gym as clients. The findings in this chapter contextualize disability in the gym and provide important insights into the experiences of individuals exercising in this space. Moreover, this chapter also works as a foundation of knowledge on which the rest of the thesis is built upon as it was these experiences which shaped participants' motivations and desire to be a gym instructor; these motivations and desires are discussed in **chapter five**. In

chapters six and **seven,** I present participants' experiences of gym instructor training through application of dialogical narrative analysis (DNA). Specifically, in **chapter six** I present participants' initial experiences and meanings of training as they worked together, and the collective story they crafted to resist the oppression they had experienced in the gym. Thereafter, in **chapter seven,** I explore participants' latter experiences of training and how narratives they had originally drawn upon developed through time. In this chapter I focus on *how* participants continually made meaning from their training and *why* some participants dropped out of the programme. In **chapter eight,** I bring to a close participants' journey to be gym instructors and present how they perceived they impacted the gym environment and made the gym a more inclusive space. The final chapter of this thesis, **chapter nine**, brings this thesis to a close by discussing and summarising contributions to knowledge through empirical, methodological and practical implications.

1.3 The Researcher in the Research

Reflexivity is the practice of 'bending back on oneself' and being critical of how ones' background, assumptions, experiences and behaviour impacts the research process and can shape the relationship between the researcher and the researched (Finlay, 2003). Within the field of disability research reflexivity has become increasingly important, particularly when researchers have not experienced disablement themselves (Goodley, 1999). As Macbeth (2010) contends, the relationship between a non-disabled researcher and a disabled participant becomes even more complicated as the power relations between the two may lend to a perception of hierarchy with the non-disabled researcher taking a dominant role. Reflexivity in disability research is imperative to acknowledge how a researcher co-constructs the research with their participants, thereby crafting a more equal partnership. As such, throughout this research, I strove to be reflexive in my involvement in the research

process and consider how my involvement and biases could have influenced questions asked, relationships with participants, data analysis and interpretations of the data (Finlay, 2002a).

The purpose of reflexivity is not an empty or egoist act, or to probe relationships for the sake of it, but to be a springboard for further interpretations about the research process and co-constructed nature of research (Randall & Phoenix, 2009). There are various ways to 'do' reflection and which guide a reflexive journey. For this thesis, I used a mixture of *introspective analysis* and *intersubjective reflection* (Finlay, 2005). *Introspective analysis* is used by researchers to look in themselves to their past experiences and emotions and acknowledge how their past influences their present. This type of reflexivity can provide insight and be a basis for interpretations as well as allow the researcher to become more explicit about the link between knowledge claims, experiences of both participants and the researcher, and the social context of the research (Finlay, 2002b). In being reflective through introspection, I then could not distance myself from the participants in this research and could acknowledge the relationship I had with them. To be reflexive about my relationships with participants, I used *intersubjective reflection*. This kind of reflexivity involves exploring the mutual meaning involved in the researcher-participants relationship, to "focus on the situated, emergent and negotiated nature of the research encounter and…how unconscious processes structure relations between the researcher and participant" (Finlay, 2003, p 8). In other words, the self in relation to others is the focus.

As a starting point to introspective analysis, I provide an insight into my personal connections and motivations regarding this research topic (Gough, 2003). As such, I present a brief, open introduction to myself as a person and a researcher, and the active decisions I made in being reflexive. Moreover, my aim in being a reflexive researcher who is conscious of intersubjective relations was not to fall into the trap of being what Fitzgerald (2009) described as a 'parasite researcher'; a researcher who 'uses' disabled people's experiences for

their own professional progress, treats them as subservient in their role in the research and with no purpose to challenge social oppression (Davis, 2000). Instead, I entered into this research wishing to cooperate and learn from a population with more knowledge than I about their experiences. In the field of disability research, it has also been argued that "there is no room for the distant outsider" (Goodley, 1999, p.42). As such, throughout the research I strove to be as inclusive and involved in the research as was ethical to do so. By utilizing an inclusive approach I felt there was a greater feeling of participants being co-researchers rather than passive subjects (Walmsley, 2004). As Goodley (1999) stated, despite knowing next to nothing about the daily experience of disablement, non-disabled researchers who take an inclusive approach have the opportunity to shape and construct analytical conceptions of a disabling society and actively oppose such oppression. As such, I was critical of how to position and introduce myself to the participants in this study. Thus, to be inclusive, I needed to scrutinize my subject position as a researcher and relationship to participants. This I present now.

I am a 27 year old, white, non-disabled female aspiring to be an academic researcher in the field of disability studies with the purpose of doing ethical, inclusive, emancipatory work which has a direct impact on improving the health and well-being of disabled people. I am much younger than most of my participants, have much less life experience and am blessed that I have a supportive, loving family. I was raised in a middle class village by two parents who are still together and a very close extended family. This family background was very different to many of my participants who were raised in working class areas by single parents. I also have a much higher level of education compared to many participants which was obvious as I introduced myself to them as a researcher in an institution of higher learning. This, I found, was the first barrier I had to address. By virtue of my occupation and class background, I might be considered to occupy a position of power in relation to my

participants. This is not something I wished or felt comfortable with so from the beginning I eagerly positioned myself to participants as a naïve, student-researcher, openly stating I was there to learn from them if they would let me and that they were the experts of their experiences. Moreover, I did not want to reinforce or accentuate the unequal power differential which exists between disabled people and non-disabled people in the wider world (Stone & Priestley, 1996) by virtue of my lack of impairment or my supposed higher levels of education. This is, indeed, exactly how I felt throughout the research process and I strove to learn as much about participants' experience as possible. As such, I tried to reverse the perceived social relations of research production where "disabled people and their organisations are at the apex of the research hierarchy" (Stone & Priestly, 1996, p. 704) by positioning participants as experts and myself as a naïve, novice researcher (Davis, 2000).

Although I do not have experience with a recognised or diagnosed impairment, I do have personal experience of chronic pain and injury and the frustrations of being invalidated by individuals who supposedly have more knowledge and, as such, more power. This, I believe, is one reason I was so drawn to and passionate about this research project. Sport and exercise has always been a defining part of my life crafting my identity, being a basis for my social life and friendship groups, and being a coping mechanism for stress in everyday life. Sport also resulted in my experiences of chronic back pain. During a core PE lesson at 16 years of age I landed awkwardly on a trampoline and felt immediate and intense pain in my spine. The following three months I was continually told by doctors and nurses that I had pulled a muscle, despite numbness and electric shock like pain from my lower spine down my legs. After months it settled but I was left with sciatic pain and back stiffness on a daily basis. I now live with constant back pain and multiple disc herniations which have impacted my personal and professional life. As well as the physical ramifications of disc herniations such as intense pain, and an inability to move, I experience a definite negative effect on my

mood. I am irritable, upset, angry and frustrated at people who do not understand that it is not merely a sore back that is stopping me leaving my home but debilitating, excruciating pain assuaged only by strong medication which allows me to do nothing but sleep. Through this research process, I have experienced 2 disc herniations which have resulted in not getting my thesis completed on time, missing conferences and presentations and anxiety about how this physical injury controls my life when it occurs. During times when my back pain is manageable I do as much sport and exercise as I can to relieve symptoms, improve my mood, cope with stress and anxiety and enjoy a social life. I was hesitant to share my experiences of chronic pain with participants as I didn't in any way wish to be perceived as dismissing their own individual experiences or that I in some way understood what they had gone through. I did, however, share my experiences where I felt it would be beneficial and helpful for participants to know my experiences and promote a more equal relationship between us.

I hope these last pages do not come across as egotistical or self-centred. As Riessman (1993) stated "the construction of any work always bears the mark of the person who created it (p v)", therefore I feel presenting myself to readers in such a way constitutes important contextual information that helps the reader appreciate my personal connection to the research. I do not claim any personal knowledge of participants' disablement experience, and I do not intend to allow my own voice and past experiences to overshadow the experiences of my participants, which must remain the focus of this thesis. I do feel, however, that my own experiences created within me a deeply felt empathy for people who are not listened to.

Chapter Two: Literature Review

2.0 Overview

This PhD will cut across a range of conceptual and theoretical ideas from the fields of disability studies, health and well-being, exercise and the gym. Accordingly, this literature review provides an overview pertaining to these topics as each are relevant to the research context and chapters that follow. The first section of this chapter addresses the models of disability by which disability can be understood and the consequences of defining disability in these ways. The second section focuses on the impact disability can have on an individual's health and well-being and introduces the role of exercise in improving health and well-being. Thereafter, the third section draws attention to the facilitators and barriers this population experience when trying to exercise before presenting the exercise domain under investigation in this thesis, the gym. The final section establishes narrative as a method of inquiry to explore individuals' journey from gym client to gym instructor and introduces the PhD project in more detail as well as the research questions under investigation.

2.1 Defining Disability

As the experience of disability is central to this thesis, it is imperative to critically examine how disability is understood and interpreted. Disability means different things to different people (Wendell, 1996), therefore it is impossible to provide one overarching, all-encompassing definition of what it is to be disabled. Instead, as Smith and Bundon (2016) stated, having a grasp on *how* disability is examined is vital for any individual working with disabled people in any context. Accordingly, it is imperative scholars in this area have an understanding of the many positions, theories and perceptions of disability which have been formed (Söder, 2009) and how these positions influence a researcher's understanding of what constitutes disability (Goodley, 2011). The focus of this first section is to critique the various ways disability is understood in scholarship and society. These *models* are fundamental to society's understanding of disability, how researchers understand disability and how researchers conduct research. It must be noted that although the field of disability refers to

these theories of disability as 'models', very few can be considered literal models for practical application as they are not built on empirical evidence, used for data collection or have the necessary components to satisfy definitions (Owens, 2015). Instead, their usage is in the generating of understandings to represent a particular type of theory which seeks to explain disability (Llewellyn & Hogan, 2000).Thus, theories of disability discussed are referred to as models in this thesis to reflect the literature.

2.1.1 The medical model.

The *medical model*, sometimes referred to as the individual model of disability, was arguably the first real understanding of disability when it was postulated in the field of medicine during the 19th and 20th centuries (Bury, 2001). Historically, it was the first dominant model for understanding disability. This model is grounded in rehabilitation and restitution holding that disability is purely a medical problem, a distinct pathology, which must be diagnosed and treated in the hopes of finding a solution (Naidoo, 2006). In this way the medical model of disability conflates impairment and disability, reducing the experience of disability to an essentialist, individual pathology where disability is caused by parts of the body not working properly (Smith & Perrier, 2014). Indeed, Johnson (2003) described a person with a disability as having "a personal, medical problem, requiring but an individualized medical solution; that people who have disabilities face no 'group' problem caused by society or that social policy should be used to ameliorate" (p.595). As a result of this understanding, proponents of the medical model – mainly those in the medical profession – created and perpetuated discourses that shaped disability as merely a biological product (Brittain, 2004). As the medical model shapes understandings of disability in a way where researchers perceive disability to be a pathological problem which requires treatment and can be cured, this paints a picture of the human being as flexible and alterable while society is fixed (Llewellyn & Hogan, 2000).

The dominant medical discourse associated with the medical model caused many issues for disabled people and has been criticized. For example, as the medical model shapes understandings of disability around a medical, biological assumption of 'normality' (Goodley, 2013), this can cause a dangerous 'normal/ abnormal' dualism as Smith and Perrier (2014) argue:

> "Defining disability as any lack of ability resulting from an impairment to perform an activity within the range considered normal, the medical model constructs disabled people as defective (i.e. 'not normal') and others ('the normals') as definitive or superior human beings who can assume authority and exercise power" (p.4).

This dualism can have serious repercussions for disabled people and may be a contributing factor to the societal stigma which is associated with disability. Indeed Brisenden (1986), a disabled academic, stated the medical model "may lead only to distortion and misunderstanding and to a view of disabled people as a category of rejects, as people flawed in some aspect of their humanity" (p. 173). In other words, the individual with an impairment must work (and is expected to work) to align to the cultural and social norms of society in order to fit in (Goodley, 2011) and may be subjected to disabling interactions with non-disabled individuals if they do not. For example, disabled people may be subject to discriminatory behaviours such as stares, restriction to one area, or even abuse from others which can result in them feeling angry, self-consciousness, marginalized and lacking self-worth (Reeve, 2012). Indeed, as Dewsbury, Clarke, Randall, Rouncefield and Sommerville (2004) stated, medical models should be criticized for their view that disabled people are in some way 'lacking' and unable to fully integrate in society. Instead, researchers have advocated for a revised understanding of disability which brings accountability to society's role in constructing disability.

2.1.2 The social model of disability.

The UK *social model of disability*[6] was proposed by the Union of the Physically Impaired Against Segregation (UPIAS) as a protest to the medical model. Founded by Vic Finkelstein and Paul Hunt[7], this revolutionary model was a paradigmatic leap (Olkin, 2009) offering a brand new vision of disability. This group advocated for an understanding where disability was a societal construction as individuals with impairments were oppressed through systematic patterns of exclusion built into the social fabric of their lived world (Hughes and Patterson, 1997).

Although the proponents of this model acknowledged the presence of impairments and that impairment effects do pose difficulties for people, they argued that these difficulties did not make up the substance of disabilities. A conceptual severing of the causal link between impairment and disability was seen as necessary to distance this new paradigm from the medical reductionism of the medical model which had underpinned disability theory for so long (Shakespeare & Watson, 1997; Thomas, 2004). As such, the social model defines disability as "the disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments and thus excludes them from the mainstream of social activities" (Oliver, 1996, p.22).

A key strength of the social model is its political power, evident through the influence this understanding of disability had in creating anti-discrimination legislation through Disability Discrimination Acts (Lutz & Bowers, 2005; Shakespeare, 2014). These acts challenged the discrimination of disabled people in society and fought for disabled people to

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[6] There are different variations of the social model of disability. For example, both the North American social model and Nordic social relative model differ from the UK social model (Smith & Bundon, 2016). The focus of this thesis is the UK social model to reflect where the research was conducted.

[7] Although originally developed by Finkelstein and Hunt, disabled academic Mike Oliver coined the phrase 'social model of disability' in 1983 in reference to these ideological developments and was a key contributor to developing scholarship of this model.

have equal access and total inclusion. This model was revolutionary not only in highlighting the role of society in creating a person's disability, but also in liberating disabled people from being the problem. As Smith and Perrier (2014) contended, disabled people were enabled by the social model as it recognised that society is often the problem; however, the solution to disability can also be found there.

Although many important achievements have been made through the social model, there are also criticisms from scholars in the field of disability studies that this model has created as many problems as it has solved (Shakespeare, 2014). First, the simplicity of the social model has been critiqued for creating another dualism (similar to the medical model) by conceptually separating impairment from disability (Thomas, 2007). Lived experiences with impairment are therefore excluded. Furthermore, Reeve (2004) stated that this model puts too much emphasis on socio-structural barriers and ignores personal impairment experiences. This is an opinion supported by Hughes and Patterson (1997) who argued "disability is experienced in, on and through the body, just as impairment is experienced in terms of the personal and cultural narratives that help to constitute its meaning" (p.335). Arguably, wanting to separate itself so fiercely from the original medical model of disability (which was perceived as essentially reductionist with its impairment/disability causality) has resulted in the social model itself falling into the trap of essential theorism. Indeed, Söder (2009) argued that the essentialist theoretical perspective of the social model (similar to that of the medical model) acts as a 'straight jacket' to developing disability theory as there is no lee way or negotiation away from a reductionist understanding of the causal effect of *society* being responsible for disabling people.

A further problem with the social model is that the original ideas associated with this initially politically driven, emancipatory movement have been forgotten and are almost

unrecognisable from its original concept. Indeed, Oliver (2013) stated his ideas have been

manipulated and misappropriated:

> "At no point did I suggest that the individual model should be abandoned, and neither
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> did I claim that the social model was an all-encompassing framework within which
>
> everything that happens to disabled people could be understood or explained.
>
> Subsequently, however, the social model took on a life of its own and it became the
>
> big idea behind the newly emerging disability equality training" (p. 1024).

Finkelstein (2001) has also voiced his concerns regarding the misuse of this model arguing

that it has come to be interpreted as an all-encompassing explanation for the presence of

disability; "sadly a lot of people have come to think of the social model of disability as if it

were an explanation, definition or theory and many people use the model in a rather sterile,

formalistic way" (p. 6).

Originally created to be a unifying banner for activists seeking emancipation and

fighting oppression (Davis, 2000), this model was never meant to be a scientific theory but a

tool for practical action (Shakespeare, 2006). As such, although the social model has been an

important tool for bringing to light society's contribution in creating disability, its usefulness

in interpreting disability in psychology may be limited as it has never really reflected the

lived experience of disabled individuals (Goodley, 2011). The lives of disabled people are

influenced by both the fundamental aspects of impairment and their social context (Lutz &

Bowers, 2005). Moreover, disabled people do not live their lives in physical environments

alone but within societal interactions. A focus on the social environment alone says little

about societal attitudes to disability in the world disabled people live and their encounters

with people in society. Indeed, Brittain (2004) insisted of the social model, "such

transformations alone will do little or nothing to destroy the underlying disablist values

within society or the institutional structures within which people with disabilities are forced to operate" (p.431).

Accordingly, neither the medical model nor the social model reflect the multifaceted nature of disability (Lutz & Bowers, 2005). Scholars further argued that it is impossible to understand disability, exclusion and discrimination without studying interactions between individuals and context (e.g. Thomas, 2004). This requires an open, respectful approach where interactions which shape experiences are under investigation; this approach has been defined as *relational interactionism* (Thomas, 1999). It was then that a move came in the late 1990's for a more *social relational* understanding of disability which took into account the lived experience of disabled people and the interactions they had with the environment.

2.1.3 The social relational model.

Thomas (1999, 2007) reformulated the UPIAS definition of disability described in the previous section to produce an extended social relational definition of disability. She stated Finkelstein's understanding of disability did not assert that all restrictions of activity are socially caused; rather it is the social relational character of restrictions which is the issue thereby making disability prejudice a new form of social oppression associated with relationships between impaired and non-impaired (Thomas, 2004). The concept of being oppressed allowed for a different perspective of disability. Rather than being equated with restrictions of activity, disability and the experiences of being disabled were constructed within the oppressive relationships experienced between disabled individuals and society or other people (Thomas, 2007). This allowed for the concept of *disablism* to be associated alongside other oppressive experiences such as sexism, racism and homophobia. Thus, disability in this model is defined through the concept of disablism as:

"a form of social oppression involving the social imposition of restrictions of activity on people with impairments and the socially engendered undermining of their psycho-emotional well-being." (Thomas, 1999, p.60).

Disablism, in this social relational sense, can be experienced as two forms of social oppression: *structural disablism* and *psycho-emotional disablism*. Structural disablism refers to the built environment which operates outside the individual such as inaccessible environments, social and physical forms of exclusion, discrimination or any kind of oppression acting on the person implied by the social model (Reeve, 2012). What differs and creates a more extended social relational understanding of disability in this model, is the deliberate inclusion of psycho-emotional disablism; disabling barriers which operate within the person and on their psycho-emotional well-being (Thomas, 1999). There are two sources of psycho-emotional disablism; *direct* and *indirect* (Reeve, 2006). Direct psycho-emotional disablism arises from relationships a disabled individual has with other people or themselves while indirect psycho-emotional disablism emerges alongside the experience of structural disablism, in other words what messages from structural disablism do individuals take on board that impact their psycho-emotional well-being? The relationships and responses that an individual receives from another person will have a direct impact on their psycho-emotional well-being. Should this be a negative or invalidating response such as being stared at, having jokes made about them, dealing with callous remarks or comments (Reeve, 2006), this can result in feelings of anger, otherness, lacking self-worth and feeling excluded (Reeve, 2012). Indirect psycho-emotional disablism is more subtle than direct psycho-emotional disablism and arises from the experiences of structural disablism. In other words, the experience of structural disablism such as an inaccessible building can evoke an emotional response such as anger and hurt at being excluded. These acts of exclusion operate at both a material and

psycho-emotional level as the message given to disabled individuals is one of "you are out of place, you are different" (Kitchin, 1998, p. 351).

The social relational model includes the experience of a physical impairment and the difficulties these may cause (such as pain, tiredness) as it states disabling experiences occur *on top of* impairment effects (Thomas, 1999). This model acts more as a 'spring board' to future disability theory and policy as it is a more fluid, interactional understanding of disability (Gustaveson, 2004). Indeed, Thomas (2004) argued that this model offers a firmer grounding for theoretical, empirical and policy work in disability studies. It also allows for an enriched psycho-social appreciation of disability as it permits for the deployment of a range of theoretical perspectives, opposing the reductionist theories of medical or social models.

There are, however, scholars who are critical of the social relational model too. One issue perceived in this model is that social oppression operates at its centre, thus disability research is committed to finding all disabled people oppressed (Shakespeare, 2014). To address this, Shakespeare proposed an *interactional model of disability* that aimed to "neither reduce disability to an individual medical problem, nor neglect the predicament of bodily limitation and difference" (p.2). This interactional approach suggested there are many different factors at play that could be addressed to improve quality of life of disabled people. For example: "coaching or therapy to improve self-esteem; medical intervention to restore functioning or reduce pain; aids and adaptations; barrier removal; antidiscrimination and attitudinal change; better benefits and services" (Shakespeare, 2014, p.83). A further issue Shakespeare (2014) saw with the social relational model was that it aligned too closely with the social model proposed by Finkelstein and Hunt. In turn, Thomas (2008) criticized Shakespeare's interactional approach as being too biologically reductive and therefore too closely aligned with the medical model.

While both the social relational and interactional model have their limitations, they each seek to contend that disabled people's lives are shaped both by impairment and the effects of disablist social factors (Thomas, 2008). Although the social relational and interactional approach may be deemed more appropriate for use in investigating disability experiences, these models still see disability or the experience of disability as something negative either through physical dysfunction, social exclusion or social oppression. To combat this, some disability scholars and activists called for a new model of disability which drew upon personal experiences of disability and used the voices of disabled individuals to inform it rather than the suppositions of non-disabled academics.

2.1.4 Affirmation model.

Swain and French (2000) proposed a somewhat radical perspective away from traditional disability models called the *affirmation model*. While previous models perceived disability as a personal tragedy and something which must be endured, the affirmation model challenged these presumptions and embraced the possibility that disability could enhance an individual's life; essentially, bringing positive meaning to how disability impacts peoples' lives and social identity. The affirmation model posits that disability can be beneficial. Examples of this include pursuit of new interests, avoidance of class judgment, potentially a better quality of education at a school specializing in that impairment (although the opposite can also be argued) (Corker, 1996), a lack of expectation to conform to society (Shakespeare, 1996) and heightened understanding of oppression (French, 1991). While the social model is generated by experiences in a disabling society, citing the problems within society, the affirmation model is founded on the experiences of disabled people as valid individuals who can determine their own lifestyle, identity and challenge the notion that 'the problem' lies within the individual and/or impairment. It is about affirming a positive identity of being

disabled and asserting the value of life as an individual with an impairment and aims to affirm a positive identity of disability.

The affirmation model, however does also have weaknesses. The examples of 'positive benefits of disability' given by the authors aforementioned appear to be instances of 'making the best of it.' Rather than being happy as a result of disability consequences such as special education, having to be imaginative in regards to sex life, and taking up interests as employment is more difficult all appear to be substitutes or examples of resilience to replace something which has been lost (Shakespeare, 2007). Although a person may indeed be content in their current situation, it does not necessarily mean they are happy or see their current situation as more beneficial than when they were non-disabled if they acquired their impairment.

As this first section has illuminated, there are many ways disability is understood and interpreted; the models discussed above being but a few ways to do so. Although I personally align more strongly to a social relational understanding of disability, throughout this thesis I shall at some point draw upon all aforementioned models to inform interpretations. This approach also aligns with Martin's (2013) argument that *all* disability models should be used to better appreciate the experiences of disabled individuals. To further appreciate the lived experiences of disabled individuals, a knowledge of the impact disability can have on an individual's physical, psychological and social well-being is also required.

2.2 Disability, Health and Well-being

People who have acquired their impairments in later life, as well as the pain and trauma from initial injury (Gorgey, 2014), may experience a myriad of secondary health issues such as obesity and heart disease (Rimmer & Marques, 2012), muscle atrophy (Rimmer, 1999) and muscle degeneration (Stensrud, Risberg & Roos, 2015). People with a

congenital impairment may also experience physically detrimental impacts of their

impairments such as pain, muscle degeneration and spasticity (Crawford & Dearman, 2016;

Krigger, 2006). They too can experience co-morbid health issues associated with their

impairment such as those mentioned above. Psychologically, disability can cause many

mental health issues (Tate et al., 2015). For acquired impairments, these can include

depression and anxiety (Craig, Tran & Middleton, 2009) frustration at a loss of freedom and

independence, increased dependence on others, disrupted relationships, difficulty coming to

terms with injury and a fractured sense of self (Sparkes, 1999). Although people who were

born with their impairment may not experience the same fracturing of self and disrupted

relationships people with acquired impairments go through, they are not untouched by

psychological hardship. For example, people with congenital impairments may lack a sense

of worth and self-esteem (Bogart, 2014). Thus, although disabled people may experience

different instances of psychological detriments depending on how they acquired their

impairment, all are at risk of compromised psychological health and well-being. Socially,

instances of isolation (Geyh et al., 2012), feelings of abandonment, perceptions of not

belonging, and experiencing discriminatory or marginalizing behaviours from others are also

prevalent in this population (Campbell & Oliver, 2013). All these experience can negatively

impact an individual's health and well-being.

2.2.1 Disability and health.

Regardless of which disability model a scholar aligns to, an appreciation of how

disability and impairment impact an individual's health and well-being is required to

contextualise this thesis in the wider parameters of health and exercise psychology,

particularly with regards to disabled people's health and well-being. The World Health

Organization (WHO) defined health as a "state of complete physical, social and mental well-

being, and not merely the absence of disease or infirmity" (WHO, 2015). Unchanged since

the latter 1940s, this definition was initially praised for its commitment to seeing health as inclusive of psychological, social and physical domains, not merely the absence of disease (Huber et al., 2011). In recent academia, however, the use of the word *complete* and the association of this word to a medical understanding of disability (that disability is something to be overcome) has been criticized. Complete physical, social and mental well-being would leave most of us unhealthy most of the time (Smith, 2010) and leaves those with a chronic illness or impairment irreparably and conclusively ill (Huber et al., 2011). Moreover, this definition takes away an individual's autonomy to cope with life's ever changing and challenging physical, social and psychological demands and the agency to live a life of fulfillment and happiness with an impairment (Smith, 2010).

Rather than utilize the WHO definition, disabled people may understand health to mean something different. As Nazli (2012) explained, "for people with disabilities, health does not mean being disabled; rather, it means not being ill. Thus, unhealthiness equals illness. Although these people have physical disabilities, they are healthy because they are not ill" (p.238). Huber et al., (2011) concurred stating that theorizing health in the field of disability may be better understood by a more dynamic understanding of health which can be conceptualized as "the ability to adapt and self-manage" (Huber et al., 2011, p.343) in the three domains of health: physical (physiological); mental (psychological); and social (relationships with others). To appreciate these three domains and how they contribute to good health, they may be better understood as constructs of well-being.

2.2.2 Disability and well-being.

Well-being is a complex, contested construct within psychology (Keyes, Shmotkin & Ryff, 2002). Although not a simple way to interpret health, it does allow for an appreciation of disabled people's experiences of health without imposing medicalized terminology. Generally, the concept of well-being is understood as "optimal psychological function and experience" (Ryan & Deci, 2001, p.142). This explanation, however, fails to recognise the wide array of terms and definitions of well-being used and developed in the literature over the past fifteen years. This may be attributed to the various subjective ways which 'optimal functioning and experience' can be perceived and understood. For example, for one person optimal functioning is to reach one's own potential to achieve what they want to achieve; for others, optimal functioning is a subjective feeling of happiness and contentment that one is living a 'good life'. To reflect this difference, two distinct positions have been highlighted originating from two different philosophical positions; *hedonic* and *eudemonic*.

The hedonic tradition understands well-being to be about the pursuit of happiness and pleasure to obtain what is deemed a 'good life' (Keyes et al., 2002). This hedonic view of well-being in psychology comprises of a subjective evaluation of one's quality of life and happiness, and has consequently been labelled subjective well-being (SWB).To obtain SWB, academics stipulate three elements are required; life satisfaction, increased positive affect, and an absence of negative affect (Diener, 2000; Keyes et al., 2002). The second tradition, eudemonic, understands well-being to be a key indicator of human potential and flourishing (Ryff & Keyes, 1995). Termed psychological well-being (PWB), authors highlight six key dimensions of human experience which are central to a well-lived life; a sense of self-acceptance, positive relationships with others, a sense of purpose in life, living with a degree of self-determination or autonomy, the ability to manage one's environment effectively, and feeling that one is growing or progressing toward one's potential (Keyes et al., 2002; Ryff & Keyes, 1995). Whilst hedonism and eudaimonism are two distinct constructs of well-being,

there are some mutually influential components (Keyes et al., 2002; Linley, Maltby, Wood, Osbourne & Hurling, 2009). For example, without happiness and life satisfaction it is unlikely that psychological growth and development will occur, and when meaningful life experiences are lacking, happiness and life satisfaction may decrease (Lundqvist, 2011).

There are some problems with these understandings of well-being. First, within the literature of health and exercise psychology, PWB, SWB and other terminologies such as emotional or mental well-being are used interchangeably or incorrectly meaning our knowledge of well-being is clouded (Durkin & Joseph, 2009; Jovanovic, 2011; Lundqvist, 2011). This can result in the translation from theory to evidence-based practice being problematic. Moreover, although the concepts of SWB and PWB have been formative in the development of well-being research and interventions in health and exercise psychology, scholars in this area do tend to universalize the concept of well-being which leaves little room for the appreciation of lived experience and how disabled individuals experience well-being in different contexts, with different people and at different stages of their lives (Andrews, Chen & Myers, 2014).

In response to these concerns, a new approach to well-being has been added to the literature which takes into account the lived experiences of individuals. Proposed by Andrews, et al., (2014), this perspective prioritises an affective, feelings-based approach to well-being which, rather than highlight the 'whats' of well-being, highlights the processes by which well-being emerges in everyday situations and contexts. Rather than a conceptual understanding, an affective approach suggests that "well-being arises initially as an energy and intensity through the physical interaction of human bodies and non-human objects, and is experienced as a feeling state" (Andrews et al., 2014, p. 211). The authors highlighted that as well-being is something felt, an appreciation of the phenomenology is also required to understand well-being as well the conceptual constructs of PWB and SWB. In subsequent

chapters, I draw upon both conceptual and affective approaches of well-being to interpret findings and explain participants' experiences of well-being through their training.

2.2.3 Supporting health and well-being through exercise.

One key way to enhance health, SWB, PWB and affective well-being in disabled people is exercise (Canning & Hicks, 2014; Hitzig et al., 2008; Perrier, Smith & Latimer-Cheung, 2013). For example, exercise can improve individual's physical health through reducing pain (Norrbrink et al., 2012) distributing body fat more evenly (D'Oliveira et al., 2014) and can lead to greater functional capacity (Martin Ginis et al., 2012). Furthermore, exercise also has the potential to improve both SWB and PWB through alleviating the negative psychological affects of disability such as depression (Hicks et al., 2003). For example, exercise has been shown to enhance perceptions of empowerment (Blinde & Taub, 1999) self-confidence, self-belief (Graham, Kremer & Wheeler, 2008), positive identity (Kay et al., 2010) and enhance subjective and psychological well-being (Williams et al., 2014) which can improve an individual's psychological health. Socially, participation in exercise can also enhance social well-being through increased social status (Arbour et al., 2007), reduction in discriminatory and stigmatizing behaviours from non-disabled individuals (Tyrell, Hetz, Barg & Latimer, 2010) and reduced isolation (Sporner et al., 2009). Moreover, Gorgey (2014) argued that many of the secondary ailments experienced by individuals after injury are also preventable through exercise. Problematically, however, disabled individuals are amongst the most sedentary population in society with research highlighting up to 50% of this population being completely sedentary and many more insufficiently active to experience these important physical and psychosocial benefits of exercise (Carroll et al., 2014; Martin Ginis et al., 2010). Reports have suggested, however, that the low numbers of disabled people exercising sufficiently is not attributed to a lack of interest as 70% of disabled people want to

be more active and are motivated to do so (English Federation of Disability Sport, 2015). Accordingly, there must be other reasons for why disabled people are unable to exercise.

2.3 Disability and Barriers to Exercise

Research has highlighted various barriers to exercise which disabled people encounter. Some researchers have highlighted individual, personal barriers such as lack of energy (Henderson & Bedini, 1995), lack of time and motivation (Scelza, Kalpakjian, Zemper & Tate, 2005), lack of knowledge of how and where to exercise (Heller, Ying, Rimmer & Marks, 2002) and fear of injury (Vissers et al., 2008) as reasons why disabled people are inactive. The idea that disabled people are stopped from exercising because of some kind of physical deficit or lack of personal motivation is problematic, however, as this aligns to a medicalized perspective of disability which places responsibility to be active squarely on the shoulders of the individual and leaves social oppression unchallenged (Goodley, 2016). Thus, a more socialized view to evaluate barriers to exercise may be a more prudent approach to develop a contextually meaningful, nuanced appreciation of disabled people's experiences in public exercise facilities.

From this socialized perspective, research has highlighted numerous structural barriers which hinder a disabled individual's agency to exercise in certain spaces. For example, a lack of access into facilities (Rimmer & Marques, 2012), inaccessible or unnegotiable built environments (Kehn & Kroll, 2009), and unsuitable equipment (Dickson et al., 2011) have all been distinguished as key reasons why disabled people are a minority population in exercise spaces. These are important issues and must be considered when investigating ways to craft more inclusive exercise spaces for disabled people and promote health enhancing behaviours. This socialized perspective, however, is also one dimensional in that a purely socialized lens does not appreciate the lived experiences of disabled people in

exercise domains. Nor does it appreciate how an exclusory physical space marginalizes disabled people in such a way that their psycho-emotional well-being is compromised. The psycho-emotional consequences disabled people may experience when trying to negotiate an exclusory environment can be highlighted by applying a social relational lens of disability.

As Finkelstein (2001) stated, "it is society that disables us and disabled people are an oppressed group" (p. 2). Understanding disabled people to be an oppressed group allows for the concept of *disablism* to be applied, thereby providing a deeper insight into the lived experiences of disabled people (Thomas, 2007). Disablism refers to the social oppression disabled people encounter (Goodley, 2016). Contextually, within exercise settings, a lens of disablism allows scholars to recognize the social imposition of restrictions of activity on disabled people and the socially engendered undermining of their physical health and psychological and subjective well-being through discriminating practices (Thomas, 2014). This lens also illuminates how physical barriers not only stop this population participating in exercise, but what these barriers mean and do to a persons' sense of self. As previously mentioned in this literature review, disablism arises in two forms: indirect psycho-emotional disablism relating to the impact of exclusory messages through encounters with structural barriers, and direct psycho-emotional disablism pertaining to negative interactions a disabled individual has with other people or themselves (Thomas, 2007). Experiencing either type of disablism can have a profoundly negative effect on a disabled persons' psychological health (Reeve, 2012; Smith, 2013). For example, previously in this section, I have highlighted that structural issues such as lack of access are key reasons why disabled people have difficulty participating in regular physical activity (Dickson et al., 2011). Applying a lens of disablism to this finding, however, also sheds light on how these physical barriers go further than merely stopping a disabled person from entering a physical space. Rather, these barriers act as '*landscapes of exclusion'* sending exclusory messages that disabled people are out of place

and do not belong (Kitchin, 1998) resulting in individuals feeling othered, isolated and lacking self-worth (Morris, 2014; Reeve, 2006). Thus, physical barriers do more than just stop a disabled person from entering an exercise space; they instil in a person the perception that they are not wanted which can consequently lead to poor self-esteem and be detrimental to an individual's psychological health (Reeve, 2014). Moreover, disablism also draws attention to the damage negative encounters with other people can have with regards to long term adherence to exercise. For example, disabled peoples' psycho-emotional well-being may be directly compromised through the negative interactions they encounter with others in exercise facilities. This includes being stared at, judged by other clients, made to feel marginalized and their lived experiences invalidated by fitness instructors and managers (Kehn & Kroll, 2009; Rolfe, Yoshida, Renwick & Bailey, 2009). Consequently, psycho-emotional disablism risks damaging individuals' psychological and emotional pathways, self-esteem and sense of intrinsic value (Thomas, 2007). As such, disabled people who encounter these oppressive practices are made to feel 'other' when trying to exercise and may be deterred from attempting to exercise in this space again despite the potential benefits they may gain from exercising.

In this section, I have presented how applying different models of disability to research on disability and exercise results in different understandings of why disabled people experience difficulty when trying to enact active behaviour. What is also important when working in the area of disability and exercise is to appreciate the social context of the fitness space which disabled people are negotiating to better understand how cultural norms may influence how disability is understood and treated in these spaces. As Sage (1993) argued, it is necessary to understand how sport and physical activity are linked to the social relations which underlie inequality, such as disablism and other types of social injustice. As such, it is important to understand the social worlds which help produce the disabling practices

aforementioned, why these practices occur and how these practices impact individuals' experiences of exercise. In the context of this thesis, the fitness space under investigation is the gym. Consequently, the next section of this literature review presents gym culture and how disability may be understood in this psychosocial context.

2.4. Disability and the Gym

The gym is a space dedicated to the improvement of physical fitness in a controlled environment with specialized equipment, health and safety legislations and qualified instructors (Sassatelli, 2010). Moreover, it is also a space which many individuals who acquired their impairments are familiar with as gym work is a key part of their rehabilitation. As such, individuals may feel confident in this exercise space due to this past experience and be aware of the potential therapeutic benefits exercising in this space can provide. Day and Wadey (2016) also identified this space as key for individuals' transition to long-term physical activity adoption after injury. Problematically, despite the gym being a potential space for health promotion and improvement, there are very few disabled people who utilize this space.

One reason for this may be the perceived dominance of *ableism* in the gym. Ableism is about, knowingly or unknowingly, the framing of images, policy, discourses and practices as if all people are able bodied (Campbell, 2009). As such, ableism casts disability as a diminished state of being human (Goodley, 2016) and rejects variation from this fully human form (Wolbring, 2008). Thus, ableism becomes another form of discrimination which marginalizes disabled individuals who have a different physicality to the ableist 'norm' (Loja, Costa, Hughes, & Menezes, 2013). Consequently, ableism can lead to exclusory practices which denigrate a disabled person's psychological well-being and sense of self (Wolbring, 2008).

The reproduction and dominance of ableism is arguably achieved through the promotion of a particular type of body. Increasingly fitness institutions, such as the gym, have become synonymous as places where the 'fit body' can be achieved (Crossley, 2008). This 'fit body' is strong, muscular and aesthetically pleasing, and has become tantamount as the normative physical state (Neville & Gorman, 2016; Sassatelli, 2010). Due to the embedded ableism in the gym, individuals who do not align to this ideal are cast as other and may be subject to discriminatory behaviors (Miller et al., 2004). As such, although the gym is a space which promotes fit bodies, it also marginalizes people whose bodies are deemed to be 'unfit' (Crossley, 2006).

Indeed, the social construction of the body has been instrumental in the exclusion of marginalized groups in sport and physical activity (DePauw, 2000). Marginality has been described as a process whereby one group's dominance in dictating what is valued results in discrimination and estrangement for those who do not adopt the characteristics of the dominant culture (DePauw, 1997). In the context of the gym, the hegemonic characteristics of strength and physical aesthetic have marginalized those who do not adopt these valued characteristics (Loja et al., 2013). Early conceptualizations of marginality focused on three basic aspects (i) *cultural* marginality (as described above) (ii) *social role* marginality which examines the inability of some groups to become full participants of a group (i.e. the dominant group) and (iii) *structural* marginality regarding political, social and economic sources of marginalization which prevent an individual achieving their full potential through consequences of, for example, poverty and disenfranchisement. Although this conceptualization of marginality provides an understanding which helps explain individual consequences of being a marginalized member of society, these three basis aspects do not consider the marginalized person in the context of cultural and social structures. As such, a reconceptualization of marginality was required.

This reconceptualization was proposed by DePauw, Karwas, Wharton, Bird and Broad (1993). These authors posited marginality was (a) socially constructed and not about 'essential characteristics' of marginalized groups (b) a dynamic process and not a static condition and (c) in the context of power relations and resistance rather than assimilation. With this reconceptualization of marginality, there is room to resist and fight against oppressive social inequalities which stop people from realizing their full potential. Moreover, by reflecting on dominant social values and how they reproduce social inequality and oppression, physical activity contexts can also provide a basis for resistance and be a site for social change (DePauw, 1997). As such, the purpose of the next section of the literature review is to present how the gym reproduces inequality and ableism with regards to disability.

2.4.1 Role of gym instructors in reproducing ableism.

One key way in which ableism is reproduced in the gym is through gym instructors. Gym instructors hold a great deal of power in the gym as they are deemed to possess knowledge which would enable clients to reach their fitness goals (Lloyd, 2005), are a crucial element for the satisfaction of the client and her or his sense of identity (Smith Maguire, 2001) and are perceived to be representatives of the gym and it's values (Sassatelli, 2006). Indeed, for gym instructors and their role in the gym, there is an emphasis on customer interaction as Smith Maguire (2001) stated gym instructors are essentially frontline service, visual, interactional representations of gym values:

> "Frontline service workers deliver particular information to the customer while
> providing an impression of the company and a connection – an invitation – to other
> consumption opportunities. That is, the purpose of services is not just with the
> immediate customer interaction, but also with the representation of the employer or

company, and the implication of the customer, via the service provider, in the broader needs of customer goods and sources" (p.386).

In other words, gym instructors are a key means by which disabled people can feel either included or marginalized in the gym as they are relational representatives of the gym. This may be problematic as Tulle and Dorrer (2012) concluded that gym instructors are themselves influenced by ableism and understand fitness to mean physicality and aesthetic. In their study, the authors noted that instructors' knowledge mainly aligned to shaping the body in a way which aligned to the expectations and ableist norms of the gym and lacked knowledge when clients had different fitness goals. As instructors are deemed to represent the gym, not recognising or having the knowledge base to enable clients to reach their fitness goals may then send an exclusory message to the clients that they do not belong in the gym and they cannot be helped. Moreover, as gym instructors hold this relational power, but also shoulder the pressure to align to the gym's ideal way of being, they are also arguably a key source of disablism. For example, how they value health is influenced by the ableist norms of the gym which can result in isolating individuals who value health a different way (Harvey, Vacchani & Williams, 2014).

Considering the literature regarding the marginalization of disabled people in the gym and the expectation of a particular way of being as a gym instructor, disabled people wanting to become gym instructors are making a choice which is highly unconventional. The fact that disabled people have elected and wanted to be a gym instructor is therefore an area which is worth investigating. The purpose of this research is to broadly investigate these individuals, thus I sought to explore their journey from gym clients to gym instructors. Specifically, I sought to explore their own experiences in the gym, their motivations for becoming gym

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instructors, their experiences becoming these individuals and what impact they believed they had on the gym. To explore this, I used narrative inquiry.

2.5 Narrative Inquiry

Narrative inquiry focuses on the storied experiences of an individual, bringing deeper understanding of human lives within their social world (Smith & Caddick, 2012). Accordingly, this thesis lends itself to narrative as this tradition also embraces how people make sense of their experiences, and why they are drawn to do certain things (Smith and Sparkes, 2008) (e.g. become gym instructors). Narrative has frequently been used to build an understanding of how people bring a sense of order and coherence to a life disrupted by serious illness or trauma (e.g., Carless & Douglas 2008; Papathomas & Lavallee, 2012; Smith & Sparkes, 2002). This may be because human beings have been widely accepted as storytelling creatures, making meaning and sense of their lives through stories; this forms an underlying assumption that humans lead *storied lives* (Crossley, 2000; Partington, Partington, Fishwick, & Allin, 2005; Phoenix & Smith, 2011; Smith, 2010). As we lead storied lives, when we are faced with crisis and a threat to our sense of self and way of being, the tendency is to turn to narrative to make sense and *meaning* out of our new circumstances (Frank, 2013; Medved & Brockmeier, 2008).

By telling stories we imbue our experiences with meaning, deriving from the recognition that as storied beings "we organise our experiences into narratives and assign meaning to them through storytelling" (Smith & Sparkes, 2008, pp. 87-88). By telling stories about our lives, we reveal much about ourselves including our thoughts, feelings, emotions, hopes, fears, views of ourselves and others. The use of narrative also allows individuals to communicate experiences, meanings and emotions which they attach to their relationships to events, embodiments, action and behaviours, thereby providing a richer, deeper, more

complex understanding of human experiences and behaviours (Frank, 2006). Thus, narratives provide a core link to different facets of ourselves and lived experiences to the events that occur in our lives making them meaningful and intelligible to us (Carless, 2008). As Mayer (2014) stated:

"Stories imbue our experience with "meaning." Events become meaningful to the extent that they can be fit into or evoke some larger narrative about ourselves or our world… It is impossible to say who we are without telling a story" (p.7).

Contextually, in this thesis narrative illuminates how participants constructed a sense of themselves and made meaning from their experiences in the gym and in their instructor training. This allows for an enriched understanding of participants experiences and motivations to become gym instructors as narrative allows for a complex, sophisticated appreciation of people as active social beings and focuses on the way people construct their personal and cultural realities through storytelling (Sparkes, 2005). Sparkes' (2005) statement also highlights two other key aspects of narrative; that our experiences are *constructed* through narrative and stories *act* on us.

The stories people draw upon to make sense of experiences and which get caught under their skin are not derived solely from the individual but are *socially constructed* (Frank, 2013). In other words, they do not simply appear or exist or are accessible to all people; instead they are social, cultural creations (Smith & Sparkes, 2009). As Phoenix and Sparkes (2006) illuminated "narrative is a form of social practice in which individuals draw from a cultural repertoire of stories that they then assemble into personal stories." (p. 109). By drawing upon these cultural resources, people can tell their own personal stories and make sense of their lives (Frank, 2010). It should be noted, however, that people's access to narrative resources depends on their social location; what stories are told where they live and

work, which stories they take seriously or not, and especially which stories they exchange as tokens of memberships (Frank, 2010). Moreover, the body is also integral to which stories are listened to and which are not. As Frank (2013) stated, people tell stories not just *about* their bodies but *out of* and *through* them as well. In other words, the body is also influential in shaping the stories that can be told about it, its relationship with others and the environment where it is located. There is therefore a reciprocal process of *infolding* and *outfolding* of experience onto and from the body (Frank, 2013). In the context of this thesis, the application of narrative inquiry provided a sophisticated way of investigating how the gym culture and the body participants had were influential in what stories participants told, which stories they disregarded, how they made sense of their experiences and how these experiences impacted their sense of self and well-being.

Narratives can shape what we think and how we behave, can open possible worlds, be powerful motivators of change and determine decisions which lie ahead (Andrews, 2014; Brockmeier, 2009). People do not simply listen to stories but get caught up in them affecting what they think, know and perceive; what Frank (2010) described as stories getting under people's skin. Thus, stories have the capacity not only to determine our lives, but to act in such a way that informs and guides our actions and our possibilities (Frank, 2006). As such, narrative can provide much insight into the motivations and stories available for disabled individuals in the gym. Stories can provide a template for people to make sense of their experiences and sense of self, who they have been and who they will be in the future (Frank, 2013). In the context of this thesis, the use of narrative inquiry permitted me to explore which stories got under participants skin and which they used as a guide to their desired future self.

2.6 Narrative, Disability and Exercise

In recent years, narrative inquiry has been used increasingly to try and understand which stories disabled individuals draw on and shape their experiences of exercise. For

example, Tulle and Dorrer (2012) advocated this method of investigation as narrative inquiry allows authors to explore how participants experiences of exercise are shaped by narratives of body and self. Research which has already been conducted in this area using this methodology has highlighted various narratives which disabled people used to make meaning from their exercise experience and why they were motivated to do so. Although these narratives were not constructed in the gym, they do have relevance in this study by providing initial insight into the actions and understandings of disabled people in the context of their exercise experiences.

Papathomas, Williams and Smith (2015) identified three particular narratives individuals with SCI draw on in regards to motivations for physical activity; *exercise is restitution, exercise is medicine* and *exercise is positive redemption*. The restitution narrative is grounded in hopes of recovery after illness or injury (Frank, 2013). Within the context of exercise, this narrative reads as "Yesterday I was able bodied, today I'm disabled, but tomorrow, through exercise, I'll be able bodied again." This narrative may be a powerful motivator for disabled people to exercise, however it can also be a dangerous narrative. Perrier et al., (2013) warned that with such a focus placed on recovery (and recovery being a very narrow possibility) there is a risk that the motivation of this narrative cannot continue in the long term. If participants become disenchanted and come to a realisation that recovery is unachievable, they are at risk of falling into what Frank (2013) called a *chaos narrative –* where life is without meaning and cannot get better.

Exercise is medicine has become a dominant narrative in the area of physical activity and tells a story of exercise alleviating and preventing a myriad of physical and psychological ailments (Penedo & Dhan, 2005). Within the context of disability, this narrative is a story of improved health and well-being and can read as "I experience an ailment, then I engage in exercise, then the ailment is eased or irradiated." Rather than a promise of a cure, this

narrative emphasises improvement, physical preservation and illness prevention (Papathomas et al., 2015). Although this is arguably a more favourable narrative than exercise is restitution and positively equates exercise to well-being (potentially a facilitator for motivating exercise in this population), the exercise is medicine narrative places responsibility of one's health squarely in one's own hands. Individuals can therefore by blamed or considered to neglect their health if they do not partake in exercise. This narrative also seems to draw upon the medical model of disability where an individual is disabled by their physical ailment alone rather than any structural or relational barriers. The exercise is medicine narrative does not take into consideration barriers out with the control of the individual.

Exercise is progressive redemption is slightly different from the other two as instead of promoting health or a cure from SCI, this narrative characterizes a positive identity change through transformative qualities of successfully overcoming barriers to exercise. This is a particularly important narrative as a sense of identity which overcomes barriers is essential given the array of barriers people with SCI face. This narrative, however, may be difficult for newly disabled people to identify with as they are negotiating their new circumstances and sense of self. Thus, the provision of multiple narratives to choose from may enable disabled people to exercise depending on their stage of recovery and motivation.

The narratives presented are an illustration of how narrative can be used as an analytical and informative framework to investigate the exercise experiences of disabled individuals. This framework, however, has yet to be applied in a gym setting. It still remains to be seen which narratives are available in this space, how these narratives are constructed and how disabled individuals make meaning from these narratives. These are gaps in knowledge which I aim to fill through this PhD thesis.

2.7 The PhD Project

This research explores the journey of disabled people transitioning from a gym client to a gym instructor. These gym instructors were trained by Aspire; a charity based in the UK whose mission is to provide practical support to people who have been paralysed through SCI through the provision of projects and programmes to facilitate health, well-being and independence (Aspire, 2017). One such programme is InstructAbility.

InstructAbility is a multi-award winning programme which trains disabled people to be gym instructors who are then able to cater to the needs of both non-disabled and disabled clientele. The wider objective of this programme, however, is for disabled gym instructors to promote diversity and inclusiveness to disabled people in the gym (InstructAbility, 2017). Delivered in conjunction with Aspire and YMCAFit, (an organisation delivering gym instructor training programmes) these two organising bodies deliver training and organise placements for successful graduates of InstructAbility. Training is delivered through an 18 day intensive course which includes both classroom and practical based lessons covering theoretical and practical knowledge about the body and exercise. This intensive course is followed by a two day training course on outreach training then another two day course focusing on disability and the gym. This training culminates in the individual being qualified as an instructor who can train both disabled and non-disabled clients. Successful completion leads to internationally recognised qualifications; the CYQ Level 2 Certificate in Gym Instructing and a Level 3 Exercise & Disability qualification. Following training, graduates then undertake a 12 week voluntary placement at either a public or private gym. It is on this placement that they are expected to take part in community outreach to promote health and exercise in the gym for other disabled individuals.

The origins of InstructAbility lay in the realisation of Aspire that the gym as an exercise space is vastly underrepresented by disabled people, but is an exercise space which has the potential to benefit this population. Moreover, this charity also realised the influence

gym instructors have in formulating the exercise experience for clients and the power these individuals have in promoting health and enabling individuals to reach their health goals. As such, they sought people to undertake the role of gym instructors but who also had experience and understanding of what it is to be disabled in the gym. They postulated that disabled gym instructors could be a way to promote diversity and improve inclusion of disabled people in this space. This research is the first in-depth empirical investigation to explore why disabled people chose to become gym instructors and the potential impact they could have on the gym environment. This topic is important as disabled gym instructors could be a way to bridge the perceived experiential gap between disability and the gym, promote the gym as inclusive of disability and improve the exercise experiences of disabled people in this space.

To develop a rich, in-depth understanding of participants' journey from gym client to gym instructor, I posited the following research questions:

1) What were participants' experiences of exercising in the gym?

2) What motivated participants to become gym instructors?

3) How did participants make sense of their gym instructor training experiences?

4) What impact did participants perceive they had on the gym environment?

The above questions shaped, but did not determine, the research design and directed the purpose of this PhD towards providing a complex, contextual, detailed account of the work of disabled gym instructors, their experiences in the gym and their journey from gym client to gym instructor.

2.8 Chapter Summary

This PhD is the first major qualitative research into the work and journey of disabled individuals becoming gym instructors. It is primarily concerned with participants' transition

from gym client to gym instructor and making meaning from their experiences throughout this process. This research aims to increase our understanding of these particular individuals including their motivations to undertake this kind of work in spite of the marginalizing, disabling experiences they may have previously encountered, and what impact they perceived they had in the gym. Moreover, a further aim of this thesis is to advance knowledge in the field of health and exercise psychology, disability and exercise promotion and narrative theory by providing applicable, transferable knowledge from this work to real world practice.

Chapter Three: Methods and Methodologies

3.0 Overview

In this chapter I will discuss the methodological approach I used to answer the research questions posed in the previous chapter (chapter two). I begin by introducing my

chosen method of inquiry; qualitative research. Next, I present the underpinning paradigm of *interpretivism* including the ontological and epistemological assumptions that guided this research; *relativism* and *constructionism*. Thereafter, possible criteria for judging qualitative data are proposed. I shall then present a brief review of my main methodological approach, narrative inquiry, before introducing my participants and how they were selected. After that, I shall discuss and justify my chosen methods of data collection and analysis. I then highlight the representational genres I used in each chapter to communicate research findings and ethical concerns relating to the conduct of this research. At each stage I offer justification and rationale for my methodological decisions.

3.1 A Qualitative Approach

Qualitative research is notoriously difficult to define as there is no clear cut definition of what constitutes this type of research; often it means different things to different researchers (Smith & Caddick, 2012). Accordingly, qualitative research may broadly be described as an umbrella term encompassing many different traditions and methods that involve collecting, describing and interpreting data in an inductive manner (Sparkes & Smith, 2014). As Walsh and Koelsh (2012) eloquently described:

> "if the field of qualitative research is at all a camp, it is a camp compromised of many small communities with distinct languages and traditions. Nevertheless, most of us who inhabit this camp prefer to affirm our common bonds. Yet, underlying these bonds are important distinctions that shape how we think – about research, about knowledge and about human nature" (p. 380).

In other words, although qualitative researchers may be united and tied together through some commonalities of core assumptions or practices, there are subtle yet important differences which create the particular essence of a camp or tradition. What links different

traditions together is the central aim and concern of interpreting and transforming qualitative data to capture the complexities of the social world we seek to understand, and to do so in a rigorous and scholarly manner (Coffey & Atkinson, 1996). Thus, qualitative research may be best defined and understood through a set of key characteristics (Madill & Gough, 2008; Sparkes & Smith, 2014; Willig, 2013).

One key characteristic of qualitative research is a focus on interpretation and meaning making. As Smith and Sparkes (2014) explain, qualitative research is "a form of social inquiry that focuses on the way people interpret and make sense of their experiences and the world in which they live" (p.14). In other words, we as qualitative researchers seek to explore *how* participants make sense of their experiences within specific contexts. A second defining feature is an emphasis on textual data which focuses on understanding qualities of social life and rich descriptions of people's lived experiences. This provides more agency to participants as, through textual data, participants can tell their own story, share their understandings and express their thoughts, actions and beliefs in their own words and on their own terms (Avis, 2005). Moreover, qualitative research can also be understood according to the paradigmatic assumptions which underpin this mode of inquiry (Smith & Sparkes, 2014; see below).

The adoption of qualitative research offers a number of advantages in relation to this research. First, in line with the purpose of this thesis to explore participants' experiences in the gym, training and as a gym instructor, qualitative research provides an opportunity to explore participants' gym life and journey in great depth and detail. By engaging with InstructAbility and participants over an extended period of time, I was able to build an 'emic' perspective whereby the phenomenon of interest (in this case participants' journeys to be instructors) is known as much as possible from an insider's point of view (Sparkes & Smith, 2014). Although it is impossible to understand participants' experiences in the gym as this is an embodied phenomenon, an emic perspective allowed me to better appreciate and gain a

multi-sensory appreciation of participants' experiences which provided the contextual familiarity necessary for doing good, rigorous qualitative research. Through engaging in an extensive period of immersion in the field with participants, qualitative research helped me build a depth of contextual familiarity necessary for producing detailed, rigorous accounts of participants' experiences in the gym and beyond (Charmaz, 2004; Gubrium & Holstein, 1997). Second, as qualitative research can involve an inductive, naturalistic approach to the world (Denzin & Lincoln, 2011), doing this type of research permitted me to build a complex, nuanced and contextually meaningful appreciation of participants' experiences from client to instructor. Third, qualitative research is focused on making meaning from experience (Smith, 2016). The adoption of a qualitative methodology, therefore, allowed me to explore how participants felt throughout their journey from gym client to gym instructor and how they made sense and meaning from their personal experiences.

Moreover, using this approach enabled me to answer qualitatively orientated research questions, in this case the *'what'* questions of the research which demanded a rich, descriptive answer. For example, *what* were participants' experiences in the gym? *What* were participants' experiences of training? *What* impact did participants perceive they had on the gym in the capacity of a disabled gym instructor? A qualitative approach also facilitates an understanding of *process*. This aspect of qualitative research is invaluable for understanding the *'hows'* of social life which result in human decision and action. As Sparkes & Smith (2014) highlighted, "the ability of qualitative research to get at the processes that lead to various outcomes is a major strength of this approach and is something that experimental and survey research is often poor at identifying" (p.17). As such, qualitative research enabled me to answer the qualitatively orientated *'why'* and *'how'* questions of this research. For example, *why* did participants feel motivated to be gym instructors? *How* did participants make sense of their experiences training to become instructors? *Why* did some participants drop out of

InstructAbility? Consequently, a qualitative approach provided many advantages in answering the research questions proposed and is the approach I chose to adopt.

3.2 An Interpretivist Approach

Another way in which qualitative research may be understood is through the paradigmatic assumptions that underpin it. Researchers all work within a set of beliefs about the nature of reality (*ontology*), how reality is known to us (*epistemology*) and how to gain knowledge of this world (*methodology*) (Bryman, 2004; Sparkes & Smith, 2014). In the context of this study, I am informed and guided by a paradigm of *interpretivism*. Underpinning this paradigm are assumptions of *ontological relativism* and *epistemological constructionism*.

Ontological relativism considers social reality as humanly constituted and shaped in ways that make it fluid and multifaceted. These multiple, subjective realities exist in the form of mental constructions and as such, in this perspective, it is accepted that physical things exist out there independent of ourselves (Sparkes & Smith, 2014). Thus, we cannot know reality outside of our subjective interpretations of it and a singular, external, knowable truth is beyond us. Instead, there are multiple, mind-depended realities that are socially constructed in contexts between participants and the researcher. In other words, how people give meaning and how they interpret actions of other people are shaped by language and culture and therefore differ between individuals and their environments (Sparkes & Smith, 2014). The role of the qualitative researcher aligning to relativism is to interpret these multiple, subjective realities and seek an expanded understanding of how and why participants have constructed and given meaning to their reality in a particular way (Creswell, 2012). In line with these ontological assertions, *epistemological constructionism* purports that researchers are part of what is studied and co-construct knowledge with participants. From this perspective, there is no subject-object dualism such as that in quantitative research, but rather

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an inter-dependent cooperation between the researcher and the researched in the construction of knowledge; in other words, the knower and the known are fused together in a partnership where findings are a creation of the interactions between the two (Sparkes & Smith, 2014).

These assumptions of reality and knowledge both shaped and directed how I did research and informed an over-arching *interpretivist* paradigm. An interpretivist paradigm is based on assumptions that "respect the differences between people and the objects of the natural sciences and therefore requires the social scientist to grasp the subjective meaning of social action" (Bryman, 2004, p.13). Accordingly, the notions of disablism, relationships and identity that I discuss throughout the thesis are not treated as true notions of internal reality, but are acknowledged as socially understood concepts that structured my interpretations about, for example, people's experiences of disablism in the gym. The underpinning philosophy of interpretivism therefore allowed me to acknowledge the immediacy of embodied experiences whilst also holding firm to the idea that people construct their experiences and interpretation of the world around them through language and storytelling. As I believe the world around us is understood through storytelling, I chose the qualitative tradition of narrative inquiry as my main methodological approach.

3.3 Narrative Inquiry

In addition to shaping how a researcher sees the world, a researcher's assumptions also influence how they gain the knowledge they seek, in other words their methodological approach. For example, as I believe reality is multiple and subjective and knowledge an interdependent construction between the knower and the known, to investigate the research questions posited in this thesis I adopted the qualitative methodological approach of narrative inquiry. I presented narrative inquiry in chapter two as the methodological approach which I felt could produce an understanding of participants' experiences and motivations, and the meanings of these experiences in the broader context of InstructAbility and the gym. At this

point I will briefly revisit narrative to highlight its numerous advantages in relation to the aims of the research.

First, stories are of importance because they are a key means by which people make sense of their lives after injury (Frank, 2013). As such, a narrative approach allowed me to investigate why participants were motivated to become instructors after injury and chose to construct an identity this way. Second, as narrative analysis emphasises human lives are culturally and relationally constructed (Smith, 2016), this approach allowed me to focus on the personal stories of participants whilst also exploring how these stories may have been shaped by narrative resources circulating within the gym and wider society (Gubrium & Holstein, 2009). Third, whilst other types of qualitative analysis focuses on one aspect of talk, narrative analysis focuses on both the *whats* (what the story is about) and the *hows* (how the story is constructed) of talk (Smith, 2016; Sparkes & Smith, 2014). Highlighted by Gibbs (2008), analysis of narratives add new dimensions to qualitative research as it focuses not only on what people say and the things they describe but how they say it, why they say it and what they felt and experienced. That said, there are multiple types of narrative analysis that take different standpoints. To fulfil the aims within this research, I utilised the analytical approaches of thematic analysis, thematic narrative analysis and dialogical narrative analysis (DNA). The rationale and justification for using these analytical approaches, as well as advantages of these types of analysis, are addressed in the data analysis section (see below).

3.4 Judging Qualitative Research

There has been much debate in recent years regarding how to judge the quality of qualitative research (Richardson, 2000; Sparkes & Smith, 2009). In 1985, Lincoln and Guba's criteria for judging trustworthiness of qualitative inquiry (credibility, dependability, confirmability and transferability) was proposed to be the universal marker of good qualitative research. Although still used in some research as an indication of rigorous

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qualitative research, these authors in 1989 acknowledged their original concept was parallel to the four criteria for judging quantitative research; validity, reliability, generalizability and objectivity. Accordingly, they acknowledged this parallel is not suitable for judging qualitative work and is also contradictory to dominant philosophical assumptions which underpin qualitative inquiry; particularly assumptions of relativism and the belief of no universal truth (Guba & Lincoln, 1989). Accordingly, criteria to judge qualitative research must match the philosophical assumptions which underpin it.

In line with the ontological and epistemological assumptions informing this thesis, I adopted a relativist approach to conceptualizing validity (Burke, 2016; Sparkes & Smith, 2014). This approach does not mean that 'anything goes'. Rather, it means that criteria for judging the quality of qualitative research are drawn from an ongoing list of characterizing traits as opposed to being applied in a universal manner to all qualitative research. As this study was guided by a relativist approach, the specific criteria I chose to guide my research and ensure the quality of research are outlined below (carefully selected from the ongoing list by Burke (2016)) and may be drawn upon by others to make their own judgements about the quality of this research.

First, I sought a *worthy topic.* I illustrated the worthiness of my topic in the previous chapter by justifying why investigating disabled gym instructors is worthy of study and how its contributions to the field of disability and exercise and exercise psychology will advance understanding in this area. Second*,* I ensured *rich rigour* by using applicable theoretical constructs, spent ample time in the field, used an appropriate sample, and applied rigorous data collection and data analysis methods. These were achieved by developing a sample appropriate for the purpose of the study, by my spending two years in the field of study collecting data, and my application of stringent data collection and analysis techniques (see below) to provide meaningful, important findings. Third, I sought to make a *significant*

contribution by ensuring the research I conducted contributed to advancing knowledge with regards to disability and the gym empirically, methodologically and practically. Finally, I sought *meaningful coherence* by ensuring the research achieved what it was designed to be about by using methods and procedures that fit the goals of the research and ensuring the study held together in terms of purpose, methods and results. Furthermore, many participants wished to see the empirical papers they helped construct through sharing their stories with me. Feedback from these participants was that the findings resonated with their experiences and they could connect and see their experiences in all themes. This is akin to naturalistic generalisability where "conclusions arrived at through personal engagement in life's affairs or vicarious experience are so well constructed that a person feels as if it happened to themselves" (Stake, 1995, p.85). This process was not member checking which seeks to ensure data is credible by matching participants and researcher interpretations together (Morse, 2015) but rather a reflection that participants were able to connect with the themes and recognise their story in the data.

Other potential criteria which were not selected include, but are not limited to, resonance, catalytic and tactical authenticity and credibility. Resonance refers to how the research influences, moves or affects particular readers through aesthetic representations and transferable findings. Catalytic and tactical authenticity pertains to the ability of an inquiry to prompt action on the part of participants and thereafter involve the researcher in training participants in specific forms of social or political training. Credibility is in regards to such aspects as how much time the researcher spent in the field and participant reflections on the researcher's interpretations of the data. Such criteria were *not* chosen for the following reasons. I did not choose resonance as the focus on this research was on participants' experiences and developing a rich, in-depth understanding of this phenomena rather than focusing on how readers are affected. Catalytic and tactical authenticity did not align to the

aims of the research nor with the interpretivist paradigm which underpins this work. This research is about experiences and building an understanding of an under researched group of people rather than the prompting of action or development of training. Similarly, credibility also did not align to my ontological relativism stance. That is, to ask participants reflections of my interpretations (member checking) would be to position that there is one reality and truth rather than multiple, subjective realities.

3.5 Sample and Participants

Participants in this thesis included (i) disabled individuals who were trained by InstructAbility and (ii) graduates of the InstructAbility programme now working as gym instructors. The purpose of this research was to investigate participants' journey from gym client to gym instructor, thus there were two key stages of participant recruitment to ensure rigorous, in-depth data about experiences could be collected; at the beginning of the research timeline by recruiting individuals who were about to undertake their training and mid-way through the research timeline by recruiting individuals who were employed as gym instructors.

3.5.1 InstructAbility trainees.

To explore the experiences of disabled people in the gym, their motivations for being instructors and their training experiences which inform chapters four to eight, I adopted both *maximum variation* and *criterion-based purposive* sampling strategies to recruit participants. I chose a maximum variation strategy to ensure representation of a variety of impairments, gym types and participant experiences which would contribute to a rich, in-depth data set incorporating a wide range of personal stories and experiences. I also chose a criterion-based strategy to ensure participants who were recruited could provide information rich cases and would be able to speak to the research questions (Sparkes & Smith, 2014). As such, I

assigned important inclusion criteria to ensure the participants selected would be able to provide knowledge about the topic under investigation. These inclusion criteria attributes were people who a) had a physical or sensory impairment, b) were over the age of 18 (and were thus eligible for full gym membership), c) had experience exercising in a gym and, d) were about to begin their InstructAbility training.

Following approval from the Loughborough University Ethics Committee, I initially made contact with the programme director of InstructAbility who acted as a 'gatekeeper' (Sparkes & Smith, 2014) to participants. I was then invited to attend selection days for the programme. Here, I told prospective participants about the research being undertaken and distributed participant information sheets (Appendix A) for further information. Individuals who were interested in being a part of the research shared their personal contact information with me under the understanding that, if chosen, I would contact them to provide further information about the research project and confirm their interest in taking part.

Successful candidates were selected by InstructAbility[8], I contacted the successful candidates by e-mail to ask specifically if they were still interested in taking part and to answer any questions they may have had. If they were happy to take part I met them on their induction day to obtain informed consent (Appendix C), and conduct the first interview which followed a life history structure with particular emphasis on their gym experiences. For this particular recruitment sample, I continued recruiting until I had reached data saturation (O'Reilly & Parker, 2013); in other words the data which was latterly collected had little or no new information which had not been gained from previous interviews (Sparkes & Smith, 2014).

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[8] Although I was present at the selection days I played no part in the selection of candidates.

The final trainee sample consisted of eighteen participants; eleven male and seven female. The ages of participants ranged between 23 to 60 years with an average age of 40. The participants reported a variety of impairments (polio, SCI, transverse myelitis, fibromyalgia and ME, hearing impairment, visual impairment, leg impairment and brittle bone disease) and represented a wide range of ethnic backgrounds (British, Indian, Trinidadian, Jamaican, Zimbabwean and Turkish Cypriot). Three participants described their impairment as congenital or acquired during early childhood and fifteen stated they acquired their impairment in their teenage years or adulthood. Eight participants were members of franchise gyms[9], eight a gym within a leisure centre and two had membership to a community gym. Further demographics can be viewed in Table 1.

3.5.2 Disabled gym instructors.

A further aim of this research was to investigate the perceived impact of disabled gym instructors working in the gym. To recruit participants who could speak to this research question, I implemented a criterion based, purposive sampling strategy (Smith & Sparkes, 2014). Rather than a sample which represents the larger population, this more specific method of sampling targets a clearly defined group who has experienced the same phenomenon (Patton, 2002; Sparkes & Smith, 2014). To be included in the research, participants were required to meet certain criteria. As I was interested in their experiences in the capacity of a gym instructor, inclusion criteria was set that participants had to a) have a physical or sensory impairment, b) be employed at a gym in the capacity of an instructor or personal trainer and c) have had experience training a disabled individual. As some participants from the previous sample had completed their training and were now in a

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[9] Franchise gyms refer to a chain of gyms whose presence is widespread throughout the United Kingdom (UK). These gyms use the same name, answer to a central management and are underpinned by the same philosophy.

position of employment in a gym, they were also included in the selection process and became part of this specific research question if they fulfilled all criteria.

Recruitment for this particular research study was done in two ways. First, some participants were graduates of the training programme and employment in a gym was the next stage in their development. I therefore continued to shadow and interview these participants in their work in the gym as I had done throughout their training. Second, to also hear the stories of disabled gym instructors who had established a prolonged career in this field, I worked with Aspire to contact past InstructAbility graduates. To ensure confidentiality in line with Aspire and Loughborough University's ethical protocols, Aspire made direct contact with prospective participants. To recruit these participants, I crafted an e-mail which was sent on my behalf by Aspire. This e-mail consisted of information about the project (Appendix B), why I was conducting the project and what was required of participants. In this e-mail I also stated if any individual *did not* want to be contacted by myself they could 'opt-out' by a certain date. Gym instructors who did not wish to take part contacted Aspire who then did not share contact details with me. Once the-opt out date had passed, I contacted individuals either by e-mail or phone asking them if they would be willing to participate in the research. It should be noted that participants recruited at this stage were also subject to life history interviews which were included in the first empirical chapter regarding experiences exercising in the gym as participants testimonies provided rich, in-depth descriptions which meaningfully added to the data set.

For this particular sample, a total of ten participants were recruited; five male and five female. The age of participants ranged from 23-60 with an average age of 40. Two participants had a congenital disability and eight were acquired. Three participants worked at leisure centre gyms, three in public gyms, two in community centre gyms, one in a

rehabilitation gym and one in a private, franchise gym. Further demographics can be viewed

in Table 2. In total, 21 participants were recruited from both recruitment stages.

Demographics Table 1: InstructAbility Trainees

Name	Gender	Age	Nationality	Impairment Details	Gym Type
Aadi	Male	33	Indian	Polio acquired aged 2. Affects legs only.	Leisure centre
Arthur	Male	32	British	Transverse myelitis. Previously used wheelchair, currently ambulatory without aids.	Franchise
Brenda	Female	54	British	Fibromyalgia/ ME. Chronic muscle and bone pain and extreme tiredness.	Franchise
Carl	Male	56	British	Head and shoulder injuries from push bike accident. Has memory problems and dyslexia from accident.	Franchise
David	Male	23	British	Acquired hearing impairment.	Leisure centre
Frank	Male	38	British	Leg impairment from injuries in combat. Occasionally uses crutches.	Franchise
Jack	Male	28	Pilipino- British	Acquired visual impairment, limb impairment and muscle loss from injuries in combat.	Leisure centre
James	Male	58	British	Chronic pulmonary hypertension.	Leisure centre
Julie	Female	60	Trinidadian – British	SCI incomplete. Occasionally uses a cane but mostly ambulatory.	Community
Kathleen	Female	32	British	SCI complete. Uses a wheelchair.	Leisure centre
Lenny	Male	40	Jamaican- British	Bulging discs. Sometimes reliant on crutches, mainly ambulatory	Leisure centre
Marcus	Male	46	Jamaican- British	Leg impairment from work accident. No longer relies on walking aids.	Franchise
Mudiwa	Female	55	Zimbabwean	SCI incomplete. Uses a cane.	Community
Polly	Female	26	British	Brittle bone syndrome. Uses a	Franchise

				wheelchair.	
Susan	Female	35	British	SCI incomplete. Uses a cane.	Franchise
Tara	Female	32	British	SCI complete. Uses a wheelchair	Leisure centre
Taskin	Male	31	Turkish Cypriot	Visual impairment.	Leisure centre
Terry	Male	35	British	Acquired visual impairment.	Franchise

Demographics Table 2: Disabled Gym Instructors

Name	Gender	Age	Nationality	Impairment Details	Gym Type
Aadi	Male	33	Indian	Polio	Leisure centre
Allan	Male	49	British	SCI incomplete	Rehabilitation centre
Brenda	Female	54	British	Fibromyalgia/ ME	Private
Jack	Male	28	Pilipino-British	Acquired visual impairment, limb impairment and muscle loss	Public
Jerzy	Male	30	British	Cerebral palsy	Public
Julie	Female	60	Trinidadian	SCI	Public
Polly	Female	26	British	Brittle bone syndrome	Leisure centre
Rosie	Female	50	British	SCI incomplete	Community Centre
Susan	Female	35	British	SCI incomplete	Community centre
Terry	Male	35	British	Acquired visual impairment	Leisure centre

3.6 Data Collection

Data collection for this study spanned a period of 26 months from October 2013 to December 2015. During this time, I attended InstructAbility selection days, training days, assessment days and work days in gyms all over the UK to capture and understand participants' perspectives and experiences at different times and across several locations to build an in-depth picture of the phenomena under investigation (Chamberlain, Cain, Sheridan & Dupuis, 2011). Throughout this process, I utilized different data collection methods in order to develop a richer and more complex understanding of participant experiences (Keats, 2009). These included various types of interviews and participant observation. In the following section, I will present how I collected data and the reasons why I made these methodological decisions.

3.6.1 Interviews.

Qualitative interviews are a means by which a researcher seeks to gain insight into participants' perceived feelings, experiences and perceptions (Sparkes & Smith, 2014). There are various types of interviews which can be used which suit different demands of research

projects such as structured, semi-structured, unstructured, group, mobile and video conferencing. For this study, I chose three different types of interview method to collect rich, multi-layered stories about their lives and experiences (Caddick, Phoenix & Smith, 2015; Sparkes & Smith, 2014). These were semi-structured, video conferencing and mobile interviews. Recognising that interviews are co-constructed between the knower and the known (Randall & Phoenix, 2009), I seek to be transparent with details of how I conducted interviews.

3.6.1.1 Semi-structured interviews.

Semi-structured interviews were used as the primary means of data collection in this research. I selected this type of interview for various reasons. First, the flexibility of this approach allowed me to alter the sequence of questions and probes used to suit each participant permitting each person to tell their story in a way which suited them (Gratton & Jones, 2004). Moreover, this type of interview also gave participants the opportunity to elaborate and make meaning out of experiences (Sparkes & Smith, 2014). Accordingly, by affording time to reflect on experiences in interviews through asking what an experience meant to them and how they felt, participants could construct the personal insights that constitute qualitative data.

Before interviews, I crafted interview schedules (Appendices D-G) which would guide discussion. Interview questions were crafted by drawing upon qualitative, methodological literature and designed to be open-ended allowing participants to express their opinions, encourage them to lead their interviews and help place them as the experts in their experiences thereby enabling unforeseen topics to be discussed (Sparkes & Smith, 2014). That said, the aims of the study also provided an implicit structure to interviews, thus questions were also designed with a broad focus on the experiences of being disabled in the gym, training to be a gym instructor and working as a gym instructor in a gym. Details of

how and when interviews were conducted are presented below. This approach ensured that although there was some degree of focus on areas of interest from my perspective, participants were also given the freedom to express their opinions and dictate the direction of discussion to include aspects of their experiences they deemed to be important (Cohen & Crabtree, 2006; Sparkes & Smith, 2014).

Prior to the commencement of interviews I provided all participants with information about the study (Appendices A and B) and gained informed consent (Appendix C). At the beginning of each interview, participants were informed of their right to withdraw from the project without having to give a reason, that they were not obligated to answer questions they did not wish to and could terminate the interview at any stage, again without having to justify their decision. To aid confidentiality and in line with ethical approval, I informed participants that all identifiable information would be removed and pseudonyms would be used.

Participants were interviewed between one and five times depending on how long they were involved in InstructAbility training. The first stage of data collection was conducting life history interviews with each participant during their introduction day at InstructAbility or, if they were an experienced instructor, as part of their one off interview. In total, I interviewed 21 participants with questions focusing on their lives, their experiences exercising in a gym before and after injury and their motivations for wanting to be a gym instructor. Questions included 'can you tell me about your experiences in the gym? What would you say are the main reasons for not going to the gym? What are the key reasons that helped you go to the gym?' Where necessary, elaboration and clarification probes were used to elicit more information and ensure understanding. Throughout these interviews I aimed to encourage participants to tell stories about how they lived their lives thereby providing detailed insight into their personal and social lives (Smith & Caddick, 2012). Furthermore, to encourage the promotion of narrative data and storytelling, participants were regularly

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encouraged to share experiences by being asked to "tell me a story about..?" or "tell me about a particular time when..?" Interviews lasted between 30 and 200 minutes and were conducted in gyms where participants would receive their training. These interviews were transcribed verbatim as soon as possible after interviews were conducted. During these transcriptions I adopted what Sparkes & Smith (2014) called a 'routine' transcription technique where I took time to reflect both on how the interview went and the data that was produced as a result. These reflections helped inform future interviews with participants as, by affording time to reflect, I could refine and construct interview guides which would help craft more meaningful, storied data which made sense to participants' experiences and focused on important phenomena.

The second stage of the interview process was interviewing participants about their experiences through their InstructAbility training. The duration of training for InstructAbility trainees was 6 months. During this time I interviewed participants at three key points through their training journey. Hermanowicz (2013) proposed that when interviewing participants at different times, the distance between these points "should be an amount of time sufficient to examine relevant change from one point to another" (p.196). Thus, time points were chosen where it was predicted changes may occur in participants' experiences as they were undertaking different parts of training. These time points were half way through their level 2 training, at the end of their level 2 training and after their level 3 training and community outreach training[10]. For these particular interviews, I designed interview schedules around participants' specific stage of training, their relationship with their fellow trainees and tutors and how their exercise experiences differed within a group compared to their previous experiences doing independent work outs (Appendix E). Questions I asked during these

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[10] For clarity in this chapter; level 2 consisted of standard gym training as delivered at any YMCAFit instructor course, level 3 is a specific course teaching gym instructors how to train a disabled individual, community outreach is a course educating individuals about how to advertise themselves as instructors and to communicate with people in the community.

interviews included "how have you found the programme so far? What is it like exercising with other disabled people? How does being part of this group make you feel?' Through this longitudinal approach, I became more familiar with participants. As such, although I approached each encounter with an interview guide, interviews frequently evolved into a more unstructured, conversational style of interview. Occasionally, I conducted group interviews with two or three participants when I felt together we could create rich, meaningful data. Observations of participants' interactions with each other informed my decision to ask if they would be willing to be part of a group interview. For example, if I observed three individuals speaking freely and openly with each other I thought speaking within a group may elicit in-depth, informed and meaningful data. These group interviews were done opportunistically and I asked all parties separately if they were happy to be interviewed as a group and reaffirmed the importance of confidentiality.

At the beginning of this interview stage I interviewed eighteen participants, however many participants discontinued their training at various stages, culminating in only eight of the original eighteen taking part in all three training interviews and completing their training. An analysis of this drop out and training experiences is presented in chapter seven. Interview length ranged from 45 to 185 minutes with the majority of interviews taking place in the gym where participants' training was being delivered. Some interviews were conducted at a place of participants' choosing had they been absent on the day I attended their training and some interviews were conducted via video conferencing at the request of participants. This method is discussed in detail later in this section. Again, interviews were transcribed verbatim as soon as possible after the interview and subject to routine reflection to inform future interviews.

The final stage of semi-structured interview collection involved ten participants (seven were also participants in the training interviews) who were currently employed in the

position of a gym instructor. In these interviews, I sought to investigate how participants perceived they impacted the gym environment; as such I crafted an interview guide that would help in the promotion of storied data providing detailed stories about their experiences in the gym and their interactions with clients, colleagues and managers (Appendices F and G). Questions included, 'can you tell me what it means to you to be an instructor?' 'What does a disabled gym instructor bring to the gym environment?' 'What impact do you believe you have had in the gym?' Interview length ranged from 120 to 210 minutes. Again, these interviews were transcribed verbatim and subject to reflection. When presenting data in subsequent chapters, and putting into practice my epistemological stance that knowledge is co-constructed, I have attempted to preserve some of the interactional features of data collection by writing myself into the analysis (Randall & Phoenix, 2009). For example, when participants words were a direct response to my questions I have included my own voice to show how knowledge was crafted co-operatively. When participants' discourses are taken from an extended narrative, I have removed my voice as the contextual relevance of my initial question may have diminished.

3.6.1.2 Video conferencing.

Some participants requested that interviews be conducted using a method allowing them to stay at home due to difficulties travelling or low energy. It was in these instances that I used video conferencing techniques. Video conferencing is an immerging method of data collection used increasingly by qualitative researchers that offers a novel way to collect data (Deakin & Wakefield, 2013; Hanna, 2012). There were numerous advantages to collecting data in this way. First, a key benefit of video conferencing was that longer and more in depth interviews could be done as there was little time pressure on the respective parties to do an interview during days when participants had training. Training days were often six hours long

with a break of one hour. To try to conduct an interview in the space of one hour would have compromised the rigor and potential quality of the interview and data collected, evident as most interviews lasted much longer than an hour. Second, it reduced the pressure on participants to travel to a designated place at a specific time, potentially committing a large amount of time and energy commuting to the interview (Janghorban, Roudsari & Taghipour, 2014). Many participants had a physical impairment which meant travelling was not convenient or easy and required a great deal of time and physical exertion to do so, particularly those who relied on public transport to attend their training sessions. Including an interview either during breaks or after training had finished was at times difficult as participants stated they were too tired or were afraid of missing their bus or train. Thus, conducting interviews via video conferencing reduced tiredness and stress associated with travel allowing for an interview experience which was more comfortable and relaxed. Furthermore, although there have been concerns raised about ethics and assurances of privacy (e.g. Deakin & Wakefield, 2013), I found that conducting video interviews actually reduced these problems. During face to face interviews, discussions were conducted on site in gyms or coffee shops. These areas generate a lot of noise, are not private and at times we were interrupted by friends or colleagues of participants. Using video conference methods meant I could conduct interviews in silence and there was no danger of being interrupted by others. This also meant more sensitive issues could be discussed as participants did not have concerns about being overheard telling stories about difficult times of their lives, stating critical opinions of others or showing emotion. Moreover, video conferencing can reduce the perceived power differential between the researcher and the participant (Bertrand and Bourdeau, 2010). For example, participants have the ability to terminate interviews instantaneously should they choose to do so.

One key issue I experienced, however, was the disruption which occurred in a video conference interview when my or the participants internet signal went down. This meant a time delay of five or more minutes before we could reconnect and try to build the flow of conversation we had had and to remember what had been said or asked. Another difficulty I had was participants sometimes chose to answer my call using the speaker only meaning I did not see their face when we were talking. Although this illustrates participants had a choice and agency of how they wished to discuss their experiences, for me this was at times disconcerting as I was unable to read their facial expressions and other non-verbal communication cues. Despite these difficulties, the use of video conferencing was invaluable in the collecting of rich, storied data.

3.6.1.3 Mobile interviews.

To develop a greater appreciation of the experiences of disability in the gym, I also used mobile interviews when visiting participants in their gym. A mobile interview is a means of interviewing participants as they move through spaces(s) (Buscher, Urry & Witchger, 2011). Here, the participants guided me through their day to day routine in the gym permitting us to discuss issues such as accessibility and unsuitable facilities as they were encountered. This also stimulated participants' memories of past negative and positive experiences allowing contextually meaningful stories to be discussed in certain areas. Moving through the lived spaces of participants also enhanced my own understanding and appreciation as a researcher of their stories by providing a multi-sensory experience of both seeing and hearing about their lived experiences (Sparkes and Smith, 2014).

Although mobile interviews were a very useful means of eliciting meaningful stories from participants, there were some difficulties. Firstly, the gym is a busy, noisy environment so at times it was difficult to conduct an interview and afterwards transcribe with heavy

background noise. Furthermore, as participants had built relationships with others we were often interrupted as friends, colleagues and clients came to greet the participant[11]. Although it was beneficial for me to see and record these interactions and relationships in field notes to build a multi-layered understanding of participants' experiences, it did at times break the flow of the interview. Finally, due to the inaccessible or narrow lay-out of many gyms, there were times where I could not walk beside my participants, particularly if they used a wheelchair. Instead I had to walk in front or behind them. I was often in an awkward physical position to ensure the participants' thoughts and stories were recorded. This awkward position may have again resulted in an interruption in the flow of the interview, however it was also beneficial for my own understanding and observational notes of the barriers and disabling physical structure of the gym.

3.6.2 Participant observation.

To complement and supplement my understanding of the storied experiences constructed through interviews, I also collected observational data from InstructAbility training and seeing participants at work as gym instructors. Participant observation enabled me to gain insight into the mundane, typical and occasionally extraordinary aspects of participants' everyday experiences that they may not have felt worthy of mentioning in an interview (Sparkes & Smith. 2014). This also allowed me to reconcile what is *said* in interviews with what is *done* in practice and is a method qualitative researchers highlight as imperative to building an appreciation and well-rounded understanding of participants' experiences. As Gubrium and Holstein (2009) stated:

> "The reality in view is about both the substance of stories and the activity of
> storytelling, it is imperative that in addition to what is said and recorded on any

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[11] At these instances I stopped recording.

occasion, researchers go out into the world, observe and listen, and document narrative's everyday practices" (p. 15).

An advantage of participant observation is that the researcher participates in varying degrees in the lives of the participants and research context (Sparkes & Smith, 2014). In this study, I was predominantly positioned in the '*observer as participant'* role, very occasionally venturing into the '*participant as observer'* role. As an observer as participant, I mainly observed but occasionally was involved in participating in the field. For example, during training days I was asked to help some participants who were struggling with terminology and some theoretical work as I had a knowledge of exercise, the body and muscles. Moreover, during assessments I also acted as reader and scribe for participants with a visual impairment. On occasion, I also ventured into the 'participant as observer role' when I was trained by disabled gym instructors and experienced first-hand what it was like being trained by a disabled gym instructor and could personally reflect on that experience. In short, I immersed myself in the InstructAbility environment at every available opportunity, yet by virtue of my status as an individual without an impairment or instructor in training I was never a 'complete participant'. Instead, I hoped to integrate myself into the group as much as possible and build constructive, open relationships with participants to learn as much as possible about their lives.

In accordance with Wolcott (2005), I was also reflective of how my role in the research may have influenced the data collected in my notes. Immediately following a period of observation, I recorded my observation in the form of detailed field notes. These field notes included, but were not limited to, what was happening, the people in the field and interactions with significant others, how I felt observing these interactions, where and why things might have happened in a certain way, the ways in which people spoke and related to each other, the conversations that took place between other participants, other gym instructors

and clients and the various discourses which were visible in gyms to give some contextual background to where participants were working (O'Reilly & Parker, 2013). In total, over 55 hours of observational data were recorded in this way. The collection of participant observation data allowed me to build a clearer, more contextual understanding of what participants discussed in their interviews and their training experiences. This approach also allowed me to reflect on my own practice as a researcher as I noted interactions with participants and reflected on interviews conducted. As such, although I do not provide examples of the observational notes I recorded in this thesis, this method of data collection enhanced my understanding of participants experiences and contributed to the analytical process by being another method which I could draw upon to rationalize the most appropriate data analysis methods to craft meaningful, coherent results.

3.7 Data Analysis

Analysis cannot be seen as a distinct, separate stage of research applied to the research body; instead the research problem, design, data collection and analysis processes should be part of an all-encompassing approach that imply one another (Coffey & Atkinson, 1996). Indeed, these authors go as far to say:

> "analysis is a cyclical process and a reflexive activity: the analytic process should be comprehensive and systematic but not rigid; data are segmented and divided by meaningful units, but connection to the whole is maintained; and data are organized according to a system derived from the data themselves. Analysis is, on the whole, an inductive, data-led activity….analysis is not about adhering to any one correct approach or set of right techniques; it is imaginative, artful, flexible and reflexive. It should also be methodical, scholarly and intellectually rigorous" (p. 10).

With this in mind, I selected different qualitative analytical techniques that I deemed would best represent the data and answer the research questions I posed in chapter two.

Although this research is broadly informed by narrative inquiry, I analysed data using thematic analysis (chapters four and eight), thematic narrative analysis (chapter five) and DNA (chapters six and seven). The use of different analytical lenses allowed me to be a *bricoleur* assembling images and interpretations to shed light on a complex phenomena and to make meaning from experience in this world, yet still maintain an epistemologically and ontologically coherent position (Denzin & Lincoln, 2011). Justification and practical application of my chosen analyses are discussed below.

3.7.1 Thematic analysis.

Thematic analysis is a form of analysis which seeks to identify, analyse, interpret and report patterns within data making it a research tool which can potentially provide a rich and detailed yet complex account of data (Braun, Clarke & Weate, 2016). Although this method does not align to a specific theoretical framework, it is still underpinned by interpretivism, and framed by ontological relativism and epistemological constructionism. This is but one reason for my choosing thematic analysis as a way to analyse data. Another reason for the selection of thematic analysis was, through the data collection process, many of the participants spoke of experiences in the gym that were more accounts rather than actual stories in the definitive sense. As Frank (2010) explained, a story at the very least contains a complicating action and some sort of resolution. Rather than a story with these key factors participants discussed separate contextual instances, which although powerful and enlightening, did not follow the structure of a narrative.

To include as much data and detail as possible of the experiences, meanings and interpretations of participants' experiences in the gym as a client and an instructor, I used

thematic analysis. There are different ways of doing a thematic analysis. For this research, I chose to conduct an inductive, latent approach. This approach permitted themes to be formed from the data rather than a pre-existing framework which may have reduced the complexity of participants' lived experiences. It also allowed for themes to be interpreted beyond description of the data and more towards theorizing data (Braun et al., 2016). In order to do a thematic analysis rigorously, I followed the six stage inductive thematic guide as outlined by Braun et al., (2016).The first step of this guide involved *immersion* in the data. This immersion occurred through the conducting, transcribing and readings of interviews. Transcripts were read multiple times until I was familiar with the breadth and depth of the content. At this stage I also noted initial ideas and recurring patterns

The second stage of thematic analysis was *generating initial codes* which identified key features or points of interest within the transcript. See Table 3 for an example of a coded section. This aspect of coding is analytical in itself as it is the initial stage where the data is sorted into meaningful groups and, as I aligned to an inductive approach, was active in crafting future themes.

At the third stage, after all data had been coded, focus of analysis changed to broader level themes. This process of *searching for themes* was done through identifying similar codes and grouping them, thereby laying a foundation for potential themes. Once this was done, I searched the groups to see if any combination of initial themes could occur to form an overarching theme and meaningful essence which ran through the data (Sparkes & Smith, 2014). At this stage I also developed a thematic map (figure a) which is reflective of links between codes, themes and different levels of themes.

Table 3: Example of coded data excerpt

Data Excerpt	Codes
But you should not be <u>expected to do something extreme</u> when <u>realistically you just want to be fit and healthy</u> and <u>you're not allowed to just be fit and healthy. I don't get that</u>. When the Back Up came to see us in hospital, they were like leaflets for this and that. I may be speaking a bit out of term but <u>you get leaflets from Back Up saying come and spend 3 days throwing yourself off a wall, come and spend a week climbing a mountain. We'll drag you up and it'll be totally soul destroying but you'll feel better after it. I won't mate, end of!</u>	Expected to do something amazing Desire to be healthy Social expectation of inspiring disabled people doing incredible things Aren't allowed to be normal Limited activity options Not everyone wants to Perception of being forced to do something they don't want to

In the fourth stage, provisional themes developed at stage three were *reviewed.* This review was done at two levels; reviewing at the level of coded data extract, and ascertaining whether themes 'worked' in relation to the data set. Level one was done through reading through collated extracts and questioning whether there appeared to be a coherent pattern. When this was confirmed level two required a similar process except it involved the entire data set. At level two, I went back to the original thematic map constructed and assessed whether it worked in relation to the data, if themes were distinctive, if the themes were clear and if the data within themes were coherent. At this stage, some themes were collapsed into others and became sub-level themes to add richness and depth to an overarching theme. For example, the theme initially titled 'inclusivity' (figure a) was combined with subthemes from the other topics to craft a theme which was reflexive of the inclusive impact disabled gym instructors had on the gym environment as seen in figure b. When level two was complete, I felt this reflected experiences of participants well and an overall, coherent story was being told about the data. At this point I moved to stage five.

Stage five involved *defining and renaming themes* to identify the essence of what each theme was about and telling a 'story' of what each theme meant. I also considered how each theme was part of a story which reflected the overall tale of the data with regards to the research questions. I did this through a process of identifying subthemes to tell this story which was useful when the theme itself was complex and nuanced. Once I was happy these requirements were met, I crafted theme names which were concise, understandable and immediately recognisable for readers to make sense of a theme's content.

The final stage of analysis was *writing the report.* It is vital that this report "provides a concise, coherent, logical, non-repetitive, and interesting account of the story the data tell – within and across themes" (Braun & Clarke, 2006, p.93) as this is another opportunity to refine analysis as writing in itself is analysis and can produce new ideas (Richardson, 2000). Finally, what was also required was that themes were embedded in an analytic tale providing clear interpretation of data (Sparkes & Smith, 2014) and supported through conceptual and theoretical frameworks, thereby aligning to a latent approach to thematic analysis. These reports and application of conceptual and theoretical frameworks are presented in chapters four and eight.

Figure a. Initial candidate thematic map

Challenging Intimidating Environment

Changing Perspectives of Disability

Representing
disability in the gym

Educating non-
disabled instructors

Can do v can't do

Inclusivity

Addressing
structural barriers

Disability adapted
work-outs

Role models for
clients
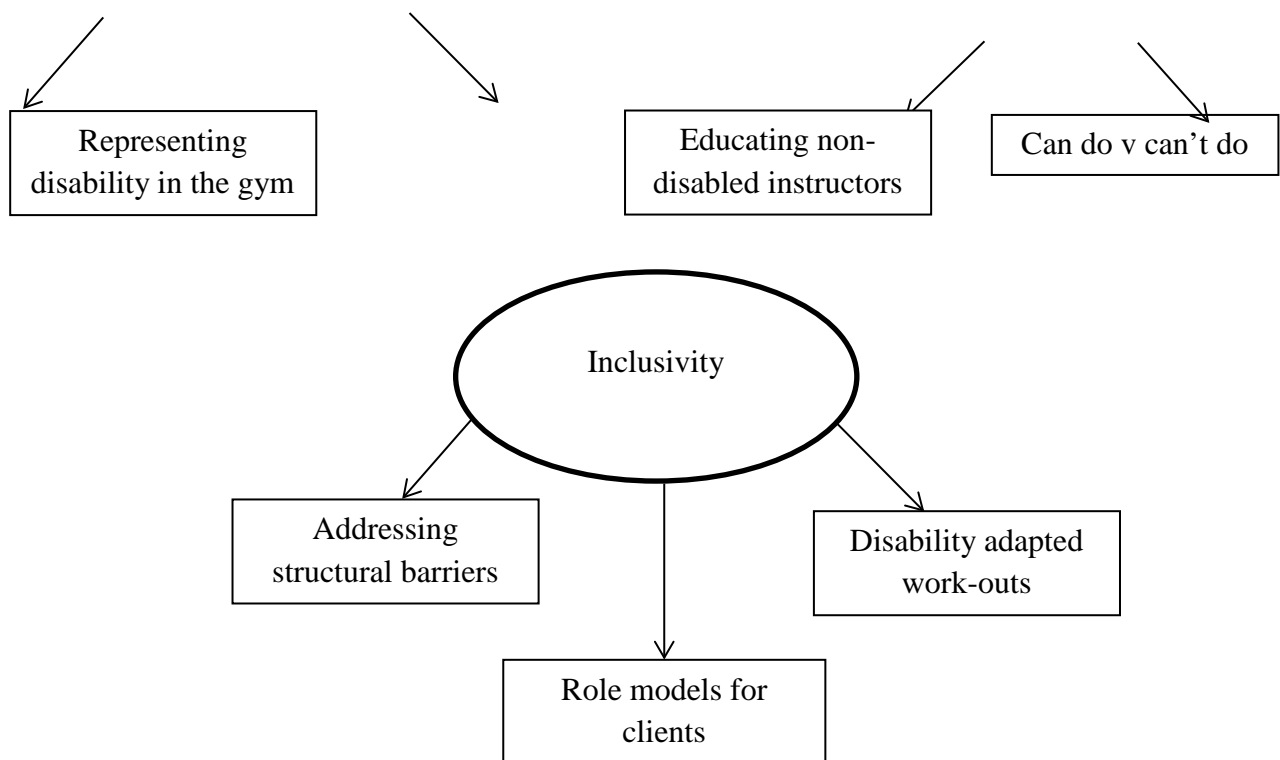
Figure b. Reviewing themes

Promotion of an
Inclusive
Environment

Accessible physical
environment

Provision of a
relatable narrative

Embodying an
alternate way of being
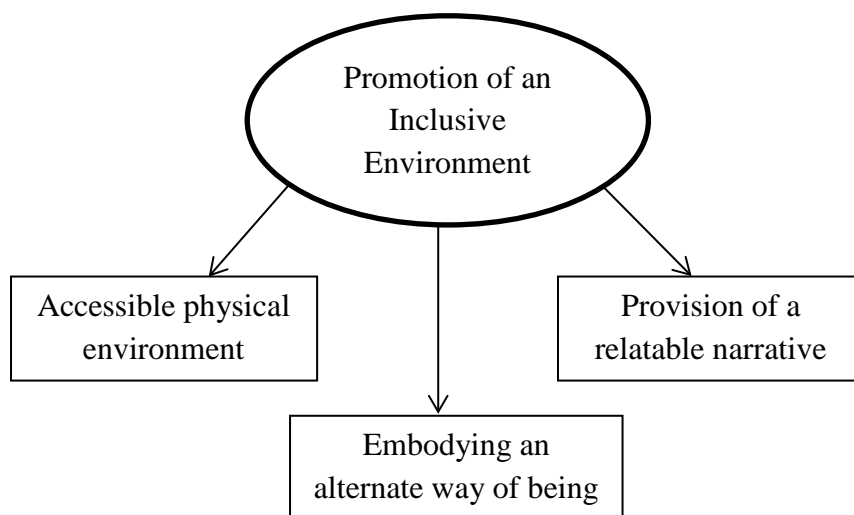
3.7.2 Thematic narrative analysis.

     A key aim of the research was to investigate why participants wanted to be gym

instructors and the motivations behind their decision. To do this, I deemed a thematic

narrative analysis as the most appropriate method to do so. As Sparkes and Smith (2014) stated, narrative analysis:

"reveals a great deal about the socio-cultural fabric of lives, subjectivity, feelings, agency and the multi layered nature of human experience over time and in different sets of circumstances. The analyst seeks to combine emphasis on people as agents of their behaviour and a humanistic image of the person alongside unpacking the cultural discursive practices that people often take for granted, but which play a key role in shaping human experience and conduct" (p.131-132).

Thus, a thematic narrative analysis allowed me to further investigate what stories participants were drawn to, how they made meaning from experience, what their motivations were and which narratives played a role in their decision to become gym instructors.

Like a thematic analysis, the first stage of doing a thematic narrative analysis was *immersion* in the data through experiencing the field, conducting and transcribing interviews and re-reading transcripts multiple times. Thereafter, I wrote *initial thoughts* on my first impressions of each participant's reasons for being a gym instructor. I did this by highlighting reoccurring phrases, key events, characters and turning points in participants' narratives. Once I had done this for all participants, I made connections across all participants' stories to *identify key themes* constructed by them through looking for threads such as specific words or phrases shared by participants across transcripts. For example, in the context of this study, a key thread across all participants was their altruistic desire for other disabled people not to experience what they had experienced in the gym. This was a key motivation for participants to undertake training to be a gym instructor. At this point I provisionally named the themes.

Thereafter, I *tracked the narrative* by seeing where respective, provisional themes appeared in their life history context, if there were any interactions or interplay with themes, and the context in which each theme appeared. In the fourth stage I moved away from

participant statements to tentatively *connect their story* and motivations with various

theoretical contexts which could relate to themes and issues raised by participants. For

example, I drew upon the work of Pollner and Stein (1996) and narrative maps to tentatively

analyse why participants were called to become gym instructors. Following this, I committed

to *naming the theme and writing the story* highlighting interrelationships between themes. I

did this by attempting to write a rich story that encapsulated what each theme was about, what

this theme said about the person and the cultural contexts that shaped them.

The next stage involved *comparing and contrasting* the above for all participants to

find the most meaningful themes. This I did through visually representing plot summaries and

differences as well as theoretical contexts. The final report for this analysis can be found in

chapter five.

3.7.3 Dialogical narrative analysis

In chapters seven and eight I present data analysed using DNA. DNA "studies the

mirroring between what is told in the story – the story's content – and what happens as a

result of telling that story – its effects" (Frank, 2010, pp.71-72). In other words it is concerned

with not only the story told by participants, but also what stories do *for* and *to* people. Thus,

the principle analytical concern with DNA is the appreciation of stories as *actors* in people's

lives (Frank, 2010). Applicably, one way in which narratives act is by shaping our

understandings (Frank, 2006). Understandings are constantly being reshaped by cultural and

social stories which encompass us and our understandings (Frank, 2006). In the case of this

research, a DNA approach sheds light on how individuals experienced and understood

exercise as a disabled individual in the gym and thereafter as a member of a collective group.

That is, while people may have an embodied intuition of their own exercise experiences, this

intuition is constantly being reshaped when stories are relationally shared with others and

stories circulate in culture and society (Frank, 2006). How an individual makes meaning from

a story will be influenced by their social relationships and the storytelling preferences of the group (Caddick, 2016), thus exercising within a group of peers may reshape how a disabled individual experiences exercising in a gym. As Smith (2016) illuminates, "movement of thought can take the analyst in unexpected and fertile directions, breathing fresh life into moribund concepts, encouraging theoretical curiosity, and provoking new ways of seeing in the process" (p.12). Thus, adopting DNA as a heuristic guide and method of questioning can spur imagination and inspiration that in turn can lead to new insights and understandings of the gym, disability, training with peers and disabled instructors. This method of analysis can also artfully represent storied lives and extend analysis to what stories *do* as well as what is *said* (Frank, 2010) allowing an appreciation of process and understanding of action and behaviour. In order to allow stories to move and appreciate what stories do, rather than the prescriptive steps of such analysis as thematic, I used a more open guide to identify stories, themes in stories, and how these stories are culturally and relationally constructed (Frank, 2010); specifically, through asking *dialogical questions* (Caddick, 2016). The following section will address how I applied these steps to the data I collected.

The analytic process began with a period of what Maykut and Morehouse (1994) described as *indwelling* where I collected data, transcribed this data, documented initial impressions and closely re-read transcripts multiple times. The next stage involved *identifying stories* in the text as well as the *narrative themes and structures* within these stories (Caddick, 2016; Smith, 2016). I accomplished this through loosely coding the data transcripts and field notes with conceptual comments which would later help in the building of analysis, but also would keep the story intact. In this research, stories which shaped individuals' exercise experiences and relational experiences with peers were sought. As part of the unique analytical focus of DNA, the data were considered in relation to various *dialogical questions*

(Frank, 2012) which were asked to highlight what stories do and the effects that stories had in participants' lives. As Caddick (2016) stated:

> "social, cultural and relational dynamics that shaped not only the type of stories they told about their …experiences but also the way they told them, their reasons for telling them and the consequences of telling these particular stories for their personal and social lives. Asking dialogical questions are a crucial means of opening up social, cultural and relational dynamics of stories" (p. 229).

The dialogical questions I selected and justification for selection are supplied in Table 4. For clarity, I contextualise the DNA application I used on data for chapters six and seven. Specifically, questions included how stories helped participants create and sustain an *identity*, how stories *connected/ affiliated* people into groups, how participants made sense of their story and their position in the stories through the narrative *resources* they had available and what *function* stories had in shaping participants' understandings of exercise. The analytic process of DNA also consisted of writing numerous draft reports which were used to develop thought and test interpretations. What is imperative to note however, and is a key commitment of DNA, is that these accounts and the final reports do not 'finalize' participants' lives by offering the last word on who they are or who they might become (Frank, 2012). As Smith (2016) contended, although a report can take on a realist tale (which will be discussed in the next section) given the commitment of unfinalizability, any necessary ending to a report is purely provisional. While chapters need to close for practical matters, the participants are still alive and rather than have given their final word, they can tell and draw upon new stories and resources where they may become someone different (Frank, 2010).

Table 4: Dialogical Questions

Type of Question	Example	Rationale
Identity	How did participants' stories shed light on who they saw themselves to be and wanted to be?	To aid in understanding motivations participants had in wanting to become a gym instructor and future selves which they may aspire to be.
Resource	What narrative resources did participants draw upon to shape their experiences and identity as a gym instructor?	Illuminated how participants used the cultural resources (in this case disability narratives and gym narratives) available to make sense of their experiences and situate themselves in that story.
Connection/ affiliation	How did the participants' story relate to other disabled individuals?	Stories we tell can connect us to others who may share our story, but also disconnect us from others who cannot relate to our experiences. Connection questions illustrated the social process of storytelling and how stories united or separated individuals.
Function	What did participants' stories do to them, how did they shape their actions and spur them to action to be instructors?	Function questions aided in understanding of how participants' stories informed their actions, drove them to want to be an instructor and helped them shape their conduct on their journey to being instructors.

3.8 Representational Genres

There are five empirical chapters in this thesis which tell a chronological tale of participants' journey from disabled gym client to gym instructor. To tell this tale, I have adopted different representation genres I feel are best suited to translate the research and achieve the aims I presented in chapter two. First, chapters four and nine present participants' experiences exercising in the gym and working in the gym respectively. These chapters provide a beginning and end to the story of the thesis. To present this research, I adopted the style of a *realist tale.* A realist tale is a dominant means of representing qualitative findings and operates to faithfully represent the participants' point of view whilst drawing upon theoretical and conceptual frameworks to explain findings. It is written in traditional academic prose, framed by the voice of a disembodied author (Sparkes & Smith, 2014) and is characterised by *experiential authority* (the researcher is absent from the text), *participants' point of view* and *interpretive omnipotence* (a theoretical account of the story) (Sparkes & Smith, 2014). As Sparkes (2002) stated:

> "The realist conventions connect theory to data in a way that creates spaces for participants' voices to be heard in a coherent text, and with specific points in mind. When well-constructed, data-rich realist tales can provide compelling, detailed, and complex depictions of a social world" (p.55).

My purpose selecting a realist tale to present the first and last empirical chapters is to persuade the reader of my interpretations and demonstrate the socially scientific understandings that I drew upon to make sense of the data. It is, however, possible to modify a realist tale as Sparkes (2002) suggested in order to illuminate the researcher's role in the construction of data. In order to acknowledge my interpretive role in the construction of data and findings, I include my contribution in constructing data with participants throughout the thesis where appropriate. The purpose of this is to 'disrupt' the authorial absence that traditionally characterise realist tales and position myself as a reflexive researcher.

Chapter five, seven and eight are analysed through a narrative lens and presented from the standpoint of a *story analyst.* A story analyst is concerned with the context of the story; the where's and when's whilst still addressing the *whats* and the *hows* (Gubrium & Holstein, 2009). Story analysts conduct an analysis of the narrative whereby "the researcher steps outside or back from the story and employs analytical procedures, strategies and techniques in order to abstractly scrutinise, explain and think about its certain features" (Smith & Sparkes, 2008, p.21). That is, I conducted an analysis *of* participants' stories; placing the participants' stories under an analytical lens in order to scrutinise, think about, and theoretically interpret certain elements of stories. I adopted the position of a story analyst as I wished to investigate how narrative was used by participants and apply deeper layers of understanding to scrutinize how narratives were constructed, their structure and what they did on and for people. As I was working with people closely and asking them to share with me their stories which could do things on and to them (such as cause upset or anxiety), I had many ethical considerations to attend to.

3.9 Ethical considerations.

In quantitative research, ethical consideration typically ends after being granted institutional permission to conduct research (Lahman, Geist, Rodriguez, Graflia & DeRoche, 2011). Within qualitative research however, ethics may be considered not as a static event but a continual, reflexive process (Miller, Birch, Mauther & Jessop, 2012). It is this consideration of ethics which I undertook throughout the research process.

The first aspect of ethics within the research process was in the form of procedural ethics (Sparkes & Smith, 2014) whereby ethical approval was granted by the Loughborough University Research Ethics Committee. This exercise must be carried out by all researchers doing empirical research and can be viewed as a check list or mandatory code of conduct

which focuses only on participants' rights ensuring no harm comes to them to achieve research outcomes (Guillemin & Gillam, 2004). For example, the sharing of personal stories may cause participants distress during and after interviews. Precautionary steps were thereby implemented to help prevent and manage this potential result (e.g. allowing participants to set boundaries of how much of their stories were shared and my provision of contacts of health care professionals and networks for additional support).

Although procedural ethics are done with the intent of protecting participants, many scholars have argued this is not sufficient for the study of people "due to the irrepressible nature of all human research and to the in-depth, long term relationships that may develop between participants and researchers in some forms of human research" (Lahman, 2011, p.1399). Thus, I aimed to achieve what Lahman et al., (2011) described as *aspirational ethics*. These authors described aspirational ethics as "the highest stance the researcher tries to attain in ethics above and beyond minimum requirements" (p.1400). These ethics involve respecting the dignity and autonomy of the research participant. This involves balancing the interest and commitment a researcher has to the objective of the research and gaining rich data as well as their obligation towards the care and well-being of participants. This research process also involves sensitising oneself to the reaction of others in various research situations (e.g. when an interview question causes distress). Although there is no prescriptive way to deal with ethical dilemmas which arise, aligning to a *reflexive, relational* ethical process encourages adapting to such situations in an ethical, responsive and moral way (Lahman et al., 2011; Sparkes & Smith, 2014). For example, terminating the interview, reassessing the ethics of the question which caused distress and providing participants with a way they can access professional help for support.

One key component of *relational* ethics is negotiating the boundaries of the research relationship. I was in contact with participants in this study for over two years, visited them frequently throughout this time and also communicated with them through e-mail. I was therefore mindful of maintaining awareness of my primary position as a researcher, though some relationships with participants did morph into friendships. In addition, I wanted to hear participants' stories and though I did not actively ask about difficult times and experiences, some participants did choose to share such events with me. Although I was grateful for the openness of these individuals in sharing their stories, I was also mindful when a select few discussed such interactions as 'therapeutic'. It was in these situations where I strongly acknowledged that I was in no position to replace a counsellor, had no qualifications to do so and asserted my role strictly and only as a researcher (Bondi, 2013; Sparkes & Smith, 2014; Willig, 2013).

3.10 Summary

In this chapter I have described and justified my approach for conducting this PhD research. I have outlined qualitative research, my reasons for choosing this approach, philosophical assumptions underpinning the research and the procedures I followed to collect, analyse and present my research findings. Moreover, I presented some criteria by which readers can assess the quality of my work and the ethical standards that guided my conduct in practice. The next section of this thesis presents the beginning of participants' journey by outlining their gym experiences and their motivations for being a gym instructor.

Part One: Beginning the Story

In this first empirical section, I begin the story of this thesis by presenting participants' experiences of exercising in the gym. At this stage, they identify as gym clients who come to the gym in the capacity of a consumer to enhance their health and well-being. It is also, however, in this space where they are subject to disabling practices. Rather than act as a barrier to the gym, for many individuals they cited these disabling practices as a key reason why they desired to become a gym instructor. As such, the second chapter in this empirical section presents why participants wanted to be gym instructors.

Chapter 4

Setting the Scene: The Barriers,

Facilitators and Experiences of Disabled

People Exercising in the Gym.

4.0 Overview

The aim of this opening empirical chapter is two-fold. The first purpose of this particular chapter is to address the gap in knowledge regarding experiencing exercise in the gym as a disabled person. By qualitatively investigating participants' experiences in the gym and identifying barriers and facilitators of gym use, this chapter fills this gap in knowledge. Second, investigating participants' gym experiences lays a foundation for the story of the thesis and is the starting point for participants' journey from gym client to gym instructor. As such, this opening empirical chapter is a platform on which the subsequent empirical chapters can be built upon to develop a rich, detailed story of the research. To fulfil these purposes I applied an inductive thematic analysis on interview transcripts from all 21 participants involved in this research. From this analysis I identified four key themes which provided insight into the experiences of participants. These were (i) experiencing enhanced wellness, (ii) perceived conflict between gym values and disability (iii) influence of a previous gym identity and (iv) experiences of psycho-emotional disablism.

4.1 Experiencing Enhanced Wellness

All participants perceived the gym to be a place where they could improve their overall wellness and quality of life. Specifically, they discussed three ways this was done; physical improvement, enhanced social life and psychological respite.

4.1.1 Physical improvement.

Participants stated their initial motivation for exercising in the gym was through the belief that this behaviour would result in physical improvement. This related to improved function, reduced pain and improved fitness that enhanced independence:

"I knew from the start (*of recovery*) how important exercise was to improve…I started to build my level of fitness and my pain was better… After that I thought 'ok fair enough, this (*exercise*) is the way forward' and that was the key point where I went back to the gym…I just rebadged gym fitness because that's what kept me strong…when I do go to the gym I can do my shopping on my own really easily and feel less vulnerable...I can build up to a level of fitness and performance that my GP couldn't give me an assurance on so that gave me a physical baseline of real, real positiveness for the future." (Julie, SCI, 60)

The desire to physically improve has been highlighted in previous research (Kehn & Kroll, 2009). Importantly, for participants in this research physical improvement related to increasing independence, reducing pain, improving function and contributing to overall quality of life rather than improvement of an aesthetic nature which is perceived to be the dominant interpretation of good health in the gym (Neville & Gorman, 2016). To interpret this finding further, specifically why participants held the belief that exercise had healing benefits, I drew upon narrative theory to explore which resources participants had drawn upon and informed their beliefs about exercise.

Narrative is a way of understanding human lives within a social world through investigating which stories an individual draws upon to make sense of their experience (Frank, 2010). By analyzing which narratives an individual chooses, researchers can gain a greater understanding of the lived experience of that individual (Smith & Sparkes, 2008). Put into context, participants' belief that exercise would improve physical health could relate to a narrative of 'exercise is medicine' which has the plot of "I experienced an ailment, then I engaged in exercise, then the ailment is eased or eradicated" (Papathomas et al., 2015, p. 5). All participants seemed to be aware of this narrative. This could be attributed to individuals' experiences in hospital and rehabilitation centres. Here, the exercise is medicine narrative is

told continually by doctors, nurses and specialists to encourage patients to partake in active rehabilitation to regain as much physical function as possible (Williams et al., 2014). As such, when participants left their rehabilitation centres, this narrative may have stuck with them and acted as a motivation for them to continue exercising in society.

4.1.2 Enhanced social life.

Participants also saw the gym as a social space where they could make new friends and interact with people; "it's social because people do speak to you and say hello and you just feel part of something rather than being secluded again" (Susan, SCI, 34). Many of these social experiences in the gym then progressed to outside the gym walls:

> "We'll meet up and somebody will say "I'll see you next week then?" and I'll then think 'ok.' Then I'll think (*next gym trip*) 'oh so and so's going to be there and so and so's going to be there.' It sort of makes me think 'I don't want to let them down so I'll go.' It builds up this peer support…It's that rapport I look forward to and it's just very nice to get other people to recognise that you can actually make a really nice social life, and you feel great afterward and you can actually help post recovery. I've made a collection of friends and even after the healthy eating we all go out for a curry!" (Tara, SCI, 32)

The importance of this finding must be contextualized within the wider social experience of participants. This perception of belonging and acceptance is very different from general social experiences where participants discussed feeling ostracized through negative social interaction. For example, Arthur discussed his initial difficulty leaving his home after acquiring his impairment due to the disabling interactions he had experienced from members of the general public; "I didn't go out for months because I could not stand the stares and being continually ignored…you just feel completely worthless and abandoned" (Arthur,

transverse myelitis, 32). There is evidence to suggest society as a whole sees disability as a personal tragedy (Shakespeare, 1994), resulting in disabled individuals feeling isolated, lacking self-worth and othered (Reeve, 2014). Within the gym, however, positive social interactions with others could counter this negative experience through fostering an inclusive environment resulting in individuals feeling they belong to a community and enhancing perceptions of social acceptance and self-worth.

4.1.3   Psychological respite.

Participants also discussed how exercising in the gym gave them a sense of psychological respite from the stresses associated with having a disability. These stresses included the presence of a disability itself, medications and claiming benefits:

> It's freeing I guess, peaceful… You just forget everything that's wrong, forget the benefits stress, forget all the medication you're on, forget sometimes that you have a disability because you are doing something. I can't tell you the psychological boost it gives, it's that hour, hour and a half break from the stresses of life that gives you new energy to face the challenges ahead. (Carl, chronic head and shoulder injuries, 56)

The finding of respite through exercise has also been discussed by Caddick et al., (2015) who found retired veterans suffering from post-traumatic stress disorder fully embodied a sense of relief from their suffering through surfing. In this research, a similar conclusion can be made. Having a disability is more than a physical impairment and there are many personal, social and legal anxieties which may be experienced contributing to poor mental health (Tate et al., 2015). Exercising in the gym however, provided a sense of release from these stresses and, for some, left them feeling energized to tackle awaiting challenges.

In sum, participants felt exercising in the gym enhanced various aspects of their well-being. Drawing from conceptual frameworks of well-being, specifically the work of Ryff and Keyes, it is apparent that gym work can enhance disabled people's well-being in both a hedonistic (SWB) and eudemonic (PWB) sense. For example, the positive feelings participants discussed are characteristic of SWB as they have increased positive affect through exercise. Moreover, the physical, social and psychological benefits of exercise participants describe are also indicative of enhanced PWB through the various tenets of well-ness in this theory. Take, for example, Tara. Her experiences of exercise included developing friendships which lasted outside of gym walls. This experience achieves the positive relationship tenet of PWB. Moreover, Julie's account regarding the physical improvements she felt shows enhancement in the tenets of autonomy, managing her environment and progressing to her goals. As such, exercising in the gym can have a positive impact on disabled peoples' well-being.

4. 2 Perceived Conflict between Idealized Image of Gym and Disability

In the previous theme, I highlighted the many benefits individuals experienced through gym use, however for many participants the gym environment itself was a barrier. Not aligning to cultural values of the gym and instructors being influenced by institutional discourses was deemed to inhibit gym use and were issues participants had to fight against in order to continue exercising in the way they wished. What helped them resist these barriers were other disabled clients exercising in the gym who acted as aspirational figures and tempered the perceived barriers of an unfriendly environment.

4.2.1 Not aligning to cultural gym values.

One key difficulty participants discussed was that a particular physical image (strong, muscular and aesthetically pleasing) was valued in the gym. As participants felt they did not

align to this physical image (particularly those with visible physical impairments) they described being made to feel 'other' and excluded in this space:

> "Not all gyms are the same but…in most I've been to if you're not what I call a meathead then you just do not belong and you are not wanted there and you are made to feel not wanted…if you don't have an excessive amount of testosterone, are the perfect physical specimen or grunting your way lifting weights then you do not belong… We're not necessarily the image they want to portray. I think that's the problem. Image is an old hat but that's still what they want to sell themselves on." (Susan, SCI, 35)

The valuing of particular traits in the gym over others can be interpreted through the concept of ableism. To recap, ableism is "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 form. Disability is cast as a diminished state of being human" (Campbell, 2001, p 44). Thus, individuals are seen as less worthy if they don't conform to strict corporeal standards and values set by an institution (Loja et al., 2013), in this case the gym. In the gym, the rigidity of values such as musculature and physical aesthetic can become culturally embedded resulting in an unwavering understanding of what constitutes health. Individuals who perceive health in a different way, (e.g. improved physical function), may feel invalidated and marginalized as an understanding of their needs are left wanting.

4.2.2 Limited interpretations of health.

Linked to the previous sub theme, participants noted the values of the gym were embedded within the gym's sociocultural fabric and gave very few alternative interpretations of health. For example, slogans on gym walls such as 'no pain, no gain' promoted the

experience of pain as a positive, necessary step to achieving health. These discourses left little room for the possibility of an alternate experience. Consequently, participants perceived they were invalidated when they tried to share their own stories which were contrary to gym discourse:

"The little boys just tell you to pump till it hurts. For someone who's got fibromyalgia or anyone over 40, any age, if your body is telling you something is hurting you please stop!... When I said to him my knees hurts he said do another 20. And I looked at him and I wanted to call him the b word so I did the other 20 and it killed me. I got off the leg press, I got off it, before I knew it I was flat on my bum looking at the ceiling. My knee gave way. Know what he said to me? "When you've got up, on the running machine." (Brenda, fibromyalgia and ME, 57)

Frank (2006) stated there is often incongruity between what disabled individuals are experiencing and the institutionally legitimated stories that are told about their experience. Participants discussed a similar phenomenon when trying to share their stories of exercise which went against the dominant discourses in the gym. The pain experienced by disabled people was perceived as a warning that they were causing harm to their body; however instructors understood this pain to be a positive and necessary step to earn the body admired in gym culture (Andreasson, 2014). These conflicting understandings of exercise illustrate there is a limited availability of interpretations of health for those who do not fit the typical model presented in dominant discourses (Rossing, Ronglan & Scott, 2016).

4.2.3 Disabled clients as aspirational role models.

While the previous two subthemes discussed issues regarding a lack of alternative understandings of health in the gym, the presence of other disabled individuals in this space provided aspirational figures participants could relate to:

"I did come across a guy with a disability using the gym…and that reinforced for me that it was ok regardless because I enjoyed it. I think seeing someone else with a disability made me think 'yeah he's doing it and so I can do it'…I talked to him a lot and we developed a bond and friendship. It was because of seeing someone else who was working with an impairment in the gym and he encouraged me saying, "'if it's something you want to do, don't just discard it and think you can't do it. Pursue it.'" So that's what I did." (Jerzy, cerebral palsy, 30)

Frank (2006) stated people need to "hear their own voices and, by knowing others' stories, become empowered to tell their own" (p. 422). In other words, disabled individuals may feel more supported and accepted in the gym if there is someone they can relate to. For many, this support came in the shape of another disabled person who acted as an aspirational figure strengthening the belief that a disabled person can exercise in the gym and do so on their own terms. The presence of a disabled individual in the gym may provide additional resources and interpretations of health which others can draw upon, reduce perceptions of otherness and promote the gym as an inclusive space to exercise.

4.3 Influences of a Previous Gym User Identity

Many participants had been a gym user before acquiring their impairments. The influence of this previous identity, however, was markedly different for women and men. For women, a previous identity acted as a facilitator to reinitiate gym use as they sought to reclaim a sense of self. For men, they negatively compared their current body to their past body.

4.3.1 Reclaiming a sense of self.

A previous identity as a gym user was a key reason for initiating gym use for women. They saw reengaging in a particular activity they had done before their injury or illness as a way they could reclaim a sense of self:

> "I would get into the bathroom and I would just cry my heart out. I would sob and sob and sob and just think I can't kill myself. I wanted to…I was in hospital and I was like, if there's one thing I can get back, if there's one thing from my previous life I can get back again, I can get back to exercise…I thought this is something I can get back to and I love and I know that I love. I was at that point of grieving. I was grieving my lost identity and exercise was a huge part of that." (Kathleen, SCI, 32)

Acquiring a disability can result in a fracturing of identity leaving the individual lacking a sense of self (Dziura, 2015). Giddens (1991) stated that if an identity can be sustained through life, this enables individuals to maintain a sense of self. Put in the context of this study, if an individual is able to sustain an identity of a gym user before and after injury their sense of self can be reclaimed after a potential loss of identity. The women in this study identified with this as they felt exercising in the gym was something they could 'get back' from their previous life. Arguably, this continuity provided a sense of 'normality' despite having a 'new' identity as an individual with an impairment. Indeed, Shakespeare (1996) noted that newly disabled people often try to align to their old self in order to feel as 'ordinary' as possible. Watson (2002) concurred stating that some people with an impairment redefine their identity not by including bodily traits but through a construction of what, to them, normalcy is. In this case, it was normal to be active and go to the gym.

4.3.2 Negative comparisons with a past identity.

While a previous identity as a gym user enabled women to reclaim a sense of self, for men this past identity acted as a barrier to their engagement in the gym as they felt ashamed or embarrassed at the body they now possessed compared to the body they had before injury:

"I just felt intimidated going into the gym because I was big and now over the years I've put on weight and I feel ashamed or embarrassed because of who I am now. I used to run for miles with a backpack on! So that put me off...you look at it totally the wrong angle. You think they're looking at you or judging you but they're not. You know you have an issue or know you have a problem or you've suffered from putting weight on because of your problem." (Frank, chronic leg injury, 38)

While previous research investigating the intersection of gender and disability has concluded disabled women experienced a 'double handicap' (Deegan & Brookes, 1985) as men were given the opportunity to embody masculine practices (such as lifting weights) (Blinde & McCallister, 1999), in this study the opposite was the case; the intersection of *masculinity* and disability was the 'double handicap.' Men were continually comparing their past body to their current impaired body. This comparison lead to feelings of embarrassment, disappointment and shame as their body no longer looked or functioned in a way they felt it should, an essence of what Frank (1996) described as a '*dys-appeared*' body. This dys-appeared body may have impacted the men in this study rather than the women as, before injury, men had fully embodied the masculine, muscular values of the gym. As these values became embodied, returning to the gym after injury was problematic as they were no longer able to fully identify and achieve what they believed a man in the gym should be.

4.4 Experiences of Psycho-emotional Disablism

Participants discussed one of the key barriers to gym use was their experiences of psycho-emotional disablement from both the physical structure of the gym and interactions with others in the gym.

4.4.1 Disabling messages from the physical environment.

Participants discussed the difficulties they had in managing the structural barriers of the gym. These included a lack of access into and within the building, and unsuitable, inaccessible equipment; "if you can't provide physical access it's pretty pointless going further than that… there's a lot of machines I can't use because I can't get my chair in or I just can't physically do it" (Aadi, polio, 33). Although previous literature has highlighted access as a key barrier to exercise (e.g. Rimmer et al., 2004) these studies have not delved deeper into how these experiences can compound psycho-emotional well-being, a defining experience of participants:

> "At the end of the day, if they're (*gyms*) meeting legal requirements they're doing more than enough and they're not gonna get sued and some care so little that they're willing to take the chance and still not make it accessible. You will get that in a lot of places, a hell of a lot. Even though you have the law that states they have to they still don't… The access only relates to the frontage; getting in and out. How is that inclusive if you don't provide a toilet for someone? How can you feel anything but you're not wanted? Your money isn't as valuable as the next persons." (Kathleen, SCI, 35)

By drawing on disability theory, the experiences described above can be interpreted using the social relational model proposed by Thomas (1999) and the concept of disablism.

To recap, disablism is "a form of social oppression involving the social imposition of restrictions of activity on people with impairments and the socially engendered undermining of their psycho-emotional well-being" (p.73). Disablism arises in two forms; indirect psycho-emotional disablism relating to the impact of exclusory messages through encounters with structural barriers and direct psycho-emotional disablism pertaining to negative interactions a disabled individual has with other people or themselves (Reeve, 2012).

The experience of structural disablism described above is an example of indirect psycho-emotional disablism. This experience can evoke emotional responses such as anger, perception of a lack of self-worth and hurt at being excluded (Reeve, 2006). These physical barriers act as 'landscapes of exclusion' sending disabled individuals the message "you are out of place, you are different" (Kitchin, 1998, p. 351) which can have a detrimental effect on psycho-emotional well-being as disabled individuals feel more othered, isolated, and lacking in self-worth (Reeve, 2012). Morris (2014) concurred, stating the experience of being excluded from physical environments reminds disabled individuals that they are different and can leave them with a feeling of not belonging in the places where non-disabled people spend their lives.

4.4.2 Disabling interactions within the gym environment.

Participants also discussed experiences of direct psycho-emotional disablism in their interactions with instructors in the gym which made them feel unwelcome:

"I went in as a guide to find out what the prices were and have a look round to see who was there. I can actually remember...the look on the face of the receptionist like 'Christ!' and one of the membership guys came round...I didn't go to the gym that day, I went back the next say at the crack of dawn 6 o'clock...you can kind of, in the gym

you can feel the eyes on the back of your head; 'what's fatty doing in the gym?'"

(Terry, visual impairment, 35)

Direct psycho-emotional disablism occurs at the point a stranger reacts to the disabled person and in the words and deeds that exclude or invalidate (Reeve, 2012). The experience of being stared at by others is an action which invalidates an individual based on public perceptions of normality, beauty and perfection (Hughes, 1999). Hargreaves (2000) developed this further stating people with physical impairments "are looked upon, identified, judged and represented primarily through their bodies, which are perceived in popular consciousness to be imperfect, incomplete and inadequate" (p.185). Effectively, disabled bodies in the gym go completely against the aesthetic values the gym aligns to. A failure to match the culturally 'normal' body can result in perceptions of being stigmatized and judged (Garland Thomson, 2009). This finding illustrates how and why a disabled individual may perceive the gym as unsuitable for them to exercise, despite the specialized equipment and supposed knowledgeable instructors present.

4.5 Summary

The purpose of this chapter was to contextualise disability in the gym and provide important insights into the experiences of individuals in this space. This chapter provides new knowledge regarding disability in the gym by investigating experiences of and meanings behind exercise for this population in this space. Key findings of this chapter highlight that participants were subject to various instances of indirect and direct psycho-emotional disablism which they identified were key reasons why disabled people may find the gym a difficult place to exercise. Disablism in the gym related both to the physical environment sending messages of exclusion and negative interactions with gym instructors which invalidated their lived experiences. Despite this, participants continued to go to the gym to

improve various aspects of their physical, psychological and social well-being which they believed was possible through exercise. Although participants were motivated to go to the gym for improved health, they also noted that this too was difficult as the gym valued a particular corporeal self which participants felt individuals with impairments did not align to. They were able to resist the disablism they experienced, however, by looking to other disabled individuals as aspirational figures who showed that a disabled person can exercise in the gym despite the difficulties they may experience.

The results of this chapter conclude that disabled people experience multiple barriers which can have a negative effect on their sense of self. Despite these difficulties, participants continued to exercise and, furthermore, had elected to join a programme to train to be a gym instructor. Arguably, this is not an expected reaction; to want to work in a space which casts disabled people as other. As such, in the next chapter, I seek to investigate why participants desired to be a gym instructor in spite of the disablism they had been subject to.

Chapter Five

Why this Path? Exploring Disabled People's Motivations for Becoming a Gym Instructor

5.0 Overview

In the previous chapter, participants' gym experiences were constructed as various forms of ableism and disablism. Although disablism is associated with negative affect and can lead to withdrawal and dissociation (Reeve, 2014), in the case of this research participants were instead motivated to become gym instructors. In other words, rather than remove themselves from the oppressive gym environment, they pursued a role that would immerse them further into it. In this chapter, I unpack participants' motivations for this seemingly counterintuitive response. Specifically, I pose the following questions; why did disabled people want to be gym instructors? What experiences informed their decision to follow this path? What did participants hope they could achieve by becoming a gym instructor?

To answer these questions, I conducted a thematic narrative analysis on the data from all 21 participants. Thematic narrative analysis examines the 'what's' of talk and is useful for theorising across a number of cases by constructing common thematic elements across participants' testimonies (Riessman, 2005). Moreover, narrative is an organising principle for all human action and, as such, sheds light on the narrative structures which guide how we understand the world and make moral decisions (Sarbin, 1986). As such, a thematic narrative analysis allowed me to not only build an understanding of *what* the reasons were for participants becoming a gym instructor (which could be accomplished through an inductive thematic analysis) but to explore *how* they were guided to this decision by the various societal narratives they were exposed to. After finalizing analyses, I crafted four key themes which reflected participants' motivations to be gym instructors. These were (i) *a need to challenge disablism*; (ii) *a desire to make a social impact*; (iii) *guiding influence of InstructAbility* and (iv) *hopes from becoming a gym instructor*.

5.1 A Need to Challenge Disablism

In the previous chapter, I highlighted the psycho-emotional disablism participants were subject to in the gym and how these negative experiences could act as barriers to exercise participation. Rather than deter participants from continuing to exercise in this space, the negative emotions they associated with the gym (anger, hurt, frustration) instilled in them a desire to continue attending. This desire was not only to improve their own health and well-being, but a need to ensure others were not subject to the same discriminatory practices they had experienced:

> Brenda: "What I'd gone through made me so angry that every time I came back from the gym having seen and experienced those boys making jokes, sniggering, telling me to do things that would hurt me I just felt so emotionally drained from keeping my mouth shut. Then something just snapped and I decided I was the only one suffering from being silent so I decided the next time they were horrible I would say something. I went in with a new purpose and was almost looking for something to fight about (*laughs*)."

> ER: "What happened the first time you did something?"

> Brenda: "Well, there's a lovely lady in a wheelchair who has cerebral palsy and she likes walking on the treadmill. I used to help her from her chair on the treadmill but they're right at the front window. I don't think they liked her being there right at the front in the big glass window because one day they put her on another machine away from the window saying she didn't need to use it. Anyway, he put her on this machine as he said that it would be better for her. I said "if you don't want to do the running machine that's entirely up to you but if you do want to do it and you've been doing it for 3 years and it's helped you why would you want to lose that skill and the muscles

that you must have doing that?" When I spoke to him (*gym instructor*) about it he didn't even look me in the face about it and walked away."

ER: "Wow. How did you feel doing that? Standing up to him I mean."

Brenda: "I didn't get the response I wanted but I felt brilliant having said something. Like a weight had been lifted and I didn't have that angry ball in your chest feeling when I left. That just cemented for me that it wasn't a case of wanting to fight back it was a case of needing to fight back. So, yeah, from then on I was fighting for the little guy!" (Brenda, ME and fibromyalgia, 56)

It has been argued that we are feeling bodies and act on how we feel (Burkitt, 2014; Cromby, 2015). In other words, the various sensations and desires felt in our bodies can compel us to certain identities. Contextually, participants were compelled to embody an activist identity as a result of the feelings they had within themselves. For example, Susan described an instance where the anger she felt seeing a disabled person being trained poorly 'boiled over' to a point where she decided to take a stand:

Susan: "I was working out with Tom (*Susan's partner*) and he said "oh my God, look at that." I turned round and the personal trainers were with this chap in the wheelchair and Tom was saying "they're asking him to do things that are just nigh-on impossible and it's just pointless. It is pointless. And it's bloody dangerous!" I heard what they were saying to this poor guy and it made me feel sick to my stomach. I'd experienced these sorts of things myself but seeing it happen to something else I just couldn't stand it anymore, I boiled over and I stormed over there and basically shouted at them."

ER: (*laughs*) "Oh my gosh! What did you say?"

Susan: "I don't really remember. Something about they don't know how to do their jobs and being useless (*laughs*). I just remember feeling the sickness in my stomach go and the look on the guys face of being somewhere between astonishment and relief and the PT's faces being in shock and Tom's face in absolute, total shock (*laughs*). But I guess that for me was the turning point that I knew I needed to do something and take a stand against these PTs. I couldn't see anyone speaking for us apart from us so why not me? (*laughs*)." (Susan, SCI, 34)

A key reason for participants desire to become gym instructors was an embodied, socialized and relational force; *affect*. The 'affective turn' in psychology investigates how an individual's emotions and feelings contribute to an understanding of how they experience a phenomena and why they act in certain ways (Clough & Halley, 2007). Feelings and affect are dynamic, purposeful and constitutive of becoming and change; they guide us to certain paths and compel us to certain identities (Cromby, 2012; Cromby 2015). Accordingly, the testimonies of Brenda and Susan highlight the role affect played in participants' desire to actively resist disablism in the gym. Both women discussed their acts of resistance as being triggered from 'within'; from an affective place where what they were seeing made them "feel sick" or "a red hot ball of rage". For each participant, these feelings reached a point where they were compelled to act. These feelings (nausea and anger) could be described as *affective somatic markers* which guide behaviour and inform action (Damasio, Everitt & Bishop 1996). In other words, rather than cognitive processes which some literature highlights as a trigger for decision making (e.g. Schwenk, 1988), for participants in this research they were called to act against the disablism in the gym because of how they *felt*.

The decision to act on these affective influences became a *turning point* in participants' life narratives. Turning points are experiences in which someone undergoes a substantial change (McAdams, 1993). They are usually triggered by negative events in which one

understands something new about oneself or faces a decision about a different path to take in life (McLean & Pratt, 2006). Indeed, Thorne, McLean and Lawrence (2004) found that more negative events are associated with more meaning and are therefore more likely to be a reason why an individual chooses to act in a certain way. In this research, participants' meanings of disablism and the feelings they associated with this oppressive act compelled them to act in a way which actively resisted disablism. Soon, however, these isolated incidences of activism and helping others did not satisfy participants. Instead they were eager to challenge disablism on a wider scale.

5.2 A Desire to Make a Social Impact

Participants discussed a desire to go beyond isolated instances of resistant acts described above and further towards being in a position to have an environmental impact. Specifically, they wished to be in a position where they could actively contribute to the gym becoming a more diverse and inclusive space for disabled people to exercise:

"The gym needs diversity, you know, raising awareness. Just because someone is in a wheelchair doesn't mean that they are a write off. It also doesn't mean that they are an inspiration. It doesn't. They're normal people that want to earn a living, that want a bit of respect, that deserve a bit of respect, that can look good, can feel good, should be given the opportunity to feel good and just take part in life and society. I think the time has come for us to take a stand and to act. I know a lot of people in my situation hide away for the rest of their lives but with our personal experiences we can reach them and show them we can be part of the gym and belong there. The more the able bodied population is exposed to people like me, it can only be a good thing. Yeah, I have a dream (*laughs*)! But I do want change and my little role to play in it is going to be small but it's valid and important. I want opportunities after I'm dead and buried

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for people not to have to feel the way I've felt at times and the way I still feel sometimes. Something needs to happen that changes things and why can't it be us?" (Kathleen, SCI, 32)

In this research, participants' active choice to become a gym instructor in order to promote inclusion and challenge disablism is evidence of their desire to do *social missions*. Social missions are collective, social, political problem-solving ventures which can be passive, institutional acts or, alternatively, high-risk, active, unconventional behaviours that convey what is needed for a better society (Corning & Myers, 2002). Contextually, participants' decision to actively challenge the discrimination of the gym and their ultimate decision to become gym instructors is representative of high-risk, active, unconventional behaviour. Past research has highlighted the work of disabled athletes in doing social missions in the sporting domain (e.g. Bundon & Hurd Clarke, 2015, Smith et al., 2016), however there is a lack of empirical work with regards to promoting diversity and tackling oppression within the field of exercise and health (Corning & Myers, 2002). This finding therefore fills a gap in knowledge by proposing reasons why disabled individuals wanted to do social missions in the gym. In the context of this research, participants were motivated to do social missions through an understanding of what being oppressed in the gym felt like and a desire to ensure other people did not feel the same way. Indeed, Aadi (polio, 33) noted that although he would help anyone in the gym his main desire was to help other disabled people:

"Of course if anyone wants my help I'll help them but my reason for being an instructor is to help people like me. The able bodied have everything they need so for me it's natural to prioritise other disabled people over them." (Aadi, polio, 33).

Thus, although participants desire to do social missions was motivated by *prosocial behaviour,* where actions are intended to benefit one or more people other than themselves

(MacIntyre, 1967), they were focused on helping others like them. There are many theories which could be used to interpret this. First, Hornstein's (1982) work on the self-other relationship posits that we are drawn to help others like ourselves – akin to Aadi's statement regarding wishing to help other disabled people first. Hornstein (1982) suggested that when certain others are in need, specifically those with whom we are linked as 'us' and 'we' rather than 'they', we experience a state of promotive tension in which "one is aroused by another's needs almost as if they were one's own" (p.230). Once so aroused, we are motivated to reduce this tension by helping our fellow group member. In the case of this research, participants identified with other disabled people and wanted to do social justice by challenging disablism in the gym to help 'their group'.

5.3 Guiding Influence of InstructAbility

Participants expressed a deep seated desire to do social missions in the gym but did not specifically state they wished to do so in the role of a gym instructor. This changed when InstructAbility gave participants a narrative resource which they felt drawn to and which made sense to them. Through the medium of an advertisement (Figure c), the narrative of InstructAbility stated *'We are seeking individuals, like you, who have experienced and overcome barriers to exercise and who want to help other disabled people in the gym. If you join InstructAbility, we will train you to become a gym instructor. You will then be in a position to help and support others in the gym.* This narrative resource worked on participants in various ways which instilled in them a desire to become a gym instructor.

First, the advertisement's narrative told a story of disabled people transitioning from gym clients to gym instructors and being in a position to help others. This narrative spoke to participants in a way which made them feel that the story was directed towards them:

"It was like an eureka moment it really was. I had come from doing a work out and the advert was in the locker room. I honestly felt it was destiny; this is for me. For months I'd been searching for ways to further my exercise and my work and as soon as I read 'disabled instructor', yes, of course! That's it! To be honest I felt a complete idiot for not thinking about it before because it seemed so obvious to me that this was it, my calling in a way I suppose. But then how many disabled gym instructors do you know? Not exactly common is it?" (James, chronic pulmonary hypertension, 56)

This feeling of a story being meant for them is akin to what Frank (2010) termed *narrative habitus*. As Frank (2010) discussed:

"some stories are heard, immediately and intuitively as belonging under one's skin. Narrative habitus is a disposition to hear some stories as those that one ought to listen to, ought to repeat on appropriate occasions, and ought to be guided by" (p.53; emphasis in original).

As such, narrative habitus is a person's embodied disposition toward hearing certain stories as 'for them'. In the case of this research, participants were made aware of the story to become a gym instructor and were caught up and hailed by this story thereby allowing them to start seeing the person who they wanted to be. Moreover, although participants wished to embody an activist identity and do social missions, they had not necessarily envisaged doing so as a gym instructor. Thus, narrative (specifically the idea of a disabled person becoming a gym instructor) also worked on participants as a *subjectifier* arousing the participants' imaginations to see themselves in this role. That is, not only did this story help organise and make sense of participants' embodied feelings (e.g. the anger they felt at their disabling experiences) but it also did the work of identity subjectification; "telling people who they ought to be, who they might like to be and who they can be" (Frank, 2006, p. 430). In other

words, it introduced participants to an identity which would allow them to do the social

missions they desired.

Figure c. InstructAbility advertisement

Another way the InstructAbility narrative influenced participants' decision to become a gym instructor was that it did more than *show* individuals a possible future self, it also provided a connective sequence where participants could see *how* to become this person:

"The way I saw it was that this was a way that I could feel fulfilled and do what I want to do. It was like InstructAbility had laid a road of where I wanted to get to…Literally seeing someone in a wheelchair training in the advert showed me it was possible and that if I did InstructAbility I would be one of them and it gave me a direction of what I need to do to become that person. So, I guess you could say I was more focused because I knew then what I needed to do rather than just drifting and having a go at stuff that might work." (Polly, brittle bone disease, 26)

As well as presenting a possible future self, the narrative resource provided by InstructAbility provided a *narrative path* to become this person. Narrative paths are guides that show people a way to do things they want to do and be people they wish to be (Partington, et al., 2005). These paths are laid through people sharing information, advice and providing orientation about how to navigate social worlds and negotiate new identities in unfamiliar situations (Pollner & Stein, 1996). By providing a preview of what could be, narrative paths "may increase or reduce anxiety, motivation and morale depending, of course, on what is portrayed as awaiting the traveller" (Pollner & Stein, 1996, p. 219). Contextually, by presenting a possible self as a gym instructor and a means to achieve this self, the narrative path provided by InstructAbility may have contributed to participants' specific motivation to become this person. As Phoenix & Sparkes (2006) stated, narrative paths shape the actions of people by directing them towards specific activities in the present which will result in specific outcomes in the future. Thus, the provision of this new narrative may have contributed to participants' motivation to become a gym instructor as with more resources at their disposal,

different ways of being and acting were opened to them (Frank, 2010; Parsons & Lavery, 2012).

5.4 Hopes from Becoming a Gym Instructor

Once exposed to the idea of being a gym instructor, participants discussed numerous aspirations they had (both personal and professional), which they hoped they would accomplish as a result of adopting this role. These were a *renewed sense of purpose, challenging oppressive perceptions of disability* and *enhancing their own well-being*.

5.4.1 Renewed sense of purpose.

Participants believed that becoming a gym instructor would give them a sense of purpose which they felt had been lacking:

"When I lost my job I kind of lost myself a little bit, I felt I was in limbo. But when I saw the InstructAbility advert I saw a way I could really make a difference and help people as well as make myself feel like I have a cause or, I dunno a reason to be I guess. There were loads of doors I saw I could go in with this and yeah, I guess be a person I was proud of because I was doing something that mattered and had a purpose. I never have been motivated by money; my job satisfaction is in what I can do to make a difference, standing up for the right things if needs be and leaving a positive mark on people." (Kathleen, SCI, 35).

As Frank (2013) stated, acquiring an impairment does different things to different people, including encouraging them to seek a new, meaningful life purpose. For many participants who had acquired their impairments, the narrative path which being a gym instructor created also allowed for an opportunity to perceive their physical impairments as something they could utilize in a positive way. Take, for example, Terry's testimony:

"I mean losing my vision cost me my job and my health and for a long time myself so maybe wanting to use my impairment in a positive way is a way of getting back to myself and feeling needed again. A bit like, 'screw you vision! You ain't stopping me, in fact you're gonna help me!'(*laughs*). Yeah, if I think about it, being a disabled instructor I thought would give me a chance to use my impairment in a positive way to help others who had gone through the same depression I had as well as get me in a position where I can change the gyms approach to disabled people." (Terry, acquired visual impairment, 35)

Taking into consideration both Terry and Kathleen's testimonies, participants' wish to use their impairment in a positive way is indicative of a *quest narrative*. The quest narrative views disability as a challenge with the opportunity to learn or gain something from the disability experience which culminates in something good to come out of a potentially negative experience (Frank, 2013). For participants, they foresaw being able to use their impairments and experiences of disablement to connect to other individuals and challenge the negative way impairment was understood in gyms. Moreover, participants' desire to develop an activist self with regards to being at the forefront resisting and tackling oppression is indicative of the *'manifesto'* facet of the quest narrative which is underpinned by a desire for social justice. As Frank (2013) explained, being in manifesto:

"carries demands for social action…society is suppressing a truth about suffering, and that truth must be told. These writers do not want to go back to a former state of health, which is often viewed as a naive illusion. They want to use suffering to move others forward with them" (p. 121).

The manifesto facet asserts that disability is a social issue, not simply a personal affliction. It witnesses how society has added to the physical problems that impairment entails and it calls for change, based on solidarity with those who have been affected.

5.4.2 Challenging oppressive perceptions of disability.

For many participants, their desire to be a gym instructor was also fuelled by a desire to challenge societal narratives which portrayed them as tragic figures or individuals who did not actively contribute to society:

Aadi: "It's the perfect way to show the able bodied that disabled people can be and are valued members of society. It's a bit like we're encroaching in on their territory."

ER: "In what way?"

Aadi: "In that we are obviously impaired but can do the same job or a better job than the people who look like they are all body builders. So if we can do a job which is all about being able then people might start thinking, 'hey maybe disabled people aren't weak or stupid or to pitiful.' It's going to be fun to really shock people into realising we are strong, independent people too." (Aadi, polio, 33).

As has been discussed in this thesis, gym instructors hold a degree of influence and respect in society for their strong bodies and are deemed the epitome of health and wellness. Disability on the other hand is juxtaposed to this. Participants, however, believed that by being a disabled gym instructor they could challenge wider, negative societal stereotypes of disability. As Frank (2006) stated, when people hear stories which claim to represent them, they rarely passively accept them. Selves can be damaged by stories told about them, particularly if the stories told refer to the group they belong to (Nelson & Lindemann, 2001). In this research, Aadi highlights how the tragic narrative of disability is not something he

passively accepts and is in fact something he wishes to challenge through becoming a gym instructor and exhibiting that disabled people can be strong and independent. As such, a reason why he wished to become a gym instructor was to reframe who disabled people are and what they can do; in other words do what Nelson and Lindemann (2001) termed *narrative repair*. Narrative repair is a way for individuals to actively challenge and resist disabling narratives which are used to represent them. One way to do this is to draw upon or craft a *counter story*. Counter stories empower people to resist oppressive master narratives by identifying fragments of the story which may misrepresent them (Nelson & Lindemann, 2001). This allows for a revised understanding of a person or social group, thereby providing some resistance to an oppressive narrative (Phoenix & Smith, 2011). Participants in this research identified they were misrepresented as tragic figures who could not actively contribute to a working society. To challenge this, participants were motivated to become an individual who openly contrasted to this image and, as such, could repair the damage done by tragic narratives of disability.

5.4.3 Enhancing their own well-being

Participants also discussed their hopes of personally benefiting from gym instructor training. Take, as an example, Mudiwa who had experienced what could be described as a plateau with regards to how exercise contributed to her physical and psychological improvement. She was hopeful of learning new knowledge about exercise which would facilitate further improvement:

Mudiwa: "I exercised for many years and for the last months I don't think I improved very much. With the knowledge here I think I can get to know the exercise to help me be even better both in my body and my mind."

ER: "What do you think you will gain?"

M: "I think I'm going to gain more confidence in myself and in helping others. I'll be empowered by knowledge…I think I'll also become more fitter which will help with my life and recovery and just getting around and things…it would be nice to gain employment and to teach people about disability, why it is there and those things." (Mudiwa, SCI, 55)

In other words, as well as the various altruistic motivations participants had with regards to helping people, they were also motivated to become gym instructors and be social missionaries from an *egoist* motivational stand point. This does not mean participants had selfish desires, rather that they were also hopeful of feeling an enhanced sense of well-being from becoming a gym instructor. For example, bringing the testimony of all participants together, finding a sense of purpose and the belief they will be doing good by helping others satisfied needs of SWB by increasing life satisfaction, increasing affect and decreasing negative affect (Keyes et al., 2002). Moreover, various tenets of PWB could also be enhanced such as a sense of purpose in life, feeling that one is achieving one's potential and a sense of self-acceptance through constructing a desired identity (Ryff et al., 1995). Also, considering the influence the affective turn had on participants' motivations to become an activist, the 'feelings based' approach to well-being (see Andrews et al., 2014) may also be realised as participants may feel a sense of happiness and fulfilment in their ability to make a difference and directly tackle the reason why they had initially felt such powerful emotions.

5.5 Summary

In this chapter I have presented reasons why participants wanted to become gym instructors. Many motivational influences were at play. First, participants were driven to resist disablism through affective markers they experienced when exposed to such oppression. This compelled them to resist on their own but also instilled in them a need to challenge the

cultural presence of disablism in the gym by doing social missions to promote diversity and inclusion of disabled people in this space. As well as *affect* being a motivational factor for this decision, another embodied, socialized, relational force which interpellated people to take on the identity of gym instructor and do social missions was *narrative*. Narratives shape human conduct, that is, narratives do things on and for people affecting what we think, how we behave, and what we imagine is possible (Brockmeier, 2009; Frank, 2010). Stories therefore open up possible worlds and can be powerful motivators of change and spark action (Andrews, 2014). The narrative provided by InstructAbility (that disabled people can be gym instructors and work to make the gym a more inclusive space for disabled people), caused people to be 'caught up' in a story which triggered aspirational goals and imagination of what could be, should they choose to undertake this journey. As Frank (2010) stated, stories "have the capacity to arouse people's imaginations; they make the unseen not only visible but compelling" (p.41), thus the narrative that InstructAbility provided arguably motivated participants to become a gym instructor and do social missions in the gym. The narrative path to being a gym instructor also gave participants direction by showing them what they needed to do in the present and what would be in the future. Moreover, the imaginative process also caused participants to see various personal and professional desires as a result of a future self as a gym instructor which further motivated them to follow this path. In the following chapters, I shall present whether these personal and professional desires were realised.

Part Two: Journey from Gym User to Gym Instructor

This second empirical section focuses on participants' transition from gym clients to gym instructors. It focuses on the whats, hows and whys of participants' experiences in training through dialogical narrative analysis. Specifically, in chapter 6, I explore participants' initial training experiences, how they experienced exercising as part of a peer group and the narrative they used to make sense of these experiences. Thereafter, in chapter seven, I investigate participants' continued training experiences, how their experiences and narratives evolved over time and why some participants continued and others dropped out of the programme.

Chapter Six

Collective Stories and Exercise: Investigating the Impact of Exercising with Disabled Peers in the Gym

6.0 Overview

The specific aim of this chapter is to investigate how participants experienced exercising[12] in the gym as part of a group. For this chapter, I applied a DNA to the data set of the 18 participants who were selected by InstructAbility and experienced the beginning of level 2 training. From this analysis, I identified a 'collective story' which acted on participants, helping them to make sense of their relationship with their peers and their position in the gym. Specifically, there were four dialogical components which worked on participants and shaped their gym experiences: (i) *validating gym oppression,* (ii) *unspoken understanding,* (iii) *constructing an affirmative identity* and (iv) *telling their own story.* The results of the analysis are presented in the following way. The collective story which was crafted by participants in the group and shaped experiences in the gym will first be outlined. Thereafter, the various dialogical components of the collective story which functioned to help define relationships and reshape exercise experiences will be presented.

6.1 The Collective Story: Resisting Oppression in the Gym

All participants were motivated and driven to exercise for a variety of physical, social and psychological benefits. Attempting to live this active lifestyle, however, was a struggle as they encountered oppressive practices such as being ignored, dismissed and stared at in the gym. These oppressive practices resulted in feelings of isolation, otherness and personal failure. Yet, in coming together in their training and exercising in the gym, participants managed to tell a story which emotionally bound them through being encouraged and

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[12] A key part of the level 2 training which this chapter focuses on was the practical application of what participants had learned in theory classes (e.g. different exercises, engaging certain muscle groups, designing programmes). To further reinforce this knowledge, participants exercised so they would know what an exercise was meant to feel like and would also train and instruct other participants. Thus, participants were able to experience exercising as a peer group in their training as well as gain the various qualifications they needed to be gym instructors.

encouraging others to share their grievances within an understanding group. The environment of sharing these stories and its effect is described by Brenda:

"Sharing our stories, good or bad, and people understanding our stories and how we felt is just, I can't tell you how great this is…telling and hearing people talk about how they're also treated really badly and that it isn't fair and you feel so bad about yourself. It's just nice to hear I'm not alone in this and it isn't just me and that it isn't my problem! It's the fucking gym! Sorry, I don't normally swear, it just makes me so angry! You can just tell they get it, they understand you because they've been through it themselves. I get it when people say they feel they don't fit in and when I tell my stories about the gym I know people understand me too. In the gym it's a constant battle to do anything if you're not deemed normal and we're all experiencing that fight and that just brings us together as a group and that it's not our fault. You know it isn't you and it's the gyms being rubbish but you start doubting yourself, so hearing the same things from others cements for me that my struggle to exercise is not my fault! I'm trying, fighting to be fit, we all are in spite of the gym but it won't stop us now." (Brenda, fibromyalgia and ME, 54)

Brenda's testimony summates a 'collective story' (Richardson, 1990) told by participants which bound them emotionally and gathered their individual stories to a shared narrative (Caddick et al., 2015). A 'collective story' is a shared story which a group of people tell about experiences they have in common, linking them from separate, isolated lives into a shared consciousness. In a collective story, people can share certain experiences allowing them to overcome some of the isolation and alienation of contemporary life. Thus, collective stories enable individuals to align their identity to that of a group and build close relationships with people with whom they feel a connection (Richardson, 1990). In this research, a collective story constructed relationally or dialogically between the group could therefore

offer a practical way of conceptualizing peer relationships which may act *on* individuals and

their experiences of exercising in the gym and training to be a gym instructor. The collective

story constructed by participants in this study can be summarized as follows:

> *We all want to be active but have experienced oppressive practices in the gym which*
>
> *have made this difficult. We understand the feeling of being invalidated in the gym*
>
> *but we have fought to ensure we stay active and recognise it is not our failings but the*
>
> *failings of the gym environment. We will not let this stop us and we will continue to*
>
> *exercise.*

Through interacting within the group and enacting the collective story together,

various functions of the story acted *on* participants. First, participants *connected* to others

who shared the same status and experiences in the gym. Participants were then enabled to

create and sustain an *identity* of an individual resisting oppressive practices in the gym and to

embody their desired self as an active individual. The collective story then functioned as a

counter narrative to the oppressive, disabling messages portrayed in the gym depicting

disabled people as other and provided participants with another *resource* to understand and

make sense of their experiences. In this way, the collective story also *functioned* to reshape

how an individual interpreted experiences of exercise; not as their failings but the gym's

failings and encouraged them to tell their own story and experiences of disability. These

functions of the collective story will be further discussed through the various dialogical

components of the collective story.

6.2 Dialogical Components of the Collective Story

Numerous dialogical components of the collective story functioned to shape how

participants made sense of their exercise experiences within a peer group. Ultimately, all

participants experienced disablism in the gym but the collective story helped them cope with

these oppressive practices. This was done through i) validation of their experiences of gym oppression, ii) an unspoken understanding with their peers, iii) crafting a more affirmative identity in the gym and iv) a sense of empowerment to tell their own story.

6.2.1 Validation of gym oppression.

The first function of the collective story was a sense of validation that the negative experiences participants had encountered in the gym were wrong and unjust rather than something they had to accept. Participants discussed how being permitted to voice their grievances by those listening fostered a sense of belonging and mutual understanding within the group. This sense of validation is evident through Polly's testimony describing the support, recognition and encouragement she received when she shared her past experiences of exercising in the gym:

> "I spoke about all the times I had felt crap because I couldn't use a piece of equipment or get into a room because of my chair. I sort of tailed off because I didn't think anyone would want to hear (*my story*) then Tara chirped up and said 'preach it, sister!' She'd been through the same things and I could see her nodding her head with what I was saying, saying 'yup' and then Marcus and Chris carried on and all spoke of the same things…I guess it just made me feel that it wasn't right and it wasn't just me and for the first time I felt really encouraged to speak about these issues rather than seen as a moaner or just kind of not being able to manage so it was my problem. I dunno, I just felt really empowered when they got it! When I complained to the gym they just cut me off and dismissed me saying there was nothing they could do so I just had to go with it. Not being dismissed and other people getting it was really, really nice."
> (Polly, brittle bone disease, 26)

The gym is a space which is deemed to value ableist ideas about a particular type of physical self; the toned, strong, physically aesthetic individual (Sassatelli, 2010). This caused issue for participants as they had different corporeal realities. All participants in this research had problems negotiating the physical space of the gym due to poor access or unsuitable equipment. Although participants did raise their concerns about the unsuitability of the physical space to cope with difference, they were dismissed by gym employees and told to 'go with it' and adapt to their surroundings. It could be argued the influence of ableism in the gym (in particular ableism casting disability as a diminished state of being human (Campbell, 2001)) has instilled in gym employees a medical model understanding of disability. They therefore saw disability as a result of impairment and any lack of ability to perform an activity within the range considered of a normal person is because of this impairment (Goodley, 2016). Consequently, a disabled person's ability to negotiate the gym's physical space is deemed to be their responsibility; as such they are expected to find a solution to *their* problem (Smith & Bundon, 2016). This perspective of disability leaves social oppression unchallenged (Goodley, 2016) and disabled individuals subject to exclusory and oppressive practices situating them as the problem (Wolbring, 2008). These practices can have a profoundly negative effect on a disabled person's psychological health and sense of self (Reeve, 2012; Smith, 2013). The collective story however functioned to validate that the oppressive practices that participants had experienced were not unique to their individual story but were also experienced by others. Upon hearing others had experienced the same disabling practices in different gyms, this acted on participants by highlighting that 'it wasn't just them' and that the oppressive practices they had experienced were unjust, not their own personal failings and not something they had to accept[13]. Consequently, participants discussed a feeling of 'empowerment' when others understood their experiences. This is akin

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[13] In chapter five participants discussed how *seeing* others being oppressed triggered an emotional response to resist disablism. In their training experiences participants could *verbally* acknowledge and communicate these feelings to understanding others, validating for them that disablism was widespread and affected many people.

to people acting as *supportive witnesses* to each other's stories. These supportive witnesses not only encouraged storytelling and sharing of experiences, they also fostered an environment of acceptance and support (Frank, 2013). The act of witnessing each other's stories then worked to strengthen the bonds between participants as they shared and recognised their own story in others' stories of invalidation. Accordingly, this supportive process and validation of experiences enabled participants to enact a social self which felt more authentic to their lived reality; that they were being stopped from exercising in the gym rather than stopping themselves.

6.2.2 Unspoken understanding.

As participants could act as supportive witnesses understanding and recognising others' stories of invalidation, a powerful connection was formed between participants which was enacted when exercising in the gym and training. An example of this is through Polly's story of exercising in the gym with her colleagues and, in particular, her connection with fellow wheelchair user, Chris:

> Polly: "When we started working out altogether it was really good and just hilarious. Rather than seeing one wheelie, there were three of us and others with crutches, one limping, you could tell people were just shocked! It was hilarious though... I'd look across the gym and see Chris transferring to the weights bench and the guys about him looking impatient. We made eye contact and it was like telepathic, I knew exactly what he was thinking and feeling with those guys hovering over him."

> ER: "How do you think he felt?"

> Polly: "That he had to hurry up as he was wasting their time and being slow because he had to transfer, that he was in the way. That is how you feel, but it's that sort of

feeling that you don't understand till you've been through it. I rolled my eyes and he laughed a bit which I think helped him feel more at ease that I understood and he should just ignore the big bruisers and he wasn't the only wheelie there so we had his back." (Polly, brittle bone disease, 26)

While sharing their stories of oppression, participants felt they were in a position both to understand others' experiences of disablism and have their own story understood. In essence, the collective story functioned to *connect* people together through a shared understanding of oppression in the gym. After sharing their stories of disabling practices in the gym, and realising their colleagues had the same experiences, there existed a tacit unspoken understanding between participants. This understanding was used in the gym to show support, particularly in instances which may previously have discouraged them from continuing to exercise. Take, for example, Polly and Chris. As they had previously discussed shared experiences of disablism, Polly felt there existed an unspoken understanding between the two which functioned in the gym allowing her to act as a supportive other who could help Chris resist the oppressive actions of other gym users. This deeply embodied knowledge and unspoken form of communication is akin to what Shotter (1993) termed 'knowing of the third kind.' This knowledge involves a deeply embodied and tacit form of recognition or communication, exhibited through Polly and Chris' ability to understand each other through a simple eye roll. Contextually, having understanding peers to exercise with may enhance participants' gym experiences through a connection with others who could encourage and support them in the gym. Moreover, connecting with others and supporting each other in the gym may also work to resist the oppressive practices within by shifting attention away from a personal, individualized problem of disability and further towards social oppression from individuals and an environment unable to adapt to difference (Smith & Perrier, 2014).

6.2.3 Constructing an affirmative identity.

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The collective story also helped participants to resist the disablism they experienced in the gym through crafting an affirmative identity. Take, for example, Arthur and how the collective story enabled him to re-evaluate his time in the gym giving him a different perspective of his experiences:

> Arthur: "You don't expect to see disabled people here because we don't really fit into the image they want to put out. We're not muscle bound or massive or looking to get really hench … I felt different and was stared at and didn't feel like I belonged anymore and I didn't go again until now because I thought I was the one with the problem. Now I have a different view because there are other people like me who have had difficulties and that changes how you see it a bit."
>
> ER: "How do you mean?"
>
> Arthur: "Well instead of thinking 'I have a problem, it's my issue', you think 'hang on, why is it my issue? Is it my issue if all these guys are the same?'" (Arthur, transverse myelitis, 32)

Master narratives are stories which are culturally dominant and contribute to socially shared understandings of what a person should be and do (Nelson & Lindemann, 2001). The master narrative of the gym says individuals should seek to improve their physical appearance and build muscle (Sassatelli, 2010). As made clear in Terry's testimony, those unable to be this person may construct a negative sense of self as they perceive they do not belong or see themselves at fault (Wendell, 1996). The collective story, however, acted *for* participants as it gave them a *counter story* to re-evaluate their experiences and role in their story. Counter stories empower people to resist oppressive master narratives by identifying fragments of the story which may misrepresent them and situations (Nelson & Lindemann, 2001). This allows for a revised understanding of a person or social group, thereby providing some resistance to

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an oppressive practice (Phoenix & Smith, 2011). In Terry's case, hearing and being part of a collective story allowed him to retell his story in a way which positioned him not as a problem but as merely experiencing problems; in this instance disablism. As narratives function as self-identity resources and actors, this allows for new, more affirmative identities and experiences of participants to be formed (Smith 2013). Consequently, the forming of new identities and interpretations of past experiences has the potential to stimulate self-awareness, a sense of emancipation and empowerment (McGannon & Smith, 2015) which can facilitate exercise behaviour in an oppressive space. For example, through the collective story, individuals recognised themselves as people who would continue to exercise in a disabling space in spite of the difficulties they may encounter. The collective story therefore involved an embodied performance of identity whereby participants could safely and unabridgedly enact a more affirmative identity. Rather than a tragic identity of a failed gym user, participants could instead enact an affirmative identity of someone actively resisting oppressive practices in the gym to continue exercising. Moreover, the experience of exercising and training with other disabled individuals gave further support to individuals' desire to be a gym instructor as through hearing others' testimonies, this cemented for them that there was a need for individuals to challenge disablism in the gym.

6.2.4 Telling their own story.

The collective story also acted *on* participants by instilling in them a sense of empowerment to challenge disabling practices they had experienced beyond the gym in wider society. One example of this is the conversation which occurred between Susan, Kathleen and Terry as they socialized between work outs:

Susan:" I remember having a conversation with my occupational therapist and he said 'what do you want to do after this?' I said '…I want to show a different side to

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disability that isn't tragic and isn't inspirational.' He asked if I wanted to do any other activities and I said,' you know what? I don't want to be one of those labelled people that has to go skydiving or has to go bungee jumping because I'm disabled....' Everybody can do that but I want to be doing just regular sports or going to the gym and just be happy. I don't feel obliged to go jump off something."

Kathleen: "See I felt quite patronised when they (*SCI charities*) came onto the ward looking for you to sign up to go skydiving or climb Snowden…and I think it makes big promises that you are going to feel amazing at the end of it."

Susan: "No I wouldn't, I'd feel shit! I wouldn't entertain it."

Kathleen: "No I wouldn't! What happens if you don't?"

Susan: "You're either gonna kill yourself or do nothing at all. There's no intermediate."

Kathleen: "Yeah you're in or out. If you don't fit the mould, too bad. I'd have jumped at the chance to exercise again and get back to just normal stuff but that's not an option. It's not good enough because we're not normal and not allowed to be normal, no. Would I heck jump out a plane before, why would I want to now?!"

Terry: "Totally right. I hate that. It's like I'm failing if I'm not doing something unbelievable. Going to the gym and being active isn't good enough."

Kathleen: "Yeah!"

Susan: "Yeah! I just want to be considered as a regular person and not a regular person wanting to be amazing. That's what I'm wanting to show people here. Happy, healthy, normal, not extraordinary." (Susan, SCI, 35; Kathleen, SCI, 32; Terry, visual impairment, 35)

Through continued dialogue between participants in the gym, the collective story continued to work to do things *on* participants. In this case, participants felt empowered in the supportive, understanding group environment to discuss disabling experiences they had encountered as a result of society's depiction of disability and the limited available identities these individuals could claim. As Wendell (1996) argued, in groups disabled people can openly and powerfully challenge assumptions such as the idealization of the body and stereotypes of disability. Drawing upon Nelson and Lindemann (2001), in society it appears the supercrip narrative is the master narrative. This narrative positions disabled people as tragic heroes who are expected to do, and want to do, extraordinary feats to go above and beyond their disability to overcome it, defy odds and promote a positive identity (Berger, 2008). If disabled people do not align to this identity they are deemed to reproduce and reinforce disabled people's inferior positionality (Kama, 2004). Although the supercrip narrative may seem more favourable than a personal tragedy narrative which situates disabled individuals as dependent, weak, and subjects of pity (Shakespeare, 1994), it is still oppressive in that it dictates who disabled people are supposed to be and does not represent the majority of disabled peoples' sense of self (Riley, 2005; Wendell, 1996). In response, participants used a counter story to reclaim their experience of disability and desired self, in this case telling a story of exercising in the gym as someone seeking to be active for health and becoming individuals who can actively resist oppression by sharing this story with other people. The strength to challenge the master narratives of society shows the solidifying power of the collective story as it helped participants resist oppression and potentially worked to help motivate them to continue exercising and training as they could claim an identity which made sense to them and helped positively shape their exercise experiences with peers.

6.3 Summary

In this chapter I have presented how exercising together as a peer group allowed participants to craft a collective story which facilitated their desire to resist oppression in the gym. Through the various dialogical components of this story, participants' previous experiences of disablement were validated and reshaped not as their fault but the fault of the gym. Moreover, through hearing other people's stories and crafting a narrative which made sense to them, participants were able to craft a more affirmative identity and begin to challenge the societal perceptions of disability which they so desired to do. Resisting the gym through their presence was also an act they had desired to do (see chapter five) and as part of a group they were given more confidence and drive that this ambition was possible. Problematically, although participants' experiences of exercising with peers were generally positive, as time progressed training became more difficult and this once united group were divided. This I present in the next chapter.

Chapter 7

Narrative Movement: Negotiating and Making Meaning from Gym Instructor Training

7.0 Overview

The final chapter of this section focuses on participants' gym instructor training experiences. As highlighted in chapter six, participants were initially a united group who crafted a collective story which worked on them in various ways. As training progressed, however, this once united group were divided and over half of the participants dropped out of

the programme. The purpose of this chapter is to explore why this happened. To do so, I

conducted a DNA to explore how participants made meaning from their continued training

experiences and what impact this had on their involvement in the InstructAbility programme.

From this analysis, I identified that as participants moved through their training, so too did the

narratives they drew upon to make sense of their experiences. Specifically, rather than one

collective story, two conflicting narratives evolved which split the participants as they either

aligned to a *narrative of activism* or a *narrative of desired belonging*. Akin to the narrative in

chapter six, these stories were constructed dialogically between participants in the sense that

rather than one singular voice there were multiple voices which crafted the narratives and its

various components (Gubrium & Holstein, 2009). Consequently, the dialogical components

of the activism and desired belonging narratives shaped participants' training experiences and

strongly influenced their decision to continue with InstructAbility. These components were (i)

the InstructAbility environment, (ii) *divided connection* and (iii) *(un)realised identities*. These

dialogical components worked *for* some participants by validating their reason for being a

gym instructor and allowing them to achieve their desired identity, but worked *against* others

by excluding them from the group that had initially given them a sense of belonging. To

present findings of this chapter, I first use a narrative typology to describe the activism and

desired belonging narratives. Thereafter, I unpack how the components of these narratives

worked on participants and guided their actions.

7.1 Building a Typology: Conflicting Narratives

A narrative typology is a set of narratives that constitute various ideal types (Frank,

2013). Typologies allow for naming differences between narratives which represent different

experiences. These typologies can more readily show how stories weave together and identify

changes in stories over time. Moreover, they also reflect the work that stories do, how they do

it and, importantly, can reflect issues such as who is holding their own, who is not and why this is so. By building a typology, I can communicate how and why participants' InstructAbility experiences changed as their training progressed. Also, I can capture not only the content of these narratives but also their functions; what they did. These functions will be discussed in the dialogical components section. First, I present the two narratives participants crafted; a narrative of activism and a narrative of desired belonging.

7.1.1 Narrative of activism.

For some participants, as training progressed so too did their desire to enact social missions in the gym and be the individuals who would instigate inclusion and diversity in this space:

> Terry: "It's ticking every box at the moment. Everything I wanted and expected is happening and as training keeps going I'm feeling more and more that this was the right decision for me. Now we're really in it I'm chomping at the bit to get in there and do my stuff; get disabled people in the gym, showing PTs what we can really do, show people that this (*points to eyes*) doesn't have to be a barrier but still get that it's hard, like when you are stared at or called names and all that stuff. Yeah, just start to challenge how people think about disabled people working in a gym."

> ER: "So you feel prepared for the task?"

> Terry: "Oh yeah, absolutely. In training we've learnt how to adapt exercises for different disabilities, we've learnt how to get in touch with the community and disability organisations, everything I think. I just want to get in there and get stuck in and do it for real." (Terry, acquired visual impairment, 34)

Thus, for activists the narrative they constructed could be presented as:

We have experienced and understand the consequences of impairment; both physically and in others' disablist attitudes. Through InstructAbility, we will gain the training we need to become a gym instructor. This will enable us to actively resist disablism and make the gym a more inclusive space.

In essence, the activist narrative tells a story of individuals receiving the necessary training they require to become people who can resist disablism in the gym. These individuals are eager to put their training to use, specifically by promoting inclusion and diversity of disabled people within the gym and challenging potentially negative perceptions of disability in this space. They believed they would be able to do this and become gym instructors through the training InstructAbility provided. Not all participants, however, aligned to this narrative.

7.1.2 Narrative of belonging.

For participants who did not aspire to be activists, they were primarily focused on a sense of belonging and happiness from doing InstructAbility:

"I feel better with less pain and I can feel I am stronger. What they teach us is different to what I had done before and they showed me how to make exercises work so now I would improve and do things easier like shopping or going to see friends. This is what I was hoping so I am happy. With Julie, she understands what it was like for me and I am now able to relate with other people and also talk about my injuries when before I was ignored and told not to talk about them…We are a community and we have a place here which I think is a very good thing and it will continue to make me happy as long as we are all together." (Mudiwa, SCI, 55)

This narrative can be presented as:

We have experienced being ignored and told not to talk about our experiences. At InstructAbility, we are enjoying the benefits of exercise, socializing with understanding others and have a place within a group. This sense of belonging and contentedness will continue for as long as we are together.

For those seeking a sense of belonging, their purpose for continuing InstructAbility was to personally benefit from the shared knowledge of exercise which they could apply to their own work-outs, to continue being part of a group who understood their experiences and to belong within a community. For individuals in this narrative, their continued presence at InstructAbility depended on the sense of community that primarily existed in the group.

Smith (2016) stated that acknowledging narratives move and change honours the fidelity of lives in and across time. As such, this concept lends to this research as participants' narratives and experiences would not remain the same throughout their months of training. Instead, as participants gained new knowledge and experiences from InstructAbility they developed as individuals and crafted new, conflicting narratives which made sense to their respective experiences and desires. Why the collective narrative evolved to two conflicting narratives can be interpreted using the concept of *narrative movement*. This concept is built on assumptions that as people move and change so too do the narratives they draw upon and construct to make sense of their experiences (Frank, 2013). Although narratives move and develop, past narratives are not forgotten. Instead, they are recycled and fragments from these narratives are taken up in the telling of new stories as part of a larger movement of thought (Frank, 2010). This is evident in the development of the activist and desired belonging narratives *from* the collective story; participants took different fragments of the collective story to shape their new narratives. Specifically, activists retained the *resistance* fragment which became a foundation for their desire to be social missionaries, the belonging group retained the fragments of *validation* and *togetherness* which became a foundation for their

desire to have a place in the group. With participants being 'in' one of the two narratives, their sense of self, continued presence at InstructAbility and their relationship with each other also changed. To explain these changes, I present the various dialogical components of the narrative of activism and narrative of desired belonging.

7.2 Dialogical Components of Conflicting Narratives

The effects of the two narratives regarding participants' sense of self, their motivations for continuing training and their relationship with each other can be appreciated by asking a variety of dialogical questions. The first dialogical question I asked related to the *resources* participants had available to make sense of and shape their experiences. In other words, who did the resources available work for and against? How did resources validate or silence participants' narratives? Second, I asked questions relating to how narratives *connected, disconnected* and *affiliated* individuals to and from others. These questions included, who did stories connect? Who is placed outside the connection? Who do the stories render other to the group? I also asked questions about *identity* and how stories gave people a sense of who they were and who they may become. These included how did narratives help participants realise their desired identity? Why were some people denied their desired identity?

From these questions, I identified three dialogical components which provided an in-depth understanding of participants' experiences and reasons why some participants continued InstructAbility while others dropped out. First, the *InstructAbility environment* was a key influence in dictating how stories were received, which narrative was heard and which was silenced. Second, the two conflicting narratives created a *divided connection* between the once united group. These two separate groups lived their own narrative without merging or weaving into others' understanding. Third, as training progressed there was a sense of *(un)realised identities* – realisation dependent on whether participants were activists or sought

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belonging. These dialogical components functioned to shape how participants made sense of their training experiences and, importantly, were deciding factors as to whether participants continued or dropped-out of InstructAbility.

7.2.1 InstructAbility environment.

Participants who harboured aspirations of activism discussed a feeling that InstructAbility was the right place for them to achieve their goal of doing social missions in the gym. This feeling was reinforced through interactions they had with InstructAbility employees:

> Kathleen: "I really like that she (*tutor*) says stuff like 'when you are working', 'when you are with your client', when you are in the gym', 'when you are helping someone with a disability' because it does make it real and you see yourself in that position. I really get so excited thinking I'm going to be able to do all these things and I can't wait to start helping people."
>
> ER: "So do you feel you are in the right place?"
>
> Kathleen: "Oh so in the right place!" (Kathleen, 35, SCI)

Participants who desired belonging, however, felt InstructAbility employees reacted in a non-affirming way when they expressed their desire to do something other than activism in the gym:

> ER: "So when do you think it all went down-hill?"
>
> Mudiwa: "I think it was all ok until I said I wanted to start a women's art club for women with disabilities and that the other women in my course should join. They asked if I wanted to be a gym instructor and I said that I thought this course would be

good to meet people and to get my knowledge up of how to improve and to make friends and have a nice social life, but then I think they started to not help me so much."

ER: "In what way?"

Mudiwa: "Well I have dyslexia from the accident and at the beginning they would help me very much but now I think they do not spend time with me and maybe ignore me because they want to give more time to the people who want to be instructors. So they do not talk to me as much and I am failing now I think and I am not enjoying as I did. It is quite sad." (Mudiwa, SCI, 55)

The InstructAbility environment played a key role in the validation or dismissal of participants' reasons for doing the course. From the contrasting testimonies of Kathleen and Mudiwa (respectively in activism and belonging) it is evident that InstructAbility had a *preferred narrative* they wished participants to align to. A preferred narrative is a story which tries to connect peoples' individual experiences to an ideal or preferred story (Mattingly, 1998). Contextually, InstructAbility's preferred narrative was one of activism where participants would use their experiences of disablism to help make the gym a more accessible, inclusive space for disabled people. This narrative is deeply rooted in the InstructAbility mission, "to support disabled people into a fitness career where they can encourage other disabled people to access leisure facilities and enjoy an active lifestyle." (InstructAbility, 2017). Accordingly, this mission influenced what InstructAbility employees expected of their recruits. In essence, the *narrative environment* supported and valued a specific narrative while disregarding and silencing others (Gubrium and Holstein, 2009). A narrative environment is a socio-cultural environment and/or a physical location such as a gym or physical activity setting where certain stories are told and heard (Perrier et al., 2013). In this

thesis, the narrative environment promoted by InstructAbility was deeply rooted in doing social justice by promoting inclusion and diversity in the gym. As such, it invited stories from participants that were about activism and social missions rather than a sense of belonging.

As a result of this narrative environment, participants experienced contrasting validation and acceptance for their reason to do InstructAbility. For activists, they experienced what can be termed *narrative alignment.* Narrative alignment occurs when a person's experiences, the stories they tell and the narrative types available within the culture they find themselves in 'fit' (McLeod, 1997). In other words, one's personal story aligns to the dominant story told and preferred by a narrative environment. Conversely, where individuals fail to achieve narrative alignment (such as those in desired belonging) there may exist narrative tensions that can lead to the development of problems between individuals and the environment which they frequent (Crossley, 2000). This is evident as representatives of InstructAbility appeared to acknowledge and validate one groups reason for doing the programme (the activists) while invalidating and dismissing the other (those who desired belonging). For example, Mudiwa felt that she was given less support by InstructAbility tutors after she expressed her desire to start a recreational club rather than be a gym instructor. For activists, narrative alignment worked to enhance and sustain their sense of self by cementing that what they were doing and who they were wanting to become was 'right'; evident through Kathleen's feelings that she was in the right place. For those who desired belonging, however, their confidence and sense of self was diminished as their reason for doing InstructAbility was not acknowledged as valid. Accordingly, the preferred narrative within this environment also did the work of oppression by silencing one groups lived experiences and motivations while placing more importance onto another groups. In other words, participants in desired belonging experienced similar instances of oppression they had

previously been subject to, but this time the oppressors were their peers and tutors. Consequently, this lead to division in the once united group.

7.2.2 Divided connection.

As the two narratives started to take hold and shape participants' experiences in InstructAbility, participants in the activist narrative became frustrated with those who positioned themselves as desiring belonging:

"Some people here are not here for the right reasons. Like, we're trying to learn about exercise and the body and injury and stuff and they just want to chat and disrupt the class and are here just to have a good time. It's getting annoying. I keep thinking 'there was maybe someone more deserving than you who would do a better job and not waste our time.' I just don't get why they are here…If someone comes to you and you give them the wrong information you could injure that person. It's not like 'so let's do a bit of paperwork receptionist'; this is serious sort of thing. And also you don't want to have the stereotypical 'oh disabled person blah, blah, blah, hand them out freebies' and stuff like that. I don't know, I don't know… you could just tell that one of the people on my course she wasn't going to do well but they still took her on even though she just chatted her way through it and she was basically spoon fed the whole time… I think they would be better off doing, I don't know, helping out at social clubs or something like that. She already admitted to us straightaway; 'oh I just want to volunteer' and it was like head banging. We're all trying to fight for jobs and it was just crazy… I looked at the people on my course and yeah there's 3 of us who all got on quite well but if we were put side to side the rest of them together being instructors I'd be so, so embarrassed. We used to all get on so well but now I'm

finding I'm distancing myself from all but the three of us who actually want a job because they are making me mad." (Polly, brittle bone disease, 26)

As activists began distancing themselves from the overall group, those who desired belonging felt othered and ignored in their own supposed peer group:

Taskin: "I don't like it so much now."

ER: "Why?"

Taskin: "Well there are loads of cliques and stuff now. We used to have fun and chat all the time and it was well nice coz we got each other and were like together but now it's like us and them. I dunno I'm struggling to get up and come here at the moment just coz it's not a nice place to be. Like, all they do is study and train and study and train and talk about studying and training and I'm like 'hey guys what about going for a coffee or a drink or something' and they just say no or make excuses. I don't see much point coming here now. I much preferred what it was like early doors with a group and stuff."

ER: "Not even to finish your training and get to work in a gym?"

Taskin: "Well maybe but if working in a gym is going to be like this I don't think I want to do it anymore". (Taskin, visual impairment, 31)

Frank (2010) discussed how stories call individuals into groups and 'conduct' people, instigating performance options:

 "stories connect people into collectivities, and they coordinate actions among people who share the expectation that life will unfold according to certain plots…people have to tell stories about lives that are always in progress, using whatever narrative

components are at hand. Those stories then become one of the bases around which collectives assemble, from couples to social movements" (p.15).

The two contrasting stories which participants constructed directed them to different groups. This finding highlights that disabled individuals are not a homologous group with one vision, rather there are many other factors at play which determine how disabled individuals identify. As Deal (2003) stated "whilst acknowledging there are common experiences linked to impairment and disability (from a social oppression standpoint) other facets of identity make their experiences, and therefore, perspectives unique" (p.903). For example, activists felt anger and frustration that the desired belonging group were not doing enough to challenge negative cultural representations of disability and were using resources they did not deserve. As such, they chose to distance themselves from these individuals to become one activist collective, creating division. This division can be further explained as Fiske and Ruscher (1993) posited outsiders[14] (in this case, those who desire belonging) to the in-group (the activists) will be assumed by the latter to be either passively or actively hindering their goals by competing for the same resources or having a different agenda. Accordingly, the in-group will distance themselves from the outsiders. This is evident in this research as activists separated themselves from those desiring belonging as they perceived this group to be taking resources from more deserving individuals and saw them as a potential threat to the goal of challenging negative perceptions of disability in the gym. Consequently, as there was no longer a united group, those in the desired belonging narrative found their initial motivation to keep training no longer existed.

7.2.3 (Un)realised identities.

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[14] I position the activists as 'in-group'; and those desiring belonging as 'outsiders' as InstructAbility favoured and supported the activist narrative as discussed in the previous section.

As training continued, participants began to realise that the future selves they were aspiring to be were either becoming a reality or were no longer possible. For activists, their desired identity as a gym instructor conducting social missions was becoming fulfilled:

"Yeah the closer we are getting to the end the more real it's becoming. I'm feeling a little bit nervous thinking about actually working in a gym and being in that position but really excited at the same time. Doing the disability in the gym training was like 'oh wow this is really happening, I'll be doing this in a couple of weeks for real so I better get my head in gear.' But, no it's really nice that what we've been working for is becoming a reality and what we've worked so hard to become is going to happen." (Julie, SCI, 60)

On the other hand, those who desired belonging felt their future self was no longer something which would be possible to achieve in the InstructAbility context:

Brenda: "This is my last day by the way."

ER: "Oh no! What's happened?"

Brenda: "It's so sad, I feel so alone, so alone now. I thought I would come here and make some really great friends and have a wonderful place to come to with people who understand me but the complete opposite has happened. I just don't know what to do, it's really quite distressing. I don't see the point in coming here now, I really, really don't because I don't enjoy it, I don't want to be here, they (*InstructAbility*) don't want me to be here and I'm not going to be seeing these people again after this, that's for sure."

ER: "I'm really sorry to hear that."

Brenda: (*upset*) "It's just, I thought this was going to be really wonderful and we would be friends for years and years. It certainly started out that way but now, I don't want to see any of these people again for how they've treated me. It's making me ill, I just have to leave." (Brenda, fibromyalgia and ME, 56)

Initially, all participants viewed themselves in an affirmative way (chapter six), but as time passed some identities were further affirmed while others were deemed invalid. Which identities were affirmed and which were rejected depended on the narrative resources available. Narrative resources are linked to narrative identity in that resources are required for sustaining identity performances (Caddick, 2016). Personal identity is a social performance constituted through stories (Smith and Sparkes, 2008). People tell stories to explore who they are, how they live, and how they enact and perform identities in a social world. Maintaining this identity, however, is only possible if it is recognised as a socially valid performance. As testimony from Brenda and Julie illustrate, the socially valid performance demanded by InstructAbility aligned to the activist identity and, as such, it was these individuals who were able to hold their own throughout InstructAbility and complete their training to be instructors, thereby achieving their desired identity.

Conversely, those who desired belonging found their desired self to be wanting as InstructAbility progressed and they could no longer draw upon their narrative to make sense of their experiences. In other words, the narrative path followed by those who desired belonging, which gave them direction and an end destination (Frank, 2013), no longer existed. When it became apparent this path no longer existed for them, they had no other story to fall back on. In Frank's (2013) terms, they had lost their 'point of view' which their narrations depended on and were ultimately left struggling to find their way in a place which no longer made sense. As a result, these individuals experienced what they had initially joined InstructAbility to escape; otherness, invalidation, and disconnect. This time, however, it was

from their peers. These experiences compromised this groups' well-being through the reinforcement that this was yet another place they did not belong. Even more damaging, this message was cemented through interactions with disabled others who previously had the same story and the same disabling experiences which initially formed their bond. For many, the only choice they saw was to terminate their involvement with InstructAbility and drop out.

7.3 Summary

Phoenix & Sparkes (2007) stated, by investigating narratives we are able to discuss new meaning and significance in an unfolding plot and explore the movement of lives over time. This chapter has demonstrated the narrative movement which occurred as participants continued their training. Participants were exposed to other people's biographies, new knowledge and new experiences in training which resulted in participants' narratives *moving* from the collective story presented in chapter six to two conflicting narratives; a narrative of activism and a narrative of desired belonging. This movement reshaped participants' relationships with peers, narrative paths and sense of self. Activists' narrative was the preferred narrative of the InstructAbility environment resulting in validation that their purpose for becoming a gym instructor was 'right' and a recognition that their desired future self was achievable. Conversely, those who desired belonging experienced invalidation from the narrative environment and were not supported in their endeavours to feel a sense of belonging and connection with others. Problematically, as the activists viewed any individuals who did not aspire to be a social missionary as wasting time and resources, the initial connection within the group was severed as the activist group distanced themselves from those who desired belonging. Ultimately, this combination of invalidation, disconnect and the realisation that their desired identity would not be achieved led to participants in the desired belonging group to drop out of the InstructAbility programme. As such, although these individuals are never finalized (Frank, 2013), their continuation in this research has

ended. The next and final empirical chapter concludes this research by presenting the last

stage of participants' journey to be gym instructors; their experiences in the gym and how

they perceived they impacted this space.

Part Three: Journey's End

This third and final empirical section brings participants' stories to a close as I

investigate their experiences in the gym as a gym instructor. In chapter eight I

present, through inductive thematic analysis, what impact participants felt they

had on the gym. In the final chapter of this thesis I provide an in-depth

discussion of the empirical, methodological and practical implications of this

research and how it has contributed to the field of disability studies and exercise

psychology.

Chapter Eight

Crossing Boundaries: The Perceived Impact of Disabled Gym Instructors

8.0 Overview

This final empirical chapter draws to a close the journey of participants in becoming gym instructors. As stated before, however, although their journey comes to a close in this

thesis their lived journey continues and is never finalized. In this chapter, I again apply an inductive thematic analysis to investigate how participants felt they impacted the gym in their roles as gym instructors. Ten participants were interviewed with regards to their experiences; seven were in their voluntary placements following their training discussed in this thesis and three were employed by gyms. After subjecting the data set to thematic analysis, three key themes were identified regarding the perceived impact of disabled gym instructors. These were (i) *promotion of an inclusive environment,* (ii) *understanding disability* and (iii) *enhanced applied practice.* It should be noted to provide contextual meaning to participants testimonies I have included the type of gym they were employed at.

8.1 Promotion of an Inclusive Environment

Participants perceived the gym to be an exclusory space for disabled people to exercise. They felt, however, that their presence in the gym made this space more inclusive. This was done through the construction of a more accessible physical environment, instructors embodying an alternate way of being and providing a more relatable narrative.

8.1.1 Construction of a more accessible physical environment.

Improving physical access was a key focus of participants as they felt an accessible gym was essential in portraying the gym as inclusive of disability:

"You can have all the trained staff but if you can't get people in the building then what use is that?..The first thing I did was say, 'we're not welcoming wheelchair users…we're saying we don't want you. Get a ramp on the outside' and we built from there." (Aadi, leisure centre, 33)

Participants considered themselves influential in making the physical gym environment more inclusive as their position as a gym instructor allowed them to consult on layouts of the gym floor:

"One of the biggest impacts I think I've had has been in helping with the selection of equipment and where equipment should be. So there was one really big bit of cardio equipment missing which is quite vital. I raised it with them and asked for stuff on a wish list. I jumped on the bandwagon and said 'we need this and here's why.' So that's quite cool…When it arrived I got asked about where to put it and there really is no space so we did a walk through with my chair and they could see it doesn't fit…We were restructuring anyway but I was involved in plans to make sure that disabled people can easily access all the equipment. Now it's a really nice room." (Polly, leisure centre, 26).

Structural barriers such as lack of access and equipment (Dickson et al., 2011) are evidence of the indirect psycho-emotional disablism of the gym which creates a 'landscape of exclusion' (Kitchin, 1998) for disabled people, resulting in the perception that they are not wanted in this space. Disabled gym instructors, however, believed they addressed this exclusion by advising and showing gym managers how to make the physical environment of the gym more accessible. For example, Polly used her impairment to demonstrate to gym managers how to make the gym space accessible for wheelchair users. DePauw (1997) theorized there are three levels to facilitate inclusion of marginalized groups; access, accommodation and transformation. The improving of access and physical space of the gym accomplishes this first level of inclusion and is an important step in making the gym more inclusive to disabled people.

8.1.2 Embodying an alternate way of being.

Participants also perceived their physical difference provided some resistance to the ableist perception of the gym:

Julie: "We definitely make the gym seem more welcoming of disability."

ER: "Why do you think that?"

Julie: "What's going to challenge the meat head persona more than a middle aged woman with a limp? I'm walking about the gym but I've got 'instructor' on my back so surely you can be in a gym and not have a six pack right? I think just a different body shows that you can be different in the gym and accepted. You don't have to be muscle bound; you can be big, small, disabled and do whatever fitness you want. It just gives a few more options which may not initially be visible." (Julie, public gym, 60)

Participants believed seeing a disabled gym instructor could challenge the perception that the gym valued only one physical way of being:

"You feel like you should be young, fit, healthy, strong and you go in there (the gym) and you see all these people that are and you don't fit in. Being a human being is all about wanting to fit in on a psychological level I guess. I never studied psychology but you go in and it's like 'oh I don't fit in here, bye!'... But, me in my chair have shown that you can be disabled and exercise in the gym. I've had so many people say that they feel they can exercise here now because I'm breaking the mould and the gym employing me shows that they want disabled people exercising here." (Rosie, community gym, 50)

Ableism portrays disability as a lesser state of being human (Wolbring, 2008) and may be a key reason for disabled people perceiving they are being marginalized and excluded

in the gym. Ablesim, however, can be destabilized when someone shows the "equal value of different ways of being" (Taylor, 1994, p.51), and legitimizes a difference from the norm (Jones, 2006). Disabled gym instructors felt they did this. DePauw et al's (1993) reconceptualization of marginality which posits marginality is (a) socially constructed (b) a dynamic process and (c) in the context of power relations and resistance can further illuminate how disabled gym instructors could reduce oppression and marginality of disabled people in the gym. With this conceptualization of marginality, particularly its dynamic process and focus on power relations and resistance, there is room for people enacting social missions to provide some resistance against the social injustice of ableism in the gym and reduce the perception that one way of being is valued over another. Contextually, disabled gym instructors believed their different bodies provided some resistance to the perception that the gym is only for people resembling the ableist ideal and instead is suitable for many different physical ways of being. As gym instructors are perceived to be representative of accepted ways of being in the gym (Harvey et al., 2014), disabled gym instructors promoting the gym as accepting of those who have different corporeal realities could provide some resistance to the oppressive forces of ableism which marginalize people in the gym, resulting in the perceived marginalism of disabled people being reduced.

8.1.3 Provision of a relatable narrative.

Participants initially discussed two dichotomous perspectives of disability they felt existed in society; "you're an invalid and you're a benefits scrounger not contributing to society, or you're a Paralympic hero…that doesn't represent most of us…why do we have to be spectacular to be accepted?" (Polly, leisure centre, 26).These two perspectives are indicative of, respectively, disability seen as a personal tragedy (Shakespeare, 1994) and disabled people being 'supercrips' (Silva & Howe, 2012); "individuals whose inspiring

stories of courage, dedication, and hard work can prove that it can be done, that one can defy the odds and accomplish the impossible" (Berger, 2008, p.648). Problematically, having only these two perceptions of disability available reduces the complexity and variety of the disabled experience, invalidating the majority of individuals' reality (Riley, 2005). Disabled gym instructors, however, perceived they provided a more moderate, recognisable perspective of disability for clients which better reflected their lived experiences:

> Susan: "They think it's still quite incomprehensible to be doing the regular things that regular people do… I think people do not think we do anything; that we go back into the box and don't come out again…but flipping that, you shouldn't be expected to do something extreme when realistically you just want to be fit and health. But you're not allowed to just be fit and healthy. I don't get that."

> ER: "Yeah, how do you address that then?"

> Susan: "Well that's why I try to promote something that's real, not like inspiration stories. So I'm trying to be more of that but less inspiration and more real…I hope I show that you can come to the gym, regardless of what is wrong with you and do what you want to do just like anyone else." (Susan, community centre, 34)

As narratives function as self-identity resources, the provision of more narratives which make sense to an individual allows for new, positive identities to be formed (McGannon & Smith, 2015). Applicably, a disabled gym instructor providing a narrative of health and well-being through exercise may align more with disabled clients' sense of self. This may trigger in them the motivation to exercise in the gym as they perceive their interpretation of health aligns with that of the gym. This may result in a feeling of belonging as they see themselves represented in the narrative resource pool made available in the gym.

8.2 Understanding Disability

Participants believed they enhanced the perception of an inclusive gym through having an understanding of disability, particularly by providing relatable corporeal experiences, instilling a sense of camaraderie and being an aspirational future self.

8.2.1 Relatable corporeal experiences.

Participants discussed how their non-disabled colleagues felt disabled gym instructors were better equipped to train a disabled client:

"I remember having a conversation with one of my colleagues saying 'you've got the same qualification as me and you're here on site, why have you signposted them to me?' 'Well, you've got more in common with them, you've got a disability.'" (Jerzy, public gym, 30)

Participants discussed the importance of promoting the gym as inclusive of disability by relationally understanding the clients' embodied story of disability:

Allan: "Knowledge of suffering from a spinal cord injury…makes all the difference…you're building up a rapport, building up a knowledge and in that conversation you will get to the point where they clock on that you've been to…a spinal gym yourself; the attitudes change almost immediately."

ER: "How do you mean?"

Allan: "They see someone in front of them that has a similar injury or can relate to them; there is a level of transferrable knowledge. They will be asking not just about their injury but about spasms, pain relief, sleep patterns, what our experiences have been, all of that information is suddenly transferred to them through dialogue but also through seeing us at work…It's just a fact of life; you are going to be more receptive of people with disabilities if you have one yourself." (Allan, rehabilitation gym, 49)

A gym instructors' knowledge of training is primarily focused on crafting the body desired by an ableist environment (Harvey et al., 2014). As such, a disabled client may be subject to direct psycho-emotional disablism such as being stared at, invalidated or ignored (Loja et al., 2013) as gym instructors do not understand what it is like to be disabled. Disabled gym instructors may address this through other relatedness in regards of being a dyadic body (Frank, 2013). The dyadic body is a lived reality and is "immersed in a suffering that is wholly individual…but also shared: the ill person sees others around her, before and after her, who have gone through this same illness and suffered their own wholly particular pains" (Frank, 2013, p.36). Put into context, as disabled gym instructors had been through similar experiences of acquiring an impairment and encountering disablism in their lived experiences (like their clients) and could relate to their story, this became a basis of empathic relations. From this empathic relation, disabled instructors may make the gym appear more inclusive to disabled clients as there is someone there who understands their experiences of disability. As such, they provide a source of understanding and support for an under-resourced community in the gym.

8.2.2 Instilling a sense of camaraderie.

Through their shared experiences of disability, participants believed they had a unique camaraderie with disabled clients:

> "There is a camaraderie about it…we've all got that common denominator; whether it is a wheelchair or not, whether we have a spinal injury or something else, disability brings us together. It is a family and the wider family is the other disabilities as well…we have all gone through something unexplainable unless you have gone through it. There isn't a way to explain it so we belong to this club or this group where

we are a member and we can help others who are not so far along." (Allan, rehabilitation gym, 49)

From this shared experience, participants felt it was important to create an inclusive, supportive exercise environment to encourage disabled people to exercise in the gym:

"I understand feeling alone and scared in the gym so what I really work to do is create a really friendly, supportive atmosphere where we not only work out together but feel like a team and are there for each other…You feel part of something and understand each other as you have the same experiences of pain or disability or feeling crap because society can't deal with us. It's amazing seeing people's confidence grow and friendships form and people helping each other out using machines…or giving advice about how to deal with their disability." (Brenda, 54, private gym)

The camaraderie associated with having a shared experience can promote revealing of feelings, understanding and acceptance (Caddick, et al., 2015) and create what Frank (2013) called a 'community of pain' where individuals are brought together through their shared experiences and have a mutual understanding and appreciation of each other. It could be argued that the perceived direct psycho-emotional disablism experienced by disabled clients in the gym, through invalidation or being ignored (Reeve, 2012), is countered through the creation of a community of understanding, relational beings who are a supportive network while exercising in a potentially intimidating space.

8.2.3 Aspirational future selves.

Participants believed they could act as role models to disabled clients through their similar experiences:

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"I really think there is something about having a disability and then training disabled people. You can reach them on a different level. I think if you can show them that you've been through stuff and it'll help them if you tell them how you motivate yourself and that you can relate to them; I started from this, I struggled before but look, you can get better and better." (Jack, public gym, 28)

They wished to use their experience to guide and advise others who may require some motivation and belief to exercise:

"I want to be in that position where I can say 'I've been there and I've got here; a normal Joe on the gym floor and I'm happy'... I think to see someone with a disability in the gym instructing, I think it just gives confidence that 'yeah I can do this…I can get there.'" (Terry, leisure centre, 35)

Due to the negative portrayal of disability in an ableist environment, disabled people may lack the self-belief to exercise in this space. Disabled gym instructors felt they provided another narrative resource which clients could draw upon and feel they can exercise in the gym. The 'if I can do it, you can do it' rhetoric described by Jack and Terry is akin to what Pollner & Stein, (1996) termed *narrative mapping*. Narrative maps are guides that experienced people offer to newcomers who are at a gateway to an unfamiliar world. As a map, the stories people share provide orientation, information and advice about how to navigate a new social world and the negotiation of new identities in unfamiliar situations. Contextually, disabled gym instructors showing clients it is possible to exercise in the gym with an impairment and experience wellness through exercise. Promotion of this affirmative story about disability and exercise could provide the narrative resources this population need to believe they too can exercise in this space to enhance their well-being and sense of self.

8.3 Enhanced Applied Practice

Disabled gym instructors discussed how their experiential knowledge of disability and the practical knowledge gained from qualifications gave them a unique skill set which helped them develop practical applications for training disabled clients. This was highlighted through being more creative in training and supporting non-disabled instructors.

8.3.1 Creativity in training.

Disabled gym instructors felt they were more creative and could adapt exercises more effectively than their non-disabled colleagues:

"The guy I'm working with now, Luke, he approached me and asked if I would be willing to work with him; of course! So I asked him what his programme was before and basically he had four exercises total which he was finding really boring and not getting the benefits…he was killing himself with it so even getting away from the 'you need to kill yourself, no pain, no gain' 80s mentality was something. So instead we're using eight machines and some free weights but in a bit of a different way to accommodate his disability and I think it's been good for him." (Susan, community centre, 34)

Due to this skill, disabled gym instructors also believed they were sought out by other clients who wanted more variation in their programmes. As Susan continued:

"A chap I trained with yesterday asked me to make him a programme. Not unusual except this guy is over 6 foot! In his 40s, older chap and only done weight training, no cardio, quite a stocky build…We were working last week and this morning and he went 'this is really awkward but will you do a programme for me?' I said 'really?' He said, 'well I just felt like it's a bit cheeky because when I was training the other day I

overheard you say something and the way you think with Luke and adapting equipment to suit him, I think you could offer me some direction'." (Susan, 34, community centre)

The ability to adapt programmes to meet the needs of disabled clients achieves the second stage of DePauw's (1997) inclusion theory; accommodation. Accommodation, in this theory, relates to modifications or adaptations which are made to better integrate disabled individuals into the existing structure of an activity. Contextually, by adapting gym exercises to meet the needs of disabled clients, the gym may be seen as a more inclusive space as disabled people can fully participate and achieve their fitness goals.

8.3.2 Supporting non-disabled instructors.

Participants discussed how they supported non-disabled instructors in how to train disabled clients:

"I often get the guys just coming up and asking me 'hey I have this guy who is weaker on his right side and he wants a programme, what do you think? Surely I can't put a guy in a wheelchair on a bike?' And then it's 'well can he transfer? What level is his injury? Does he think he can cycle…?' It's just about educating guys that disability does not mean infirmity… I think I've got through to them and maybe changed perceptions a bit. We can do a lot more than you think…It's just a bit worrying that we have had the same amount of training disabled people but they never do it themselves. They always refer them to me or ask me before they do something. It's just worrying when I'm not here because it's obvious they aren't comfortable training a disabled person" (Jerzy, public gym, 30)

Participants also discussed how their colleagues were receptive of their advice in training disabled clients:

"I did actually interrupt a work out John (*non-disabled instructor*) was doing with a woman with a SCI. I asked her if she was ok and she really got upset and said that she wanted to get stronger to transfer better, not to build muscle. She has a high level of injury so her movement isn't brilliant but Jack didn't know that and thought she was being lazy and saying so. I had a word with him and he was really receptive and asked loads of questions. I advised him to lay off a bit, see what she wants to do and work specifically for that. Her transferring is so improved. But that's all Jack and just a little bit of advice from me. Now he can carry that on to the next disabled person. If he wants a bit more advice I'll be here." (Terry, leisure centre, 35)

Educating non-disabled instructors could have long term implications for inclusivity in the gym as disabled gym instructors believed they left a legacy of knowledge to their colleagues which they can use for future work with a disabled client. Wendell (1996) argued the public presence of disabled people has many potential benefits for non-disabled people as they may gain better knowledge about disability and better understand the realities of physical impairment. From the perception of disabled gym instructors, this happened in the gym as they could share their knowledge about disability with their colleagues. On a more critical note, it could be argued that the training supplied by organizing bodies is not enough to enable non-disabled instructors to train a disabled client. As Jerzy stated, he and his colleagues received the same amount of training and had the same qualification to train disabled clients however only he felt comfortable training a disabled client. Arguably, non-disabled gym instructors need more support and knowledge to help them feel comfortable training a disabled client. Disabled gym instructors could provide this support.

8.4 Summary

When participants took up the position of a gym instructor they felt they were in a position to challenge and resist many of the disabling experiences they had encountered as clients (chapter four). Through the training they received and their own lived understanding of disability, they felt they could be individuals who bridge the experiential gap between disability and the gym which could be a way of promoting health enhancing behaviour to this population. In these past five empirical chapters I have presented a story of participants' experiences from gym user to gym instructor. In the next and final chapter I present the theoretical, methodological and practical implications of this research and suggest how findings can be used to enhance the fields of disability studies and exercise psychology.

Chapter Nine: Discussion and Implications

9.0 Overview

By exploring participants' journey from gym client to gym instructor, I have offered a deep understanding of a population which has never before been researched with regards to promoting inclusion, health and exercise to disabled people. In the previous chapters I have presented participants' gym experiences, posited reasons why they wanted to become gym instructors, explored how they experienced and made meaning from their training experiences, and what impact they perceived they had on the gym; essentially, reflecting the chronological path they experienced to become gym instructors. In this final chapter of the thesis, I elaborate on the critical insights presented in the previous empirical chapters and review various ways in which an interpretative approach in this project has advanced knowledge and understanding of exercise and disability in the gym. In particular, I reflect on the impact findings in this research have on existing knowledge, highlight new perspectives, and offer suggestions for future study and practice.

Considering existing literature in the field of disability and exercise, disabled gym instructors are juxtaposed to the expected and valued physical image of the gym. The gym is a place which is culturally embedded with ableism and the belief that a particular corporeal presentation is valued above others; in this case the strong, muscular, aesthetic body is in focus (Neville & Gorman, 2016). Consequently, individuals who do not align to this particular self can experience discriminating behaviours which prevent them from fully utilizing the gym as a space to exercise (Crossley, 2006). This is particularly so for disabled individuals who are subject to various forms of disablism in the gym; ranging from indirect psycho-emotional disablism in the form of inaccessible facilities to direct psycho-emotional disablism in the form of individuals ignoring, staring or offending disabled people when they try to exercise in this space. Concerningly, as I concluded in chapter four, many instances of ableism and direct disablism come from gym instructors. As such, the choice of disabled

individuals to become gym instructors is unexpected and raises various important questions about how and why they wanted to undertake this particular role. As this is a population which has never been researched with regards to their motivations, training experiences, and their potential impact in promoting inclusion in the gym, I crafted various interpretively framed questions to focus on participants' subjective experiences which allowed me to contribute to gaps in the literature. These questions were; what were participants' experiences of exercising in the gym? What motivated participants to become gym instructors? How did participants make sense of their gym instructor training experiences? What impact did participants perceive they had on the gym environment? I have provided answers for these questions throughout the thesis. In this concluding chapter, I address a different but equally important question; *so what?* What do these findings contribute to original knowledge? What do they contribute to disability studies? What do they contribute to exercise psychology? What do they contribute to real world improvement of disability and exercise? To address these questions, I now present the empirical, methodological and practical implications of this research.

9.1 Experiencing Disability in the Gym

9.1.1 Enhancing well-being.

In chapter two, I discussed the various ways a disabled individual's health and well-being is supported through exercise. In this thesis, I add to the literature by providing evidence regarding what aspects of well-being participants experienced in the gym and, more importantly, why. Literature has discussed how the gym marginalizes people whose bodies are deemed unfit in comparison to the valued norm (muscular and aesthetic) (e.g. Crossley, 2004). Thus, to conclude that disabled individuals benefited from exercise in the gym provides important insights into how exercise can support this populations' health and well-

being - even in a space perceived to be unwelcoming. Participants discussed how their physical, social and psychological well-being was improved through exercising in the gym. For example, Julie, Tara and Carl gave examples of how exercising in this space enhanced their independence and quality of life as physical strength and function improved, was their main source of socializing with others and gave them psychological respite from the various difficulties and stresses associated with impairment and disability. Thus, exercising in the gym can improve SWB through feeling more satisfied with life and enhanced quality of life (Keyes et al., 2002); PWB through positive relationships with others, living with more autonomy, managing their environment and progressing to their potential (Ryff & Keyes, 1995). Moreover, Andrews et al., (2014) feelings conception of well-being is also actualized as through gym work participants discussed how they felt happier and perceived their everyday lives were improved. Consequently, an important empirical contribution of this finding is that even in a space perceived to ostracize disabled people, there are still opportunities for these individuals to enhance their health and well-being through exercise.

9.1.2 Meanings of gym barriers.

This thesis also provides important empirical insights about meanings of gym barriers. Literature in disability and exercise highlight various personal and social barriers disabled individuals encounter when trying to exercise (see chapter two for review). Problematically, few of these studies explored subjective experiences of barriers and, consequently, what being subject to these barriers *meant* to disabled individuals. Also, most of these studies used multiple exercise settings (e.g. gyms and leisure centres and sports). This broad approach does not allow for a comprehensive investigation of how the culture of an exercise space may influence understandings and experiences of exercise. Accordingly, I adopted an interpretivist research design focusing on participants' experiences in the gym to address these issues and highlight a new perspective in understanding barriers to exercise. From this research, I

concluded that all participants had experienced various barriers when exercising in the gym. A novel contribution from this finding is an in-depth understanding of what these barriers *meant* to participants and how they made them *feel*. Though current research concludes barriers are detrimental to exercise adherence in disabled individuals (e.g. Dickson et al., 2011; Kehn & Kroll, 2009; Rimmer & Marques, 2012), they do not give due attention to the psycho-emotional impact being subject to such barriers can have on a disabled person's self-worth. For example, Kathleen and Terry discussed how the indirect and direct disablism they experienced made them feel angry, hurt, unwanted, isolated, and that they did not belong in the gym. In other words, for them the inaccessible environment and negative interactions they encountered were more than a mere inability to enter an establishment or feel accepted; these barriers were messengers of oppression which told individuals that they did not belong and were not welcome or wanted in this space. Psychologically, this can be detrimental to a person's self-worth and self-esteem as the meanings of these barriers cement the perception that disabled individuals are other (Reeve, 2012; Thomas, 2007) and, as such, may deter individuals from undertaking health enhancing behaviours.

9.1.3 Tempering otherness.

Although participants did experience various forms of oppression in the gym, there were two ways participants felt they gym was made more inclusive of them; *supportive gym instructors* and *the presence of other disabled clients*. First, though some participants perceived instructors were the cause of the direct disablism they experienced, others stated a supportive gym instructor was a key reason why they continued to exercise. Supportive instructors created a more inclusive environment to exercise – even when the physical space was not fully accessible. As gym instructors are representative of the gym and its values (Sassatelli, 2006), they are an integral part of an individual's gym experiences. Thus, they have the power to either exclude or include disabled people from the gym. For example, if

gym instructors treat disabled individuals in a way that marginalizes or oppresses them, this communicates to clients that the gym as an institution does not consider them valid members. Alternatively, if gym instructors are able to support disabled individuals in their exercise endeavours and craft an exercise environment where clients feel comfortable and included, this communicates that disabled people are welcome and valued members of the gym.

A second way which tempered the perceived otherness of participants in the gym was seeing another disabled individual exercising in this space. Seeing another disabled individual challenged perceptions that the gym was only for a particular kind of person who fit the cultural values portrayed in the gym. The presence of a disabled individual can act as an aspirational figure or role model who people can relate to and see as a future self. Thus, having an aspirational figure present in the gym may direct disabled individuals to adopt health enhancing behaviours and perceive the gym as a space where this is possible. This finding can be further supported by social cognitive theory (SCT). This theory specifies that individuals learn behaviours by imitating others in a process referred to as modelling (Bandura, 1986). How much a model (in this case the disabled gym client) can influence the behaviour of the observer (in this case another disabled person in the gym) is determined by the perceived similarity of the model and the observer (Bandura, 1997). In other words, if an observer can see themselves and relate to the model, they are more likely to pay attention to their actions, retain what they are doing and be motivated to copy this action (Martin Ginis, Nigg & Smith, 2013). Moreover, as SCT stipulates, vicarious experiences (e.g. observing others coping with disablism in the gym and still exercising in spite of these barriers), feedback and reinforcement are primary sources of self-efficacy (Bandura, 1997). Thus, seeing another disabled individual in the gym may have increased the self-efficacy of participants as they had someone from which they could model exercise behaviour in the gym.

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Findings from this research have contributed numerous empirical implications to current knowledge, specifically how gym work enhances well-being, what barriers mean to these individuals, and how the gym can be more inclusive of disability. This particular research also resulted in numerous practical implications and recommendations which I will discuss later in the chapter.

9.2 Why Do People Do Social Missions?

A key contribution to exercise psychology this thesis provides is an understanding of why people do social missions. To recap, social missions are collective, social, political problem solving ventures which can be passive, institutionalized acts or alternatively, high risk, active, conventional behaviours that convey what is needed for a better society (Corning & Myers, 2002). Individuals in this study wanted to do social missions in the gym by challenging disablism and promoting diversity and inclusion in this space. Considering gyms marginalize individuals deemed other to the gym and instructors are expected (and under pressure) to embody the aesthetic, muscular form valued in the gym (Harvey et al., 2014), participants desire to be an instructor is a risk taking, unconventional way to do social missions. What caused them to undertake such a task? Through interpretively framed questions, I identified participants were drawn to social missions through two forces; *affective influence* and *altruistic motivations*.

As I discussed earlier, the meanings of barriers to exercise meant something to participants and resulted in various feelings (e.g., hurt, anger) which shaped how they experienced the gym. Feelings too shaped how participants reacted to others being subjected to disablism and these feelings were instrumental in their desire to do social missions. As Cromby (2015) argued, we are feeling beings and act on how we feel; thus, we are guided to take certain actions as a result. In this research, I argued that participants' desire to do social

missions came from an affective place where the emotions they felt compelled them to act against what they were seeing. Specifically, participants altruistically desired to help other disabled people by ensuring these individuals did not have to experience the same discriminatory practices participants had endured. Drawing upon Frank's (2013) typology of illness as an interpretive tool, participants desire to do social missions is emphasized through the quest narrative. The basic premise of the quest narrative is that individuals seek to use their illness and view it as a journey with something to be gained from the experience. Specifically, in this research participants were in the manifesto facet of the quest narrative which carries the demand for social action in a society suppressing the truth about suffering. As Frank (2013) stated "they want to use suffering to move others forward with them" (p.121). It is apparent from participants' desire to challenge discriminating practices in the gym and use their impairment to promote inclusion of disabled people in the gym that participants were in manifesto and, as such, motivated to be social missionaries to do social justice in this space.

The qualitative data constructed in this thesis and the various ways it was interpretively analysed has provided in-depth understandings of disabled individuals' experiences exercising in the gym and reasons why people undertake social missions in exercise settings. I have discussed how influences such as affect shape participants' experiences and held meaning for them. I also discussed how the quest narrative showed why participants wanted to do social missions and was thus a productive means to interpret an important empirical finding. More than an interpretive tool for analyses, however, narrative was an influential force which shaped participants entire journey from client to instructor.

9.3. Constructing Meaning and Experience through Narrative

The basic premise of narrative theory is that we understand our experiences and our identities through stories (Smith & Caddick, 2015). In chapter two, I built a case for why narrative inquiry was well suited for investigating disabled individuals' journey from client to instructor. I now show how narrative shaped participants' journey and revisit these arguments, supported by contextual examples from the findings in this research, to illustrate some ways this thesis progresses understandings.

9.3.1 Narratives shaping gym experiences.

One way narrative shaped participants' experiences was in the gym; specifically the available resources in the gym regarding disability and the body. Participants highlighted that some key reasons they felt they did not belong in the gym was that they did not align to the cultural values of this space (i.e. ableism) and there were limited interpretations of what constitutes good health. Consequently, as participants did not interpret health as being muscular or improving aesthetic (aligning to the gym's understanding of health) their reasons for exercising were not legitimized and they were left feeling invalidated. As Harvey et al., (2014) stated, the interpretation of health in the gym can result in the isolation of individuals who interpret health a different way. This is what happened to participants in the gym. Narrative inquiry focuses on individuals' storied experiences bringing a deeper understanding of human beings in their social worlds (Smith & Caddick, 2012). The narrative resources available within a culture are the tools by which people make sense of themselves and their experiences. However, a cultural repertoire of stories is not exhaustive and peoples' access to resources depend on their social location (Frank, 2013). Integral to what stories are available to individuals is the body as the body is influential in shaping the stories that can be told, its relationship with others and the environment where it is located. Through narrative inquiry, I

have provided a sophisticated perspective of how the gym culture and participants' bodies were influential in shaping their gym experiences and the subsequent impact these experiences had on their sense of self.

9.3.2 Narrative as a guiding path.

Narratives can also be powerful motivators and cause people to act in certain ways (Andrews, 2014). They can get under one's skin (Frank, 2010) and act in such a way that informs and guides our actions and possibilities (Frank, 2006). This is evident in chapter five where I described how the narrative of InstructAbility interpellated individuals to the identity of a gym instructor. Participants desired to do social missions, but until they were provided with a future where they could do this, they had not considered doing so as a gym instructor. More than that, the InstructAbility narrative provided them with a path guiding them in how to become this individual. As Frank (2013) stated, stories can provide a template for people to make sense of their experiences, themselves and who they will be in the future. Thus, in this thesis, I have presented how and why participants wanted to be a gym instructor, thereby providing new knowledge towards how narratives guide individuals to certain identities.

9.3.3 Narrative resistance.

By telling stories we reveal much about ourselves, our experiences, meanings and relationships with others (Frank, 2006). Stories are socially constructed but open to interpretation allowing people to craft their own narratives which align to their experiences. This is evident in chapter six when participants came together to craft a narrative of resistance which shaped how they initially experienced and made meaning from their training. Specifically, they crafted a collective story which they used to counter disablism in the gym and the disabling social master narratives of disability. This collective narrative worked in different ways and has important implications in the field of disability and exercise. First,

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participants all understood first-hand the challenges of exercising in the gym. This forged an embodied connection between them which facilitated gym use as it countered previously experienced feelings of isolation and segregation, even when disabling practices were occurring. For example, Polly described a feeling of understanding when she could support Chris through a simple glance when he was subject to impatience and stares from other gym users. As Wendell (1996) stated, it is not the fact that people have impairments that bring them together through communal experience, rather it is the negative treatment by societies that disabled people will have in common; these will often be aspects of social oppression. The common experience of disablism brought people together into a supportive group.

Second, the collective story also acted on participants through giving them a more positive embodied identity when exercising in the gym. The identity of a disabled person exercising in the gym reframed the exercise experience for individuals situating them not as tragic protagonists who did not fit into the cultural world of the gym but individuals resisting oppressive practices within. Situating the issue of negative exercise experiences as the fault of the gym, not the individual, is akin to a social relational model of disability which understands disabled people are a group who experience discrimination and oppressive practices (Thomas, 2007). This understanding and participants continued efforts to exercise in spite of oppressive practices promoted an affirmative identity (Swain and French, 2000). This has vital political meaning (Wendell, 1996) as resistant acts encompass positive individual and collective social identities for disabled people grounded in benefits of lifestyle and life experience. For example, an affirmative identity in the gym allows room for action and resistance of oppressive practices. It also allows individuals who have struggled and battled together to resist these oppressive practices and become the hero of their own story rather than a passive, tragic character (Frank, 2013). Being part of a group therefore enabled

participants to embody this positive identity which could help this population when they are faced with exercising in a domain which does not adapt to their needs.

Third, the collective story also functioned as a narrative which participants could draw upon to make sense of their gym experiences and which closely resembled their sense of self. As the participants in this study discussed, there are very limited cultural resources and understandings of disability for people to draw upon which reduces the complexity and variety of the disabled experience (Riley, 2005). This limited repertoire of resources can not only segregate many disabled individuals as they feel unrepresented and misunderstood, but may also create unassailable and inaccurate depictions of disability which non-disabled individuals draw upon to build their understanding of an unknown phenomena. If dominant cultural resources of disability are inaccurate and disabling, this can compromise the lived experiences of disabled individuals. For example, the supercrip narrative is dominant in rehabilitation and society due to the promotion of the Paralympic games and various forms of media portraying this population as inspirational figures (Silva & Howe, 2012). Where individuals do not align to this image, they are perceived to not be trying hard enough or are failing resulting in various disabling practices (Kama, 2004). In response to these oppressive master narratives, participants in this study presented a counter story where they wanted to use their social selves in the gym to promote a narrative which showed exercising in the gym was something someone could do without a desire to be extraordinary.

9.3.4 Narrative movement.

The narrative of resistance was the foundation for the future narratives participants would construct regarding their training experiences. As Frank (2013) stated, as people move and change so too do the narratives they draw upon and construct to make sense of their experiences. Narrative movement was evident in this research as I illustrated how and why

participants' narratives (and reasons for doing InstructAbility) evolved from one collective narrative to two conflicting narratives which ultimately divided them; a narrative of activism and a narrative of desired belonging. The construction of two different narratives worked on and against participants in different ways either validating that what they were doing was right and reaffirming their desire to do social missions, or invalidating their reasons for doing InstructAbility and subsequently denying individuals desired identity. Through narrative inquiry, how narratives changed and what impact this had on participants could be posited.

First, narrative theory is sensitive to and appreciates that identities are multiple and transient. Narrative scholars argue that narratives are identities and the life-stories that people tell are a performance of who they are and who they are not (Riessman, 2008). In chapter seven, participants provided examples of this process as they discussed how their group identity had changed with time. For example, individuals who aligned to a narrative of activism told a story of undergoing training to become gym instructors in order to do social missions and challenge disablism in the gym. Essentially, through seeing themselves as activists and persistently being supported in their desired identity by InstructAbility, participants constructed a sense of validation that their desired future identity was right. Conversely, individuals who desired belonging told stories of wanting to feel part of a community and have their lived experiences understood and validated by others. They did initially experience this and thus they were able to perform their desired identity. As participants and narratives moved through training, however, the identity performance of those who desired belonging was no longer deemed valid by their colleagues or InstructAbility. Thus, their desired identity was no longer possible resulting in the psycho-emotionally detrimental experiences they had initially experienced as gym clients; otherness, invalidation and disconnect. Through narrative inquiry, I was able to build an in-depth

understanding of how participants' construction of identity evolved and what this meant to them.

Second, narratives also shape what we think, how we behave and determine decisions (Andrews, 2014). People get caught up in stories affecting what they think and know, guiding our actions and our possibilities (Frank, 2006). This process was evident in participants' decision to either continue or drop out of the InstructAbility programme. As I discussed in the previous paragraph, individuals who aligned to activism found their desired identity and reason for doing InstructAbility validated, thereby allowing them to continually see a future self as a gym instructor. For individuals who desired belonging, however, the narrative they drew upon conflicted with the preferred narrative of InstructAbility and was a contributing factor to their decision to drop out of the programme. Their desired self was no longer possible and as they had lost their point of view, they dropped out of the programme.

Third, as people move and change so too do the narratives they draw upon to make sense of their experiences (Frank, 2013). In other words, stories that individuals initially crafted and drew upon to make sense of their experiences can be revised, adapted or edited to help them make sense of new experiences. This highlights that although narratives are socially constructed, people do have personal agency in constructing their own experience. This was demonstrated when individuals crafted different narratives of their experiences of training. For example, both groups adapted the collective story to make sense of their training experiences; groups however adapted this story in different ways and drew upon different fragments of this narrative to tell their new stories. It is this interplay between personal and social influences which deepens understanding of experiences (Smith & Sparkes, 2009) and consequently, has contributed to understandings of disabled individuals' training experiences.

9.4. Applied Considerations and Practical Recommendations

In this thesis, I sought to explore participants' journey from gym client to gym instructor and thus far have discussed the various empirical and methodological implications which have resulted from this study. What is imperative in any focused project of research, however, is to identify means by which there are practical implications for real world application. I began this thesis stating that disabled people are a marginalized group in the gym who experience various forms of ableism and disablism which make their full participation in this space problematic. The applied considerations and practical recommendations which have been constructed in this thesis address these issues by illustrating ways of promoting inclusion of disabled people in the gym.

First, as I discussed in chapter four, the limited access and suitability of equipment for disabled individuals was a key message that the gym was not welcoming or accommodating of disability. To address this, those in a position of responsibility in reinforcing access requirements (e.g. gym managers) must be advocates of full access to facilities and committed to implementing these adaptations. Moreover, to better understand the needs of their disabled clientele in regards to access, it is recommended that managers consult with disabled individuals to see what is needed, and how equipment and the gym layout can be made more accessible. Indeed, this was a successful strategy implemented by Polly when she led her colleagues through a tour of the gym to show them the various barriers she encountered in her wheelchair. Second, non-disabled instructors need a greater understanding and appreciation of disability and what it is like to be disabled in the gym. One way to do this is having a disabled gym instructor as a colleague to consult and educate non-disabled instructors. Participants felt this was an effective means of enhancing their non-disabled colleagues' knowledge and confidence as discussed in chapter eight. There are not, however, disabled instructors in every gym so non-disabled instructors must rely on other means to

improve their expertise. One way to do this is through education, specifically the Level 3 Disability and the Gym qualification. This qualification teaches gym instructors about disability and how to treat and adapt exercise to suit various needs. What is important to note is that non-disabled instructors must not rely on this 2 day course as their only resource in leaning about disability in the gym (as I discuss later). Rather, this course must be seen as a first step in improving their knowledge and a foundation upon which their expertise can be built.

I also argued in chapter four that other disabled individuals in the gym can facilitate disabled individuals exercising in this space. This was supported in chapter six when participants training required them to exercise as a group in the gym. How they constructed their group narrative and the impact this narrative had in shaping their gym experiences has further practical implications for promoting inclusion in the gym. The positive impact being part of a group had on participants' sense of self, identity and validation could be transferred to gym work. For example, a group exercise programme for this population could facilitate gym use as they feel a sense of connection and support in a group of their peers which empowers individuals to exercise in a space where they may previously have felt isolated and marginalized. As Martin Ginis et al., (2013) encouraged, exercise interventions should include peer mentors in their intervention delivery models as these individuals can provide various types of support, share knowledge, motivate, encourage and feedback to those who are exercising. Indeed, Letts et al., (2011) concluded that individuals with SCI preferred messengers of physical activity to be peers and health service providers and suggested an interdisciplinary engagement to effectively deliver physical activity interventions was required. In this thesis, I have illustrated that individuals who are both peers and health service deliverers perceived they became models for disabled clients to base their exercise behaviour on and could effectively deliver exercise programmes to these individuals. As

disabled instructors can be both peers and mentors, gym instructors may wish to consider implementing group exercise programmes for this population in the gym to help resist potentially disabling practices and increase the self-efficacy of disabled clients in the gym. Doing so could introduce disabled people to a difficult exercise setting and also provide peer support to negotiate the terrain and instil a sense of confidence for further and prolonged exercise in this space.

Moreover, as disabled people feel more confident and supported exercising in an integrated setting, more non-disabled people may be exposed to them. Wendell (1996) argued the public presence of disabled people has many potential benefits for non-disabled people as they may gain better knowledge about disability and better understand the realities of physical impairment. Arguably, this improvement of knowledge through seeing and interacting with disabled people could improve the perceived direct psycho-emotional disablism in the gym which has been highlighted as a key barrier for disabled people trying to exercise in this space. Moreover, the counter narrative to disablism presented in chapter six could facilitate gym use in disabled people by being another narrative option for individuals to draw upon and guide their understandings of exercise. The presence of peers in the gym who also align to this counter story take the role of embodied actors who can act as role models and show that exercising in the gym is accepted and possible.

One of the key practical contributions from this thesis is a rich exploration of how disabled gym instructors have the potential to challenge disablism and promote inclusion of disability in the gym. As I have stated, a key argument in this thesis was that ableism and disablism in the gym marginalize disabled people resulting in the perception that disabled people are not wanted in this space. Through the presence of disabled gym instructors, however, there is the potential for the gym to be perceived as a more inclusive space. Drawing upon DePauw's (1997) theory of inclusion as an example, disabled instructors may

make the gym more inclusive for disabled clients at all three levels; access, accommodation and transformation. First, in this thesis participants perceived they improved *access* through physically illustrating to managers how to construct an accessible environment. Second, participants felt their creativity and adaption of exercises permitted them to *accommodate* the needs of disabled clients which allowed them to fully participate in the gym and work towards their fitness goals. Finally, participants believed the gym was *transformed*, the third level of inclusivity, where there are reconceptualizations of the basic and underlying tenets of an exercise space; this being ableism in the case of the gym. Although I do not claim the gym is transformed in the sense of being completely changed for everyone, the reconceptualization of the underlying tenets of ableism in the gym through disabled instructors may be enough for disabled people to see the gym in a different way. I therefore argue that disabled gym instructors have the potential to make the gym more inclusive to disabled people by promoting it as a suitable, effective space to enhance health and well-being. Gym managers who seek to promote an inclusive rather than ableist or disablist environment should consider the employment of disabled gym instructors.

As well as having an impact on the perceived inclusivity of the gym for disabled clients, disabled gym instructors also felt they had a positive impact on their non-disabled colleagues. Gym instructors have a vast amount of power in the gym and are deemed to hold knowledge which will help individuals reach their fitness goals (Lloyd, 2005). Critically, however, if these fitness goals do not align to the ableist expectations and norms of the gym then gym instructors are ill-equipped to provide such knowledge (Harvey et al., 2014). Arguably, the inability of non-disabled gym instructors to meet the needs of disabled clients contributes to the disabling practices experienced by disabled clients. A novel finding from this study, however, has highlighted that having a disabled colleague who can expand a non-disabled instructor's knowledge about disability could be a way to improve not only the

knowledge of these instructors but also the relations between non-disabled instructors and disabled clients. This could be a way to address the perceived direct psycho-emotional disablism which comes from non-disabled instructors. Thus, a future recommendation for future research is to investigate the experiences and perceptions of non-disabled instructors who have disabled colleagues and how they felt better, or not better, equipped to train a disabled client.

While there is a potential beneficial impact of a disabled gym instructor educating their non-disabled colleague about disability, this finding also brings into question the current methods used to train non-disabled gym instructors about disability and the unequal focus disabled clients are given with regards to training in the gym. Currently, instructors undertake a course which lasts two days. Thereafter, those who attend are deemed to be qualified to train disabled people. This training is not sufficient to enable non-disabled instructors to feel confident training disabled clients and reinforces the social inequality of disability in the gym by committing only two days of training to this population. As DePauw (2000) argued, by limiting information about disabled individuals to special courses, such as the two day course undertaken by gym instructors, the notion of segregation (of knowledge and of disabled people) is reinforced implying that the responsibility for knowledge of disability and working with disabled individuals belongs only to selected individuals. In the case of this research, disabled gym instructors are expected to train all disabled clients as they are deemed to have more knowledge due to their personal experience and non-disabled people are relieved of responsibility, evident in Jerzy's testimony. Similar findings have been concluded in the field of disabled sport coaching. Bush & Silk (2012) argued that coach education and development follows a compartmentalized approach that is underpinned by medical discourse. Consequently, disability coach education is discontinuous and disjointed in specific training episodes and designed to deliver knowledge of impairment rather than to evaluate meaningful

application to coach practice (Cregan, Bloom, & Reid, 2007; DePauw & Gavron, 2005). Evidently, the same can be argued in current education methods to train gym instructors how to work with, or coach, a disabled person in the gym. The two day training course is a one off event and primarily focuses on teaching instructors about different physical impairments rather than social issues or the gym's role in marginalizing disabled people. In other words, a medical model understanding is currently dominant in instructor education which further substantiates disability is caused by impairment and, as such, the disabled client is expected to adapt to the gym. As argued by Townsend, Smith & Cushion (2015), instructors should learn about different understandings of disability and be reflexive in how their own understanding of disability influences their learning and practice. Although it is not possible for a non-disabled instructor to understand disability, it is possible that they can acquire the knowledge needed to adapt exercises to meet the needs of clients and have more confidence interacting with these individuals. A future recommendation of practice is to adopt a more infusion based approach (see DePauw, 2000), where being taught how to train and adapt exercises for clients with an impairment is taught *alongside* the standard training thereby giving disabled people equal focus. This would, however, require a re-evaluation and redesign of training which takes time. In the short term, to improve the knowledge of non-disabled trainers, gyms could invite a disabled instructor to deliver regular practical workshops where they can share their knowledge of disability.

This research on disabled gym instructors also contributes further to the field of exercise psychology by exploring specifically *how* people enact social missions in exercise spheres. Previous research has highlighted elite disabled athletes can do the work of social justice by challenging disablism in their sport and society (Smith et al., 2016), a similar claim can be made of disabled gym instructors as they did the work of social justice by challenging disablism and promoting inclusion in the gym. For example, participants felt they provided

resistance to both direct and indirect psycho-emotional disablism through their ability to show managers how to craft an inclusive exercise space, validating and relating to clients' experiences of disability, being a positive role model who others could look to and showing that exercising in the gym with an impairment is acceptable. Moreover, through their presence in the gym, gym instructors did the work of social missions by providing more narrative resources for disabled clients to draw upon, make sense of their experiences and reframe their expectations and beliefs about gym work. For example, disabled gym instructors challenged the notion that gym work is purely to improve physique but can be to enhance health and wellness and also provided a guide for disabled clients to see that they too could exercise in the gym successfully. Thus, drawing upon DePauw et al's (1993) reconceptualization of marginality, disabled gym instructors could be a key means to promote exercise to disabled people as they address the marginality of the gym. To recap, these authors posited that marginality was (a) socially constructed rather than about characteristics, (b) a dynamic process, not a static condition and (c) in the context of power relations and resistance rather than assimilation. In this thesis, I have highlighted that disabled people were marginalized in the gym but that disabled instructors can reduce all three aspects of marginality. First, disabled individuals were marginalized in the gym through constructed cultural values of the body and the physical structure of the gym positioning these individuals as other. Disabled gym instructors however believed that they were and could be influential in making the physical space more accessible and portraying a different way of being which does not align to ableist values. Second, through various means (e.g. narrative construction and resistance, physical presence and influence in the gym), participants in this thesis showed that being marginalized is not an end point but something that can be challenged and improved. Third, disabled instructors fought to be themselves in the gym and show an alternate, but acceptable, way of being. As such, rather than assimilate and conform to

dominant cultural values, they resisted ableism in the gym. As I stated in chapter two, with this reconceptualization of marginality there is room for social missions and to resist oppressive social inequalities; this is what disabled instructors perceived they did.

For practicing exercise psychologists, this thesis has many important implications. For example, exercise psychologists working with disabled clients may encounter difficulty encouraging their client to try to exercise in the gym due to the ableism and disablism associated with this space. The presence of disabled gym instructors, however, provides some resistance to these oppressive practices and reframes gym work in a way which is accommodating to those with different corporeal realities. Moreover, disabled gym instructors can provide a narrative map and more affirming personal narrative to disabled people entering the gym. As such these additional resources, which go beyond a personal tragedy view of disability, can also be shared by exercise psychologists to illustrate to clients that disabled individuals can successfully exercise in a gym. Furthermore, this research has highlighted that those who enact social missions have the potential to reach under-resourced communities and encourage them to adopt health enhancing behaviours (Corning & Myers, 2002). As such, exercise psychologists who are seeking to design interventions to promote exercise to under-resourced communities, such as disabled people, should consider recruiting those who do social missions. Thus, for exercise psychology researchers working with disabled people, they should do participatory action research where disabled people are actively involved in intervention delivery and design.

This research also makes novel contributions to cultural sport psychology (CSP) (McGannon & Smith, 2015). This research has provided evidence for a possible solution to the challenges of the culturally embedded ableism and psycho-emotional disablism in the gym which marginalizes disabled people; disabled gym instructors. Sport and exercise psychologists should consider working with disabled gym instructors to create inclusive

exercise options for disabled people marginalized from mainstream physical activity. By working with disabled gym instructors, sport and exercise psychologists can help co-produce the gym as an inclusive and health promoting environment. One way to do this is by amplifying the stories told by disabled gym instructors to raise their profile and further challenge ableism. Amplifying stories can expand people's narrative resources through sharing and offering different stories. By bringing in more stories, people's narrative resources can be expanded allowing people to choose from and live by a narrative which makes sense to them and their identity (Smith et al., 2016). Practitioners should also consider working with disabled instructors to target this hard to reach population by amplifying stories of disabled people exercising in the gym for enhanced health. This can be achieved through holding workshops in gyms, rehabilitation centres, hospitals and in other organisations whose purpose is to improve the health and well-being of disabled people through exercise.

Despite the positive impact disabled gym instructors can have in the gym, as I stated in chapter 7, there was a high drop-out rate of potential instructors throughout instructor training. Thus, there are recommendations to be made for future training courses and programmes which aspire to train disabled people to become gym instructors. First, programme needs to be considerate of the flexible nature of being human. As was shown in chapters 6 and 7, participants initially crafted one story which united them as a group, but as time moved so too did the narratives they crafted to make sense of their experiences. As training progressed this one narrative evolved into two different stories dividing the group and leading those who desired belonging to experience the same oppression they had been subject to before. InstructAbility were unable to support the evolution of some participants from wanting to challenge disablism to wanting to feel a sense of belonging and, subsequently, this group of people dropped out of the programme. Future training programmes need to be aware that participants' motivations may change, and must ensure

they are able to acknowledge and support these individuals rather than dismissing and invalidating their motivations. Second, similarly to recommending gym managers consult their disabled clients with regards to building an accessible gym, training programmes should consult people with various impairments to better understand how to sufficiently support prospective trainees. For example, how to ensure enough rest time to avoid excessive fatigue, how to structure learning areas such as classrooms and practical exercise spaces to be accessible and inclusive for all, how to teach content in such a way that people with additional learning or cognitive difficulties are given the support they need. Developing this recommendation further, disabled individuals should be involved at every level of a training programme's infrastructure. People who have not experienced disablement or impairment do not understand what it is like, therefore it is imperative programmes focusing on these individuals recruit and/or employ disabled people into the highest levels of management to the people who are actually delivering the programme.

9.5 Concluding Thoughts and Future Possibilities

In this thesis, I have interpretively researched disabled individuals' journey from client to instructor. In doing so, I have constructed in-depth understandings of disabled individuals' gym experiences, their motivations for becoming gym instructors, how they made sense of their training experiences and what impact they perceived they had in the gym. From this research I have discussed the numerous empirical, methodological and practical contributions this has on current knowledge. This is but a start point in this area and there are opportunities for future research endeavours arising from the thesis which can address limitations of this research and build further knowledge with regards to promoting inclusion in the gym.

First, more research is required to better understand the lived experiences of disabled individuals in the gym and lay a solid foundation of knowledge for future research and interventions to build upon. Also, a limitation of this research was that to analyse participants' experiences in the gym I used inductive thematic analysis thus resulting in themes which reflected the topics that were discussed most by participants. As the majority of participants had acquired impairments, individuals with congenital impairment experiences may not have been fully represented. Future research should investigate the experiences of individuals with congenital impairments to ascertain if their experiences are comparable or different. Moreover, in this thesis I have proposed ways in which people are motivated to and do social missions in exercise settings. This, however is a very specific population and but one example of how and why people do social missions. Undoubtedly, there are many other motivations and ways people partake in this activity and more research is required to build a comprehensive understanding of this phenomena. Further, although beyond the scope of this research, a further implication of this research could be that the narrative of resistance identified in the collective story could also help participants when they exercise independently. The dialogical components of validation, affirmative identity and telling their own story may work for participants when they exercise in the gym and experience direct or indirect disablism. With this narrative casting them as heroes resisting oppression and the components of validation and affirmative identity, participants exercising in oppressive spaces without the support of peers may still have the tools and the confidence to negotiate these spaces and reap the beneficial effects of an active lifestyle. Further research should investigate how exposure to more affirmative, resistance narratives could facilitate exercise in disabled people when they exercise independently in a potentially oppressive space. Also, although this research provides new knowledge and important insights into how disabled instructors can impact the gym and promote inclusivity of disability, these conclusions were

constructed with disabled gym instructors and therefore focus only on one side of the relationship. To address this, investigating the experiences of disabled *clients* and their interactions with disabled gym instructors would provide deeper insight into the impact disabled gym instructors have on the population they are trying to target. Moreover, the perception of a disabled gym instructor from the perspective of gym managers and those who dictate who is employed in the gym is still unknown. Further research should consider investigating how higher levels of gym management see disability and if the impact of disabled gym instructors is acknowledged by these influential individuals. Finally, though I used multiple interpretive analyses techniques to construct findings and craft an understanding of participants' journey, other qualitative traditions should be utilized to explore disability and the gym to better comprehend this experience. For example, phenomenological methodologies could be used to investigate disabled individuals' gym experiences and craft a more embodied understanding of this topic. Alternatively, an ethnographic approach could shed further light on how the social world of the gym itself and the cultural interpretations within shape disabled individuals experiences. These are but two ways to progress knowledge in this area and which can contribute different perspectives and findings to an area of research which is wanting with regards to greater understanding.

To conclude, I end this thesis with a final thought. Although the gym may be synonymous with ableism and marginalizes disabled individuals through various instances of disablism, there are opportunities to promote the gym as a more inclusive space for disabled individuals. As Smith Maguire (2008) stated, there are chances for social resistance where ideals are questioned and challenged. Participants in this thesis are an example of how marginalizing practices can be challenged and populations who are deemed "other" can be made to feel more included. There is still much progress to be made with regards to improving the oppression of disabled individuals in society, however this thesis has shown it

is possible to do so in a space embedded in ableism and deemed to exclude anyone other to a particular physical form. If more disabled individuals are given opportunities to educate and inform inclusive practices in such settings, this may facilitate health enhancing behaviours for disabled individuals. As Sage (1993) stated:

> "If we become more active in the construction of our social worlds, we become active agents rather than merely the objects of sociohistorial processes;…we make our own history by transforming social structures instead of being dominated by them" (page 154).

I therefore conclude, that it is imperative that we turn to disabled individuals to lead the way in informing us how to challenge the various forms of oppression which marginalize them from being physically active. This thesis can be the first step towards showing how oppressive environments can be more inclusive of disabled individuals; providing the right people are called upon to share their knowledge and be living testimonies of what is possible.

References

Andreasson, J. (2014). 'Shut up and squat!' Learning body knowledge within the gym. *Ethnography and Education*, *9*(1), 1-15.

Andrews, G., Chen, S., & Myers, S. (2014). The 'taking place' of health and well-being: Towards non-representational theory. *Social Science and Medicine*, *108,* 210-222.

Andrews, M. (2014). *Narrative imagination and everyday life*. Oxford, UK: Oxford University Press.

Arbour, K. P., Latimer, A. E., Martin Ginis, K. A., & Jung, M. E. (2007). Moving beyond stigma: The impression formation benefits of exercise for individuals with a physical disability. *APAQ, 24,* 144-159.

Aspire (2017). Retrieved from https://www.aspire.org.uk/ on 12th February 2017.

Avis, M. (2005). Is there an epistemology for qualitative research? In I. Holloway. (Ed.), *Qualitative research in health care* (pp. 3-16)**.** New York: McGraw-Hill Education

Bandura A. (1997). *Self-efficacy: The exercise of control*. New York: Freeman

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs: Prentice-Hall

Batson, C. D., & Powell, A. A. (2003). Altruism and prosocial behavior. *Handbook of Psychology, 19*, 463-484.

Berger, R. J. (2008). Disability and the dedicated wheelchair athlete beyond the "supercrip" critique. *Journal of Contemporary Ethnography*, *37*(6), 647-678.

Bertrand, C., & Bourdeau, L. (2010). Research interviews by Skype: A new data collection method. In J. Esteves (Ed*.), Proceedings of the 9th European conference on research methods* (pp. 70-79). Madrid, Spain: IE Business School.

Blinde, E. M., & McCallister, S. G. (1999). Women, disability, and sport and physical fitness activity: The intersection of gender and disability dynamics. *Research Quarterly for Exercise and Sport*, *70*(3), 303-312.

Blinde, E. M., & Taub, D. E. (1999). Personal empowerment through sport and physical fitness activity: From male college students with physical and sensory disabilities. *Journal of Sport Behaviour, 22*, 181-202.

Bogart, K. R. (2014). The role of disability self-concept in adaptation to congenital or acquired disability. *Rehabilitation Psychology*, *59*(1), 107.

Bondi, L. (2013). Research and therapy: Generating meaning and feeling gaps. *Qualitative Inquiry*, *19*(1), 9-19.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101.

Braun, V., Clarke, V., & Weate, P. (2016). Using thematic analysis in sport and exercise research. In B. Smith & A. C Sparkes (Eds.), *Routledge handbook of qualitative research in sport and exercise* (pp.191-205). London: Routledge.

Brisenden, S. (1986). Independent living and the medical model of disability. *Disability, Handicap & Society*, *1*(2), 173-178.

Brittain, I. (2004). Perceptions of disability and their impact upon involvement in sport for people with disabilities at all levels. *Journal of Sport & Social Issues, 28*(4), 429-452.

Brockmeier, J. (2009). Stories to remember: Narrative and the time of memory. *Storyworlds: A Journal of Narrative Studies*, *1*(1), 115-132.

Bryman, A. (2004). Qualitative research on leadership: A critical but appreciative review. *The Leadership Quarterly*, *15*(6), 729-769.

Bundon, A., & Hurd Clarke, L. (2015). Honey or vinegar? Athletes with disabilities discuss strategies for advocacy within the Paralympic movement. *Journal of Sport and Social Issues*, *39*(5), 351-370.

Burke, S. (2016). Rethinking 'validity'and 'trustworthiness' in qualitative inquiry: How might we judge the quality of qualitative research in sport and exercise sciences. In B. Smith, & A. C. Sparkes (Eds.), *Routledge handbook of qualitative research in sport and exercise* (pp. 330-339). London: Routledge.

Burkitt, I. (2014). *Emotions and social relations*. London: Sage.

Bury, M. (2001). Illness narratives: Fact or fiction? *Sociology of Health and Illness, 23*(3), 263-285.

Buscher, M., Urry, J., & Witchger, K. (2010). *Mobile methods*. Abingdon: Routledge.

Bush, A. J., & Silk, M. L. (2012). Politics, power and the podium: Coaching for Paralympic performance. *Reflective Practice: International and Multidisciplinary Perspectives, 13,* 471-482.

Caddick, N. (2016). Doing narrative analysis. In E. Lyons, & A. Coyne (Eds.), *Analyzing qualitative data in psychology* (2nd ed.), (pp. 222-239). London: Sage.

Caddick, N., Phoenix, C., & Smith, B. (2015). Collective stories and well-being: Using a dialogical narrative approach to understand peer relationships among combat veterans experiencing post-traumatic stress disorder. *Journal of Health Psychology*, *20*(3), 286-299.

Campbell, F. (2001). Inciting legal fictions: Disability's date with ontology and the ableist body of the law. *Griffith Law Review, 10,* 42–62.

Campbell, F. K. (2009). *Contours of ableism: Territories, objects, disability and desire.* London: Palgrave MacMillan.

Campbell, J., & Oliver, M. (2013). *Disability politics: Understanding our past, changing our future.* New York: Routledge.

Canning, K. L., & Hicks, A. L. (2014). Secondary health conditions associated with spinal cord injury. *Critical Reviews in Physical and Rehabilitation Medicine, 26*(3-4), 181-191.

Carless, D. (2008). Narrative, identity, and recovery from serious mental illness: A life history of a runner. *Qualitative Research in Psychology*, *5*(4), 233-248.

Carless, D., & Douglas, K. (2008). Narrative, identity and mental health: How men with serious mental illness re-story their lives through sport and exercise. *Psychology of Sport and Exercise*, *9*(5), 576-594.

Carroll, D. D., Courtney-Long, E. A., Stevens, A. C., Sloan, M. L., Lullo, C., Visser, S. N.,…Dorn, J. N. (2014). Vital signs: Disability and physical activity — United States, 2009–2012. *MMWR, 63*(18), 407-413.

Chamberlain, K., Cain, T., Sheridan, J., & Dupuis, A. (2011). Pluralisms in qualitative research: From multiple methods to integrated methods. *Qualitative Research in Psychology*, *8*(2), 151-169.

Charmaz, K. (2004). Premises, principles, and practices in qualitative research: Revisiting the foundations. *Qualitative Health Research*, *14*(7), 976-993.

Clough, P. T., & Halley, J. (2007). *The affective turn: Theorizing the social*. Durham: Duke University Press.

Coffey, A., & Atkinson, P. (1996). *Making sense of qualitative data: Complementary research strategies*. London: Sage.

Cohen, D., & Crabtree, B. (2006). Qualitative research guidelines project. Retrieved from http://www.qualres.org/HomeSemi-3629.html.

Corker, M. (1996). *Deaf Transitions: Images and origins of deaf families, deaf communities and deaf identities.* London: Jessica Kingsley.

Corning, A. F., & Myers, D. J. (2002). Individual orientation toward engagement in social action. *Political Psychology, 23*, 703-729.

Craig, A., Tran, Y., & Middleton, J. (2009). Psychological morbidity and spinal cord injury: A systematic review. *Spinal Cord*, *47*(2), 108-114.

Crawford, D., & Dearmun, A. (2016). Brittle bone disease. *Nursing Children and Young People*, *28*(7), 17-17.

Cregan, K., Bloom, G. A., & Reid, G. (2007). Career evolution and knowledge of elite coaches of swimmers with a physical disability. *Research Quarterly for Exercise and Sport, 78,* 339-350.

Creswell, J. W. (2012). *Qualitative inquiry and research design: Choosing among five approaches*. Thousand Oaks, California: Sage.

Cromby, J. (2012). Feeling the way: Qualitative clinical research and the affective turn. *Qualitative Research in Psychology*, *9*(1), 88-98.

Cromby, J. (2015). *Feeling bodies: Embodying psychology*. New York: Springer.

Crossley, M. (2000). *Introducing narrative psychology*. London: McGraw-Hill Education.

Crossley, N. (2004). The circuit trainer's habitus: Reflexive body techniques and the sociality of the workout. *Body & Society*, *10*(1), 37-69.

Crossley, N. (2006). In the gym: Motives, meaning and moral careers. *Body & Society*, *12*(3), 23-50.

Crossley, N. (2008). (Net) Working out: Social capital in a private health club. *The British Journal of Sociology*, *59*(3), 475-500.

D'Oliveira, G. L. C., Figueiredo, F. A., Passos, M. C. F., Chain, A., Bezerra, F. F., & Koury, J. C. (2014). Physical exercise is associated with better fat mass distribution and lower insulin resistance in spinal cord injured individuals. *The Journal of Spinal Cord Medicine*, *37*(1), 79-84.

Damasio, A. R., Everitt, B. J., & Bishop, D. (1996). The somatic marker hypothesis and the possible functions of the prefrontal cortex [and discussion]. *Philosophical Transactions of the Royal Society B: Biological Sciences*, *351*(1346), 1413-1420.

Davis, J. M. (2000). Disability studies as ethnographic research and text: Research strategies and roles for promoting social change? *Disability & Society*, *15*(2), 191-206.

Day, M. C., & Wadey, R. (2016). Narratives of trauma, recovery, and growth: The complex role of sport following permanent acquired disability. *Psychology of Sport and Exercise*, *22*, 131-138.

Deakin, H., & Wakefield, K. (2013). Skype interviewing: Reflections of two PhD researchers. *Qualitative Research*, *14*(5), 603-616.

Deal, M. (2003). Disabled people's attitudes toward other impairment groups: A hierarchy of impairments. *Disability & Society, 18*(7), 897-910.

Deegan, M. J., & Brooks, N. A. (1985). *Women and disability: The double handicap*. New Brunswick, NJ: Transaction Publishers.

Denzin, N. K., & Lincoln, Y. S. (2011). *The SAGE handbook of qualitative research*. Thousand Oaks, CA: Sage.

DePauw, K. P. (1997). The (1n) Visibility of disAbility: Cultural contexts and "sporting bodies". *Quest*, *49*(4), 416-430.

DePauw, K. P. (2000). Social-cultural context of disability: Implications for scientific inquiry and professional preparation. *Quest*, *52*(4), 358-368.

DePauw, K. P., & Gavron, S. J. (2005). *Disability and sport* (8th ed.), Champaign, IL: Human Kinetics.

DePauw, K. P., Karwas, M. R., Wharton, A., Bird, S., & Broad, K. (1993, February). Sport and marginality: Theory in progress. In *National Girls and Women in Sport Symposium*.

DePauw, K., & Gavron, S. (2005). *Disability and sport* (2nd ed.), Champaign, IL: Human Kinetics.

Dewsbury, G., Clarke, K., Randall, D., Rouncefield, M., & Sommerville, I. (2004). The anti-social model of disability. *Disability & Society*, *19*(2), 145-158.

Dickson, A., Ward, R., O'Brien, G., Allan, D., & O'Carroll, R. (2011). Difficulties adjusting to post-discharge life following a spinal cord injury: An interpretative phenomenological analysis. *Psychology, Health and Medicine, 16*, 463–474.

Diener, E. (2000). Subjective well-being: The science of happiness and a proposal for a national index. *American Psychologist, 55*(1), 34-43.

Durkin, J., & Joseph, S. (2009). Growth following adversity and its relation with subjective well-being and psychological well-being. *Journal of Loss and Trauma*, *14*(3), 228-234.

Dziura, J. (2015). Psychological adaptation and identity change after the acquisition of a physical disability in adulthood. A critical analysis of an autobiography. *Gallaudet Chronicles of Psychology*, *1*(3), 31-42

English Federation of Disability Sports (2015) Inclusive fitness: Accessibility for all. Retrieved from http://www.efds.co.uk/inclusive_fitness

Finkelstein, V. (2001) The social model repossessed. The Disability Studies Archive UK,

    Centre for Disability Studies, University of Leeds. Available online at:

    www.leeds.ac.uk/disability-studies/archiveuk/archframe.htm (accessed March, 2016).

Finlay, L. (2002a). "Outing" the researcher: The provenance, process, and practice of

    reflexivity. *Qualitative Health Research*, *12*(4), 531-545.

Finlay, L. (2002b). Negotiating the swamp: The opportunity and challenge of reflexivity in

    research practice. *Qualitative Research*, *2*(2), 209-230.

Finlay, L. (2003). The Reflexive journey: Mapping multiple routes. In L. Finlay, & B. Gough

    (Eds.), *Reflexivity: A practical guide for researchers in health and social sciences* (pp.

    3-20)*.* Oxford, UK: Blackwell Science Ltd.

Finlay, L. (2005). "Reflexive embodied empathy": A phenomenology of participant-

    researcher intersubjectivity. *The Humanistic Psychologist*, *33*(4), 271-292.

Fiske, S. T., & Ruscher, J. B. (1993). Negative interdependence and prejudice: Whence the

    affect. In D. M. Mackie, & D. L. Hamilton (Eds.), *Affect, cognition, and stereotyping:*

    Interactive processes in group perception (pp 239-268). San Diego, CA: Academic

    Press.

Fitzgerald, H. (2009). Are you a "parasite researcher"? Researching disability and youth sport.

    In H. Fitzgerald (Ed.) *Disability and youth sport*, (pp 145-159). London: Routledge.

Frank, A. W. (1996). From dysappearance to hyperappearance: Sliding boundaries of illness

    and bodies. *Theory & Psychology*, *6*(4), 733-760.

Frank, A. W. (2005). What is dialogical research, and why might we do it? *Qualitative*

    Health Research, 15, 964-974.

Frank, A. W. (2006). Health stories as connectors and subjectifiers. *Health, 10* (4), 421-440.

Frank, A. W. (2010). *Letting stories breathe: A socio-narratology*. Chicago, IL: University of

    Chicago Press.

Frank, A. W. (2012). Practicing dialogical narrative analysis. In J. Holsterin, & S. Gubrium (Eds.), *Varieties of narrative analysis* (pp. 33-52). London: Sage.

Frank, A. W. (2013). *The wounded storyteller* (2nd ed.). Chicago, IL: University of Chicago Press.

French, S. (1991). The advantages of visual impairment: Some physiotherapists' views. *New Beacon, 75*(872), 1–6.

Frew, M., & McGillivray, D. (2005). Health clubs and body politics: Aesthetics and the quest for physical capital. *Leisure Studies*, *24*(2), 161-175.

Gainforth, H.L., Latimer-Cheung, A.E., Athanasopoulous, P., & Martin Ginis, K.A. (2013). Examining the effectiveness of a knowledge mobilization initiative for disseminating the physical activity guidelines for people with spinal cord injury. *Disability and Health Journal, 6*(3), 260-265.

Garland-Thomson, R. (2009). *Staring: How we look*. Oxford: Oxford University Press.

Geyh, S., Nick, E., Stirnimann, D., Ehrat, S., Muller, R., & Michel, F. (2012). Biopsychosocial outcomes in individuals with and without spinal cord injury: A Swiss comparative study. *Spinal Cord, 50,* 614–622.

Gibbs, G. R. (2008). *Analysing qualitative data*. London: Sage.

Giddens, A. (1991). *Modernity and self-identity: Self and society in the late modern age*. Stanford: Stanford University Press.

Goodley, D. (1999). Disability research and the "researcher template": Reflections on grounded subjectivity in ethnographic research. *Qualitative Inquiry*, *5*(1), 24-46.

Goodley, D. (2011). Social psychoanalytic disability studies. *Disability & society*, *26*(6), 715-728.

Goodley, D. (2013). Dis/entangling critical disability studies. *Disability and Society, 28*(5), 631-644.

Goodley, D. (2016). *Disability studies* (2nd ed.). London: Sage.

Gorgey, A. S. (2014). Exercise awareness and barriers after spinal cord injury. *World Journal of Orthopaedics*, *5*(3), 158-162.

Gough, B. (2003) Deconstructing Reflexivity. In L. Finlay, & B. Gough (Eds.), *Reflexivity: A practical guide for researchers in health and social sciences* (pp. 21-36). Oxford, UK: Blackwell Science Ltd.

Graham, R., Kremer, J., & Wheeler, G. (2008). Physical exercise and psychological well-being among people with chronic illness and disability: A grounded approach. *Journal of Health Psychology, 13,* 447-458.

Gratton, C., & Jones, I. (2004). *Research methods for sports studies*. London: Routledge.

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. London: Sage.

Gubrium, J. F., & Holstein, J. A. (1997). *The new language of qualitative method*. Oxford: Oxford University Press.

Gubrium, J. F., & Holstein, J. A. (2009). *Analysing narrative reality*. London: Sage.

Guillemin, M., & Gillam, L. (2004). Ethics, reflexivity, and "ethically important moments" in research. *Qualitative inquiry*, *10*(2), 261-280.

Gustavsson, A. (2004). The role of theory in disability research-springboard or strait-jacket? *Scandinavian Journal of Disability Research*, *6*(1), 55-70.

Hanna, P. (2012). Using internet technologies (such as Skype) as a research medium: A research note. *Qualitative Research*, *12*(2), 239-242.

Hargreaves, J. (2000). *Heroines of sport: The politics of difference and identity*. London: Routledge.

Harvey, G., Vachhani, S. J., & Williams, K. (2014). Working out: Aesthetic labour, affect and the fitness industry personal trainer. *Leisure studies*, *33*(5), 454-470.

Heller, T., Ying, G. S., Rimmer, J., & Marks, B. A. (2002). Determinants of exercise in adults with cerebral palsy. *Public Health Nursing*, *19*(3), 223-231.

Henderson, K. A., & Bedini, L. A. (1995). "I have a soul that dances like Tina Turner, but my body can't": Physical activity and women with mobility impairments. *Research Quarterly for Exercise and Sport*, *66*(2), 151-161.

Hermanowicz, J. C. (2013). The longitudinal qualitative interview. *Qualitative Sociology*, *36*(2), 189-208.

Hicks, A. L., Martin, K. A., Ditor, D. S., Latimer, A. E., Craven, C., Bugaresti, J., & McCartney, N. (2003). Long-term exercise training in persons with spinal cord injury: Effects on strength, arm ergometry performance and psychological well-being. *Spinal Cord, 41*, 34-43.

Hornstein, H. A. (1982). Promotive tension. In V. J Derlega, & J. Grzelak (Eds.), *Cooperation and helping behavior: Theories and research*, (pp. 229-248).San Diego, CA: Academic Press.

Huber, M., Knottnerus, J. A., Green, L., van der Horst, H., Jadad, A. R., Kromhout, D.,… & Smid, H. (2011). How should we define health? *British Medical Journal, 343*, 1-3.

Hughes, B. (1999). The constitution of impairment: Modernity and the aesthetic of oppression. *Disability & Society*, *14*(2), 155-172.

Hughes, B., & Paterson, K. (1997). The social model of disability and the disappearing body: Toward a sociology of impairment. *Disability and Society, 12*(3), 325-340.

InstructAbility (2017). Retrieved from http://www.instructability.org.uk/ on 19th February 2017.

Janghorban, R., Roudsari, R. L., & Taghipour, A. (2014). Skype interviewing: The new generation of online synchronous interview in qualitative research. *International Journal of Qualitative Studies on Health and Well-being*, *9*.

Johnson, M. (2003). *Make them go away: Clint Eastwood, Christopher Reeve and the case against disability rights*. USA: Advocado Press**.**

Jones, P. (2006). Equality, recognition and difference. *Critical Review of International Social and Political Philosophy, 9*(1), 23-46.

Jovanovic, V. (2011). Personality and subjective well-being: One neglected model of personality and two forgotten aspects of subjective well-being. *Personality & Individual Differences*, *50*(5), 631-635.

Kama, A. (2004). Supercrips versus the pitiful handicapped: Reception of disabling images by disabled audience members. *Communications*, *29*(4), 447-466.

Kay, T., Dudfield, O., & Kay, C. (2010). *The Commonwealth guide to advancing development through sport*. London: Commonwealth Securitat.

Keats, P. A. (2009). Multiple text analysis in narrative research: Visual, written, and spoken stories of experience. *Qualitative Research*, *9*(2), 181-195.

Kehn, M., & Kroll, T. (2009). Staying physically active after spinal cord injury: A qualitative exploration of barriers and facilitators to exercise participation. *BMC Public Health, 9,* 168-179.

Keyes, C. L., Shmotkin, D., & Ryff, C. D. (2002). Optimizing well-being: The empirical encounter of two traditions. *Journal of Personality and Social Psychology, 82*(6), 1007- 1022.

Kitchin, R. (1998). 'Out of place',' knowing one's place': Space, power and the exclusion of

disabled people. *Disability & Society*, *13*(3), 343-356.

Krigger, K. W. (2006). Cerebral palsy: An overview. *Am Fam Physician*, *73*(1), 91-100.

Lahman, M. K., Geist, M. R., Rodriguez, K. L., Graglia, P., & DeRoche, K. K. (2011).

Culturally responsive relational reflexive ethics in research: The three Rs. *Quality &*

Quantity, *45*(6), 1397-1414.

Latimer A. E., Martin Ginis K. A., Arbour, K. P. (2006). The efficacy of an implementation

intention intervention for promoting physical activity among individuals with spinal

cord injury: A randomized controlled trial. *Rehabilitation Psychology*, *51*(4), 273–280.

Letts, L., Ginis, K. A. M., Faulkner, G., Colquhoun, H., Levac, D., & Gorczynski, P. (2011).

Preferred methods and messengers for delivering physical activity information to

people with spinal cord injury: A focus group study. *Rehabilitation Psychology*, *56*(2),

128-137.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Linley, P., Maltby, J., Wood. A., Osborne, G., & Hurling, R. (2009). Measuring happiness:

The higher order factor structure of subjective and psychological well-being measures.

Personality & Individual Differences, *47*(8), 878-884.

Llewellyn, A., & Hogan, K. (2000). The use and abuse of models of disability. *Disability &*

Society, 15(1), 157-165.

Lloyd, C. (2005). Competitive strategy and skills: Working out the fit in the fitness industry.

Human Resource Management Journal, *15*(2), 15-34.

Loja, E., Costa, M. E., Hughes, B., & Menezes, I. (2013). Disability, embodiment and

ableism: Stories of resistance. *Disability and Society, 28,* 190-203.

Lundqvist, C. (2011). Well-being in competitive sports – The feel good factor? A review of conceptual considerations of well-being. *International Review of Sport and Exercise Psychology*, *4*(2), 109-127

Lutz, B. J., & Bowers, B. J. (2005). Disability in everyday life. *Qualitative Health Research,* *15*(8), 1037- 1054.

Macbeth, J. L. (2010). Reflecting on disability research in sport and leisure settings. *Leisure Studies*, *29*(4), 477-485.

MacIntyre, A*.* (1967). *Egoism and altruism.* In P. Edwards (Ed.), *The encyclopedia of philosophy*. (pp. 462–466). New York: Macmillan.

Madill, A., & Gough, B. (2008). Qualitative research and its place in psychological science. *Psychological Methods*, *13*(3), 254.

Martin Ginis, K. A., Jörgensen, S., & Stapleton, J. (2012). Exercise and sport for persons with spinal cord injury. *PM&R*, *4*(11), 894-900.

Martin Ginis, K. A., Latimer, A. E., Arbour-Nicitopoulos, K. P., Buchholz, A. C., Bray, S. R., Craven, B. C., ... & Smith, K. (2010). Leisure time physical activity in a population-based sample of people with spinal cord injury part I: Demographic and injury-related correlates. *Archives of Physical Medicine and Rehabilitation*, *91*(5), 722-728.

Martin Ginis, K. A., Nigg, C. R., & Smith, A. L. (2013). Peer-delivered physical activity interventions: an overlooked opportunity for physical activity promotion. *Translational Behavioral Medicine*, 3(4), 434-443.

Martin, J. J. (2013). Benefits and barriers to physical activity for individuals with disabilities: A social-relational model of disability perspective. *Disability and Rehabilitation*, *35*(24), 2030-2037.

Mattingly, C. (1998). *Healing dramas and clinical plots: The narrative structure of experience*. Cambridge, UK: Cambridge University Press.

Mayer, F. W. (2014). *Narrative politics: Stories and collective action*. Oxford: Oxford University Press.

Maykut, P., & Morehouse, R. (1994). The qualitative posture: Indwelling. In P. Maykut & R. Morehouse (Eds.), *Beginning qualitative research: A philosophic and practical guide*, (pp. 25-40). London: Farmer Press.

McAdams, D. P. (1993). *The stories we live by: Personal myths and the making of the self*. Guilford Press.

McGannon, K. R., & Smith, B. (2015). Centralizing culture in cultural sport psychology research: The potential of narrative inquiry and discursive psychology. *Psychology of Sport and Exercise*, *17*(7), 79-87.

McLean, K. C., & Pratt, M. W. (2006). Life's little (and big) lessons: Identity statuses and meaning-making in the turning point narratives of emerging adults. *Developmental Psychology*, *42*(4), 714.

McLeod, J. (1997). *Narrative and psychotherapy*. Thousand Oaks, CA: Sage.

Medved, M. I., & Brockmeier, J. (2008). Continuity amid chaos: Neurotrauma, loss of memory, and sense of self. *Qualitative Health Research*, *18*(4), 469-479.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: A sourcebook*. Thousand Oaks, CA: Sage.

Miller, P., Parker, S. & Gillinson, S. (2004). *Disablism: How to tackle the last prejudice*. London: Demos.

Miller, T., Birch, M., Mauthner, M., & Jessop, J. (2012). *Ethics in qualitative research*. London: Sage.

Morris, J. (2014). *Pride against prejudice: Transforming attitudes to disability*. London: The Woman's Press Ltd.

Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research*, *25*(9), 1212-1222.

Naidoo, P. (2006). Potential contributions to disability theorizing and research from positive psychology. *Disability and Rehabilitation*, *28*(9), 595-602.

Nazli, A. (2012). "I'm healthy": Construction of health in disability. *Disability and Health Journal, 5*(4), 233-240.

Nelson, H. L., & Lindemann, H. (2001). *Damaged identities, narrative repair*. Ithaca, NY: Cornell University Press.

Neville, R. D., & Gorman, C. (2016). Getting 'in' and 'out of alignment': Some insights into the cultural imagery of fitness from the perspective of experienced gym adherents. *Qualitative Research in Sport, Exercise and Health*, *8*(2), 147-164.

Norrbrink, C., Lindberg, T., Wahman, K., & Bjerkefors, A. (2012). Effects of an exercise programme on musculoskeletal and neuropathic pain after spinal cord injury—results from a seated double-poling ergometer study. *Spinal Cord*, *50*(6), 457-461.

O'Reilly, M., & Parker, N. (2013). 'Unsatisfactory saturation': A critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative Research*, *13*(2), 190-197.

Oliver, M. (1996). *Understanding disability: From theory to practice*. New York: St Martin's Press.

Oliver, M. (2013). The social model of disability: Thirty years on. *Disability & Society*, *28*(7), 1024-1026.

Olkin, R. (2009). Disability-affirmative therapy. In M A. Stebnicki (Ed.), *The professional counsellor's desk reference*, (2nd ed.)(pp. 355-369). New York: Springer.

Owens, J. (2015). Exploring the critiques of the social model of disability: The transformative possibility of Andredt's notion of power. *Sociology of Health and Illness, 3*7(3), 385-403.

Papathomas, A., & Lavallee, D. (2012). Narrative constructions of anorexia and abuse: An athlete's search for meaning in trauma. *Journal of Loss and Trauma*, *17*(4), 293-318.

Papathomas, A., Williams, T. L., & Smith, B. (2015). Understanding physical activity participation in spinal cord injured populations: Three narrative types for consideration. *International Journal of Qualitative Studies on Health and Well-being*, *10.*

Parsons, J. A., & Lavery, J. V. (2012). Brokered dialogue: A new research method for controversial health and social issues. *BMC Medical Research Methodology*, *12*(1), 92.

Partington, E., Partington, S., Fishwick, L., & Allin, L. (2005). Mid-life nuances and negotiations: Narrative maps and the social construction of mid-life in sport and physical activity. *Sport, Education and Society*, *10*(1), 85-99.

Patton, M. Q. (2002). *Qualitative research and evaluation methods*. Thousand Oaks, CA: Sage.

Penedo, F. J., & Dahn, J. R. (2005). Exercise and well-being: A review of mental and physical health benefits associated with physical activity. *Current Opinion in Psychiatry*, *18*(2), 189-193.

Perrier, M-J., Smith, B., & Latimer-Cheung, A. E. (2013). Narrative environments and the

    capacity of disability narratives to motivate leisure-time physical activity among

    individuals with spinal cord injury. *Disability and Rehabilitation 35*(24), 2089-2096.

Phoenix, C., & Smith, B. (2011). Telling a (good?) counterstory of aging: Natural

    bodybuilding meets the narrative of decline. *The Journals of Gerontology Series B:*

    Psychological Sciences and Social Sciences, *66,* 628-639.

Phoenix, C., & Sparkes, A. C. (2006). Young athletic bodies and narrative maps of aging.

    Journal of Aging Studies, *20*(2), 107-121.

Phoenix, C., & Sparkes, A. C. (2007). Sporting bodies, ageing, narrative mapping and young

    team athletes: An analysis of possible selves. *Sport, Education and Society*, *12*(1), 1-

    17.

Pollner, M., & Stein, J. (1996). Narrative mapping of social worlds: The voice of experience

    in Alcoholics Anonymous. *Symbolic Interaction*, *19*(3), 203-223.

Randall, W. L., & Phoenix, C. (2009). The problem with truth in qualitative interviews:

    Reflections from a narrative perspective. *Qualitative Research in Sport and Exercise,*

    1(2), 125-140.

Reeve, D (2013). Psycho-emotional disablism. In C. Cameron (Ed.), *Disability studies: A*

    student's guide (pp. 121-124). Sage, London.

Reeve, D. (2004). Psycho-emotional dimensions of disability and the social model. In C.

    Barnes & G. Mercer (Eds.), *Implementing the social model of disability: Theory and*

    research (pp. 83-100). Leeds: The Disability Press.

Reeve, D. (2006). Towards a psychology of disability: The emotional effects of living in a

    disabling society. In D. Goodley, & R. Lawthom (Eds.), *Disability and psychology:*

    critical introductions and reflections (pp. 94-107). London: Palgrave.

Reeve, D. (2012). Psycho-emotional disablism: The missing link? In N. Watson, A. Roulstone, & C. Thomas (Eds.), *Routledge handbook of disability studies* (pp. 78-92). London: Routledge.

Richardson, L. (1990). Narrative and sociology. *Journal of Contemporary Ethnography*, *19*(1), 116-135.

Richardson, L. (2000). New writing practices in qualitative research. *Sociology of Sport Journal*, *17*(1), 5-20.

Riessman, C. K. (1993). *Narrative Analysis*. Newbury Park, CA: Sage.

Riley, C. A. (2005). *Disability and the media: Prescriptions for change*. Lebanon, NH: United Press of New England.

Rimmer, J. H. (1999). Health promotion for people with disabilities: The emerging paradigm shift from disability prevention to prevention of secondary conditions. *Physical Therapy*, *79*(5), 495-502.

Rimmer, J. H., & Marques, A. C. (2012). Physical activity for people with disabilities. *The Lancet*, *380*(9838), 193-195.

Rimmer, J. H., Riley, B., Wang, E., Rauworth, A., & Jurkowski, J. (2004). Physical activity participation among persons with disabilities: Barriers and facilitators. *American Journal of Preventative Medicine, 26,* 419-425.

Rolfe, D. E., Yoshida, K., Renwick, R., & Bailey, C. (2009). Negotiating participation: How women living with disabilities address barriers to exercise. *Health Care for Women International, 30,* 743-766.

Rossing, H., Ronglan, L. T., & Scott, S. (2016). 'I just want to be me when I am exercising': Adrianna's construction of a vulnerable exercise identity. *Sport, Education and Society*, *21*(3), 1-17.

Ryan, R. M., & Deci, E. L. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. *Annual Review of Psychology, 52*(1), 141-166.

Ryff, C. D., & Keyes, C. L. M. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology, 69*(4), 719-727.

Sage, G.H. (1993). Sport and physical education and the new world order: Dare we be agents of social change? *Quest*, 45, 151-164.

Sarbin, T. R. (1986). *Narrative psychology: The storied nature of human conduct*. Connecticut: Greenwood Publishing Group.

Sassatelli, R. (2006). Fit Bodies. Fitness Culture and the Gym. In: F. Bonami

et al., (eds.), *Human game. Winners and losers* (pp. 252-261) Charta: Milano.

Sassatelli, R. (2010). *Fitness culture: gyms and the commercialisation of discipline and fun*. Basingstoke: Palgrave Macmillan.

Scelza, W. M., Kalpakjian, C. Z., Zemper, E. D., & Tate, D. G. (2005). Perceived barriers to exercise in people with spinal cord injury. *American Journal of Physical Medicine & Rehabilitation*, *84*(8), 576-583.

Schwenk, C. R. (1988). The cognitive perspective on strategic decision making. *Journal of Management Studies*, *25*(1), 41-55.

Shakespeare, T. (1994). Cultural representation of disabled people: dustbins for disavowal? *Disability and Society*, *9*(3), 283-299.

Shakespeare, T. (1996). Disability, identity and difference. In C. Barnes & G. Mercer (Eds.), *Exploring the divide* (pp. 94–113). Leeds, UK: The Disability Press.

Shakespeare, T. (2006). The social model of disability. *The Disability Studies Reader*, *2*, 197-204.

Shakespeare, T. (2014). *Disability rights and wrongs revisited*. Oxford: Routledge.

Shakespeare, T., & Watson, N. (1997). Defending the social model. *Disability & Society*, *12*(2), 293-300.

Shotter, J. (1993). *Cultural politics of everyday life: Social constructionism, rhetoric and knowing of the third kind*. Ontario: University of Toronto Press.

Silva, C. F., & Howe, P. D. (2012). The (in) validity of supercrip representation of Paralympian athletes. *Journal of Sport & Social Issues*, *36*(2), 174-194.

Skaalvik, E. M., & Skaalvik, S. (2002). Internal and external frames of reference for academic self-concept. *Educational Psychologist*, *37*(4), 233-244.

Smith Maguire, J. (2001). Fit and flexible: The fitness industry, personal trainers and emotional service labour. *Sociology of Sport Journal, 18*(4), 379-402.

Smith Maguire, J. (2008). Leisure and the obligation of self-work: An examination of the fitness field. *Leisure Studies*, *27*(1), 59-75.

Smith, B. (2010). Narrative inquiry: Ongoing conversations and questions for sport and exercise psychology research. *International Review of Sport and Exercise Psychology, 3*(1), 87-107.

Smith, B. (2016). Narrative analysis in sport and exercise: How can it be done? In B. Smith, & A. C. Sparkes (Eds.), *Routledge handbook of qualitative research in sport and exercise* (pp. 260-273). London: Routledge.

Smith, B. (2016). Narrative analysis. In E. Lyons, & A. Coyne (Eds.), *Analysing qualitative data in psychology* (2nd ed.), (pp. 202-221). London: Sage

Smith, B. M. (2013). Sporting spinal cord injuries, social relations, and rehabilitation narratives: An ethnographic creative non-fiction of becoming disabled through sport. *Sociology of Sport Journal, 30*(2), 132-152.

Smith, B., & Bundon, A. (2016) Disability models: Explaining & understanding disability

    sport. In I. Brittain, & A. Beacom (Eds.), *Palgrave handbook of Paralympic studies.*

    Palgrave: Basingstoke.

Smith, B., & Caddick, N. (2012). Qualitative methods in sport: A concise overview for

    guiding social scientific sport research. *Asia Pacific Journal of Sport and Social*

    Science, *1*(1), 60-73.

Smith, B., & Perrier, M.-J. (2014). Disability, sport, and impaired bodies: A critical approach.

    In R. J. Schinke, & K. R. McGannon (Eds.), *The psychology of sub-culture in sport*

    and physical activity: Critical Perspectives (pp. 95-106). London: Routledge.

Smith, B., & Sparkes, A. C. (2008). Changing bodies, changing narratives and the

    consequences of tellability: A case study of becoming disabled through sport.

    Sociology of Health & Illness, *30*(2), 217-236.

Smith, B., & Sparkes, A. C. (2009) Narrative inquiry in sport and exercise psychology: What

    can it mean, and why might we do it? *Psychology of Sport and Exercise, 10*(1), 1–11.

Smith, B., Bundon, A., & Best, M. (2016). Disability sport and activist identities: A

    qualitative study of narratives of activism among elite athletes' with

    impairment. *Psychology of Sport and Exercise*, *26*, 139-148.

Söder, M. (2009). Tensions, perspectives and themes in disability studies. *Scandinavian*

    Journal of Disability Research, *11*(2), 67-81.

Sparkes, A. C. (1999). Exploring body narratives. *Sport, Education and Society*, *4*(1), 17-30.

Sparkes, A. C. (2002). *Telling tales in sport and physical activity: A qualitative journey.*

    Champaign. IL: Human Kinetics Press.

Sparkes, A. C. (2005). Narrative analysis: Exploring the whats and hows of personal stories.

    Qualitative Research in Health Care, *1*, 191-209.

Sparkes, A. C., & Smith, B. (2002). Sport, spinal cord injury, embodied masculinities, and the dilemmas of narrative identity. *Men and Masculinities*, *4*(3), 258-285.

Sparkes, A. C., & Smith, B. (2014). *Qualitative research methods in sport, exercise and health: From process to product*. London: Routledge.

Sparkes, A.C. (2002). *Telling tales in sport and physical activity: A qualitative journey*. Champaign, IL: Human Kinetics.

Sporner, M. L., Fitzgerald, S. G., Dicianno, B. E., Collins, S., Teodoreski, P. F., Pasquina, P. F., & Cooper, R. A. (2009). Psychosocial impact of participation in the National Veterans Wheelchair Games and Winter sports clinic. *Rehabilitation in Practice, 31*(5), 410-418.

Stake, R. E. (1995). *The art of case study research*. Thousand Oaks, CA: Sage.

Standal, O.F, & Jespersen, E. (2008). Peers as resources for learning: A situated learning approach to adapted physical activity in rehabilitation. *APAQ, 25,* 208-227.

Stensrud, S., Risberg, M. A., & Roos, E. M. (2015). Effect of exercise therapy compared with arthroscopic surgery on knee muscle strength and functional performance in middle-aged patients with degenerative meniscus tears: A 3-month follow-up of a randomized controlled trial. *American Journal of Physical Medicine and Rehabilitation, 94(6),* 460–73.

Stone, E., & Priestley, M. (1996). Parasites, pawns and partners: Disability research and the role of non-disabled researchers. *British Journal of Sociology*, *47*(4) 699-716.

Swain, J., & French, S. (2000). Towards an affirmation model of disability. *Disability & Society*, *15*(4), 569-582.

Tate, D. G., Forchheimer, M., Bombardier, C. H., Heinemann, A. W., Neumann, H. D., & Fann J. R. (2015). Differences in quality of life outcomes among depressed spinal

cord injury trial participants. *Archive of Physical Medicine and Rehabilitation, 96,* 340–348.

Taylor, C. (1994). The politics of recognition. In. A. Gitmann (Ed.), *Multiculturism: Examining the Politics of Recognition* (pp. 25-73). Princeton, NJ: Princeton University Press.

Thomas, C. (1999). *Female forms: Experiencing and understanding disability*. Buckingham, UK: Open University Press.

Thomas, C. (2004). How is disability understood? An examination of sociological approaches. *Disability & Society*, *19*(6), 569-583.

Thomas, C. (2007). *Sociologies of disability and illness: Contested ideas in disability studies and medical sociology*. London: Palgrave Macmillan.

Thomas, C. (2008). Disability: Getting it "right". *Journal of Medical Ethics, 34*(1), 15-17.

Thomas, C. (2014). Disability and impairment. In J. Swain, S. French, C. Barnes, & C. Thomas (Eds.), *Disabling barriers – enabling environments* (3rd ed.), (pp. 9-16). London: Sage.

Thorne, A., McLean, K. C., & Lawrence, A. M. (2004). When remembering is not enough: Reflecting on self‑defining memories in late a dolescence. *Journal of Personality*, *72*(3), 513-542.

Tomasone, J. R., Wesch, N., Martin Ginis, K. A., & Noreau, L. (2013). Spinal cord injury, physical activity, and quality of life: A systematic review. *Kinesiology Review, 2*(1), 113-129.

Townsend, R. C, Smith, B., & Cushion, C. (2015). Disability sports coaching: Towards a critical understanding. *Sports Coaching Review, 4*(2), 80-98.

Tulle, E., & Dorrer, N. (2012). Back from the brink: Ageing, exercise and health in a small gym. *Ageing and Society*, *32*(7), 1106-1127.

Turner, B. (1996). The body and society: Explanations in social theory. Thousand Oaks, CA: Sage.

Tyrell, A., Hetz, S. P., Barg, C., & Latimer, A. E. (2010). Using exercise for the stigma management of individuals with on set-controllable and onset- uncontrollable spinal cord injury. *Rehabilitation Psychology, 55,* 383-90.

Vissers, M., Van den Berg-Emons, R., Sluis, T., Bergen, M., Stam, H., & Bussmann, H. (2008). Barriers to and facilitators of everyday physical activity in persons with a spinal cord injury after discharge from the rehabilitation centre. *Journal of Rehabilitation Medicine*, *40*(6), 461-467.

Walmsley, J. (2004). Inclusive learning disability research: The (nondisabled) researcher's role. *British Journal of Learning Disabilities*, *32*(2), 65-71.

Walsh, R., & Koelsch, L. E. (2012). Building across fault lines in qualitative research. *The Humanistic Psychologist*, *40*(4), 380-390.

Watson, N. (2002). 'Well, I know this is going to sound very strange to you, but I do not see myself as a disabled person.' *Disability and Society, 17*(5): 509-527.

Wendell, S. (1996). *The rejected body: Feminist philosophical reflections on disability*. London: Routledge.

Whitley, M. A., Massey, W.V., & Leonetti, N.M. (2016). 'Greatness (un)channelled': The role of sport in the life of an elite athlete who overcome multiple developmental risk factors. *Qualitative Research in Sport, Exercise and Health, 8,* 194-212.

Williams, T. L., Smith, B., & Papathomas, A. (2014). The barriers, benefits and facilitators of leisure time physical activity among people with spinal cord injury: A meta-synthesis of qualitative findings. *Health Psychology Review*, *8*(4), 404-425.

Willig, C. (2013). *Introducing qualitative research in psychology*. London: McGraw-Hill Education.

Wolbring, G. (2008). The politics of ableism. *Development*, *51*(2), 252-258.

Wolcott, H. F. (2005). *The art of fieldwork* (2nd ed.), Lanham, MD: AltaMira Press.

World Health Organization. (2015). *Health*. http://www.who.int/trade/glossary/story046/en/ retrieved on 5th November 2016.

YMCFit (2017). Retrieved from http://www.ymcafit.org.uk/ on 19th February 2017.

Appendix A: InstructAbility Trainee Information Sheet

The impact of participation in a fitness instructor programme on quality of life of physically disabled participants

Adult Participant Information Sheet

Emma Richardson, Loughborough University, SSEHS, Loughborough, LE11 3TU,

E-mail: e.richardson3@lboro.ac.uk, contact number: 01509222757

Dr Brett Smith, Loughborough University, SSEHS, Loughborough, LE11 3TU,

E-mail: b.m.smith@lboro.ac.uk, contact number: 01509222737

What is the purpose of the study?

The purpose of this study is to investigate how the quality of life and physical health of physically disabled individuals is impacted through participation in a fitness instructors course aimed at people with a disability.

By investigating this area it is hoped that researchers will gain knowledge regarding experiences of this type of programme and inform future practice regarding physical activity and physical disability.

Who is doing this research and why?

This study is part of a PhD research project supported by Loughborough University. . The research will be carried out by Emma Richardson, a PhD student at Loughborough University, under the supervision of Dr Brett Smith. This research is supported by Aspire

Are there any exclusion criteria?

Participants must be participants of InstructAbility and have a physical disability. Also, participants must be 16 years or over.

What will I be asked to do?

You will be asked to take part in 5 interviews at different stages of the programme; before you begin the course, half way through the course, the end of the course, after level 3 training and during your work placement. At each interview session you will also be asked to complete 2 questionnaires; one about your quality or life and one about your physical activity levels.

At the familiarisation session you will be asked to complete the quality of life and physical activity questionnaires

At the first session (induction day) you will be asked to take part in an interview lasting between 1 and 2 hours and complete the quality of life questionnaire.

At the second session (half way through level 2 training) you will be asked to take part in an interview lasting between 1 and 2 hours and complete the quality of life questionnaire

At the third session (the end of level 2) you will be asked to take part in an interview lasting between 1 and 2 hours and complete both questionnaires.

At the fourth session you will be asked to take part in an interview lasting between 1 and 2 hours and complete the quality of life questionnaire.

At the fifth session you will be asked to take part in an interview lasting between 1 and 2 hours and complete both questionnaires.

Once I take part, can I change my mind?

Yes! After you have read this information and asked any questions you may have we will ask you to complete an Informed Consent Form, however if at any time, before, during or after the sessions you wish to withdraw from the study please just contact the main investigator. You can withdraw at any time, for any reason and you will not be asked to explain your reasons for withdrawing.

Will I be required to attend any sessions and where will these be?

You will be required to take part in 5 sessions throughout your InstructAbility programme. These will take place either at the leisure centre or gym you are receiving your training or doing your placement.

How long will it take?

The interviews should take no more than 2 hours and the questionnaire no more than 15 minutes each.

What personal information will be required from me?

Just your experiences of being part of the programme, your life before, during and after taking part in InstructAbility and your experiences of being disabled.

Are there any risks in participating?

There are no foreseen risks in taking part.

Will my taking part in this study be kept confidential?

Your interview will be recorded and transcribed. Details of your answers/audio files/transcriptions will be kept in a secure location in the university and any names will be changed to allow for privacy. Your stories/thoughts/words may be used in the research paper. Your answers will be kept on record for 3 years and then destroyed

I have some more questions; who should I contact?

If you have any questions you can contact Emma via email at
e.richardson3@.lboro.ac.uk

What will happen to the results of the study?

The results of the study will be written up as an academic paper, part of a PhD thesis and potentially published.

What if I am not happy with how the research was conducted?

If you are not happy with how the research was conducted, please contact Mrs Zoe Stockdale, the Secretary for the University's Ethics Approvals (Human Participants) Sub-Committee:

Mrs Z Stockdale, Research Office, Rutland Building, Loughborough University, Epinal Way, Loughborough, LE11 3TU. Tel: 01509 222423. Email:
Z.C.Stockdale@lboro.ac.uk

The University also has a policy relating to Research Misconduct and Whistle Blowing which is available online at
http://www.lboro.ac.uk/admin/committees/ethical/Whistleblowing(2).htm.

Investigating the impact of disabled fitness instructors in the gym environment.

Adult Participant Information Sheet

Emma Richardson, Peter Harrison Centre for Disability Sport, Loughborough University, LE11 3TU, <u>e.richardson3@lboro.ac.uk</u>, 01509 222757

Dr. Brett Smith, Peter Harrison Centre for Disability Sport, Loughborough University, LE11 3TU, b.m.smith@lboro.ac.uk, 01509 222737

What is the purpose of the study?

The purpose of this study is to investigate what impact physically disabled fitness instructors have in a gym environment. This may include the built environment, attitudes and perceptions of disability and the general atmosphere in the gym.

By investigating this area, it is hoped that researchers will gain knowledge regarding the experiences of instructors and the potential impact they can have in this environment. It is hoped results could inform future practices regarding physical activity and physical disability.

Who is doing this research and why?

This study will be part of a PhD project supported by Loughborough University. The research will be carried out by Emma Richardson, a PhD student at Loughborough University, under the supervision of Dr Brett Smith. This research is supported by Aspire.

Are there any exclusion criteria?

Participants must have completed their InstructAbility qualification and be in current employment (full time, part time or casual contract) at a gym or leisure centre.

What will I be asked to do?

You will be asked to take part in a one to one interview with Emma discussing your experiences of InstructAbility and working in a gym. You can elect a time and place in which you feel most comfortable and best fits in to your schedule.

Once I take part, can I change my mind?

Yes! After you have read this information and asked any questions you may have we will ask you to complete an Informed Consent Form, however if at any time, before, during or after the sessions you wish to withdraw from the study please just contact the main investigator. You can withdraw at any time, for any reason and you will not be asked to explain your reasons for withdrawing. However, once the results

of the study are aggregated/published/dissertation has been submitted it will not be possible to withdraw your individual data from the research.

Will I be required to attend any sessions and where will these be?

Interviews will be conducted at a time and place best suited to your schedule and where you feel most comfortable.

How long will it take?

The interviews should take between 1 and 2 hours.

What personal information will be required from me?

Just your experiences and stories of being part of the programme and working in a gym environment.

Are there any risks in participating?

There are no foreseen risks in taking part

Will my taking part in this study be kept confidential?

Your interview will be recorded and transcribed. Details of your answers/ audio files/ transcriptions will be kept in a secure location in the university and any names will be changed to allow for privacy. Your stories/ thoughts/ words may be used in the research paper. Your answers will be kept on record for 3 years and then destroyed.

I have some more questions; who should I contact?

If you have any questions you can contact Emma via e-mail at e.richardson3@lboro.ac.uk.

What will happen to the results of the study?

The results of the study will be written up as an academic paper, part of a PhD thesis and potentially published.

What if I am not happy with how the research was conducted?

If you are not happy with how the research was conducted, please contact Ms Jackie Green, the Secretary for the University's Ethics Approvals (Human Participants) Sub-Committee:

Ms J Green, Research Office, Hazlerigg Building, Loughborough University, Epinal Way, Loughborough, LE11 3TU. Tel: 01509 222423. Email: J.A.Green@lboro.ac.uk

The University also has a policy relating to Research Misconduct and Whistle Blowing which is available online at http://www.lboro.ac.uk/admin/committees/ethical/Whistleblowing(2).htm.

Is there anything I need to do before the sessions?

Please think of any stories or experiences you feel are important in regards to your InstructAbility training and what impact you have seen/ feel you have had at your work.

Loughborough University

Investigating the experiences and impact of gym instructors with physical disabilities.

INFORMED CONSENT FORM
(to be completed after Participant Information Sheet has been read)

The purpose and details of this study have been explained to me. I understand that this study is designed to further scientific knowledge and that all procedures have been approved by the Loughborough University Ethical Approvals (Human Participants) Sub-Committee.

I have read and understood the information sheet and this consent form.

I have had an opportunity to ask questions about my participation.

I understand that I am under no obligation to take part in the study.

I understand that I have the right to withdraw from this study at any stage for any reason, and that I will not be required to explain my reasons for withdrawing.

I understand that all the information I provide will be treated in strict confidence and will be kept anonymous and confidential to the researchers unless (under the statutory obligations of the agencies which the researchers are working with), it is judged that confidentiality will have to be breached for the safety of the participant or others.

I agree to participate in this study.

Your name

_____

Your signature

_____

Signature of investigator

_____

Date

_____

Appendix D: Interview Guide Pre-InstructAbility

<u>**Interview Guide – Case Studies Pre Instructors Course**</u>

Aim – gain an idea of individual's life at the moment (before InstructAbility course), their experiences of disability, how they feel about themselves and expectations of the course

'Grand Tour'

- Can you tell me about yourself?
    - Age, nationality, where they're from etc.?
- Can you tell me about your injury? (don't have to go into a great deal of detail)
    - Type, years since injury

Life Pre-Injury

- Can you tell me about your life before your injury?
    - Employment
    - Sport/ physical activities?
    - Other leisure time activities – hobbies etc.
    - Social life
- Can you describe how you felt at that time?
    - How would you describe yourself as an individual?
    - What was your general mood like?

Life Now

- Can you tell me about your life now?
    - How do you spend your time?
    - Employment?
    - Sport/ physical activities?
    - Other hobbies?
    - Social life
    - Experiences doing exercise/physical activity
        - Rehab?
        - If no participation ask why.
- Can you tell be about your experiences being disabled?
    - General day to day
    - Barriers
        - Social/environmental
    - Attitudes to disability
- Can you describe how you feel now?
    - How would you describe yourself as an individual?
    - What's your general mood like?
- Can you tell me about you experiences in the gym?
    - Instructors, build environment, atmosphere, experiences

- What does the gym mean to you?
- How would you describe the gym in a few words?
- In respect to someone with a disability, how can the gym be improved?
- What does being physically fit mean to you?

Programme Expectations

- What were your motivations for signing up for the programme?
  - Why are you interested?
  - How are you feeling about starting?
    - Nervous?
    - Excited?
    - Reasons why
- What are your expectations for the programme
  - Programme itself
  - After the programme
- How do you feel going into the programme?
- Is there anything you would like to add or I haven't asked you?

Appendix E: Interview Guide During InstructAbility

Interview Guide During Programme

Aim –how course is going, experiences of the course, expectations being met, how feeling well-being wise, what life's like now, what's changed

Recap Last Interview

- What life was like/typical day
- What expectation of programme were
- Going over of questionnaire
- Has anything change? What's changed?

Programme

- How have you found the programme?
    - Lessons/course
    - Instructors
    - Other people on the course
- How has it met your expectations so far?
- How are you feeling about your work placement?
    - Do you feel prepared?
- Have there been any barriers to attending the course?
- What's been the most memorable part of the course?

Life Now

- Can you describe a typical day to me now?
- What do you do outside the programme?
    - Social life
    - Hobbies
- How do you feel about yourself now?

Close

- Is there anything you would like to add or I haven't asked you?

Appendix F: Interview Guide Post InstructAbility

Interview Guide Post Programme

Aim – experiences of programme, experiences of placement, how feel about themselves, how things have changed, what is life like now

Recap Last Interview

Programme

- How was the remainder of the programme?
- What do you feel was the most important message/lesson you took from the programme?
- What's your favourite memory from the programme?
- Can you think of anyway the programme can be improved?
- How prepared did you feel for your placement?

Placement

- Where is your placement and what is your role?
- Can you describe your experiences with…
  - Able-bodied instructors
  - Management
  - Clients
  - Other gym users
- Can you describe to me a typical day in the gym?
- From the programme, what has been the most useful information etc put to practical use?
- How do you feel when you're working in the gym?
- What's your favourite part of working as a fitness instructor?
- What's your favourite memory from your placement?
- Has there been any barriers or issues in your placement experiences?

Life Now

- Can you tell me about a typical day for you now?
- How do you feel?
  - Well-being
  - Quality of life etc
- Have your experiences outside changed since you completed the programme?

Future

- What are your plans for the future?
- Is there anything you would like to add or I haven't asked you?

Appendix G: Interview Guide Employed Instructors

Grand Tour Questions

- Can you tell me about yourself?

- Demographic questions – age, where do you live,

- Can you tell me about your impairment?

Gym Experiences as a Client

- What were your gym experiences like as a client?

    o Type of gym, how long

    o Why did you go to the gym?

    o What would you consider facilitated gym use

    o What made gym use difficult?

    o What does exercise mean to you

InstructAbility Experiences

- Why did you want to be a gym instructor?

- How did you come to find InstructAbility

- Tell me about your experiences in InstructAbility

Experiences as a Gym Instructor

- Where do you work?

    o Hours, part time, full time

- Can you describe a typical day working in a gym?

- What were your early experiences like in the gym?

    o Relationships with colleagues, clients

- Can you tell me about your experiences training disabled people?

- What do you think a disabled instructor brings to the gym?

- What impact do you feel you've had working here?

- What does it mean to you to be a gym instructor?

- How have your colleagues reacted?

- What would you do to make the gym more inclusive for disabled people?

- Any other questions