

Exercising inclusion: A case study exploring a fitness center staff's approach toward serving clients with disabilities

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Abstract

Nearly twice the number of U.S. adults with disabilities are inactive compared to U.S. adults without disabilities, and prior research has identified multiple barriers that prevent people with disabilities from exercising at fitness centers. The purpose of this case study was to explore the inclusion qualities present at a health and fitness center through the functional dimension of service quality and by using systems theory as a framework. Semi-structured interviews were conducted with five employees at a fitness center, and a researcher participating in a progressive exercise program journaled about the experience. Analysis revealed that the fitness center served people with disabilities through a clinical approach, led them to become more independent in exercise through fitness education, and promoted inclusion through community building and routine. Fitness centers should emphasize independence and routine for developing a community, but de-emphasize a clinical approach to better position themselves as open systems that adjust to input from outside influences.

Introduction

People with disabilities are one of the most physically inactive groups in American society (Rimmer, 2005). Yet, fitness centers often are not inclusive for people with disabilities as existing barriers can be a lack of education on this minority group, a lack of accessible equipment, or a lack of service that meets needs. Other barriers to participation include service quality dimensions of functional (how a service is delivered), environmental (where the service is delivered), and technical (the actual service; Kettinger & Lee, 1994). If one of these dimensions of service quality is not inclusive toward people with disabilities, the opportunity or motivation to participate in physical activity can diminish.

Riley, Rimmer, Wang, and Schiller (2008) proposed an approach to enhance accessibility and inclusion at fitness and recreation facilities through collaboration with people with disabilities, consultants, and incremental change. However, few scholars have attempted to examine how a fitness center may already be inclusive and accessible and use that as a case study for other fitness centers to follow. Calder and Mulligan (2014) proposed more robust psychometric assessments of fitness centers through quantitative approaches, yet we chose to approach this issue from a qualitative perspective with the goal of gaining a rich, thick description of a user's experience and contrasting it with the fitness center's employees' view of offering inclusive service.

The purpose of this study was to explore the inclusion qualities present at a health and fitness center. Specifically, this research examined the interaction and first-person account of a person with a physical disability who participated in a progressive exercise program designed to

enhance physical activity and explore how those experiences relate to the idea of inclusion portrayed by the fitness center's staff.

Literature Review

Carroll et al. (2014), in conjunction with the Centers for Disease Control and Prevention, found that 47.1% of U.S. adults age 18-64 years with a disability are inactive. That is nearly double the percentage of U.S. adults without a disability who are inactive (27.1%). Furthermore, Carroll et al. (2014) found that those inactive adults with disabilities are more likely to have a chronic disease and that 44% of adults with disabilities were given a recommendation by their health professional for physical activity.

To counter such inactivity among U.S. adults, the U.S. Department of Health and Human Services (2008) suggests that adults of all abilities should participate in moderate aerobic physical activity for 150 minutes per week. Such physical activity offers benefits that include combating heart disease, stroke, diabetes, and some cancer (Ballard-Barbash et al., 2012; Physical Activity Guidelines Advisory Committee, 2008). However, a contributing factor for such a high number of inactive people with disabilities is that they are unable to participate in the suggested aerobic physical activity due to a number of barriers (Rimmer, Riley, Wang, Rauworth, & Jurkowski, 2004; Rimmer, 2015).

Scholars have examined barriers to physical activity among people with disabilities, but they have mostly focused on the individual and why he/she is not exercising. Rimmer and a variety of colleagues have conducted extensive work on exploring the barriers that the individual may face when attempting to pursue physical activity. Rimmer (2015) offered five examples of barriers that prevent people with physical disabilities from participating in physical activity: (a) unemployment or underemployment; (b) inability to walk outdoors due to terrain and safety; (c) inability to walk long periods of time for health benefits; (d) transportation to community fitness facilities; and (e) lack of fitness facilities with accessible equipment, classes, programs, or trained staff to adapt programs and services.

Cowan, Nash, and Anderson (2013) also explored barriers preventing people with spinal cord injuries from participating in physical activity with an emphasis on the individual. They found that socio-economic factors play an important role in the decision to exercise, as do motivation and education about how and where to exercise.

The current study aimed to contribute to existing literature by exploring Rimmer's (2015) fifth barrier to physical activity participation: lack of fitness facilities with accessible equipment, classes, programs, or trained staff to adapt programs and services. The emphasis of this study was on staff awareness of inclusion and how that may shape an inclusive environment or foster barriers through service quality. Rimmer et al. (2004) identified 10 categories of barriers related to access to and participation in physical activity at a fitness and recreation facility that stem from the facility. They were (a) build and natural environment; (b) cost/economic; (c) equipment; (d) guidelines, codes, regulations, and laws; (e) information; (f) emotional/psychological; (g) knowledge, education, and training; (h) perceptions and attitudes; (i) policies and procedures; and (j) resource availability.

Facilities have not typically met accessibility guidelines, therefore fostering an unwelcoming environment based solely on the structural barriers (Nary, Froehlich, & White, 2000). Prior work has been done exploring the accessibility of fitness centers and programs that focus their

services toward people with disabilities (Pate, 2012). Pate (2012) explored a U.S. Paralympic Training Site located at a hospital-affiliated fitness center and the service quality provided to clients. Service quality is defined by Rust and Oliver (1994) as the nature of the experience someone has with a venue, person, or product and is comprised of three dimensions: environmental, functional, and technical. The environmental dimension is a consumer's perceptions of facilities and surroundings. The functional dimension is how a service is delivered to consumers. The technical dimension is a product delivered to the consumer. Pate's (2012) study of the Paralympic Training Site focused on the environmental and functional dimensions of service quality.

The current study focused solely on the functional dimension of service quality, particularly exploring four of the non-physical and policy barriers that may prevent people with disabilities from participating in physical activity at a fitness center, as identified by Rimmer et al. (2004): information, emotional/psychological, knowledge and education, and perceptions and attitudes barriers. Definitions of each barrier are detailed in Table 1.

Table 1: Major categories of barriers and their definitions

<u>Category</u>	<u>Definition</u>
Information	Access and information both within the facility (e.g., signs, brochures) and in facility brochures and advertisements
Emotional/psychological	Physical, emotional, or psychological barriers to participation in fitness and recreation activities among persons with disabilities
Knowledge, education, and training	Barriers and facilitators regarding the education and training of professionals in the areas of accessibility and appropriate interactions involving people with disabilities
Perceptions and attitudes	Perceptions and attitudes of both professionals and non-disabled individuals toward accessibility and persons with disabilities

Source: Rimmer et al. (2004)

Rimmer (2015) suggests that fitness centers could provide support systems such as trained staff, accessible exercise equipment, and socially engaging environments to transition people with disabilities into "self-managed" physical activity (p. 1). With regard to Rimmer's suggestion of providing a trained staff, that staff's training should include disability etiquette and the proper approach to disability overall. Such educating and training of staff should also include training on the multiple models or lenses of disability. Two examples are the medical model and social model. The medical model suggests disability is a problem for the individual and can be rehabilitated or fixed, whereas the social model suggests that disability is constructed by society and an environment that is not conducive to inclusion (Oliver, 1990; Shakespeare, 2013). Given the purpose of this study, it is important to explore a specific case of a fitness center and its progressive exercise program with regard to potential barriers for people with disabilities that

stem from the non-physical environment, such as the lens or model through which disability may be viewed and the system through which service quality is provided. Therefore, this study's aim was to explore a progressive exercise program through a fitness center's functional dimension of service quality. The study was approached through the lens of systems theory.

Rainey (2009) defines a system as "an ongoing process that transforms certain specified inputs into outputs" that may "influence subsequent inputs into the system in a way that supports the continuing operation of the process" (p. 26). The fitness center under study is the system. Systems theory originated in 1928 by von Bertalanffy (1950; Covell, Walker, Siciliano, & Hess, 2007) and later applied to organizations in the 1960s by Simon (1965). Simon viewed organizations as "systems that make decisions and process information" (p. 35) and may be viewed as an open system or closed system. Closed systems are unaffected by their environments and allow no material (or information) to enter or leave (von Bertalanffy, 1950). Organizations before and during the industrialization period were traditionally viewed as closed due to the factory-like, programmed pattern of work conducted. In the 1960s and 1970s, however, a shift toward service industries also established open systems, which interact with environments and are influenced by external factors (Ashmos & Huber, 1987).

Boulding (1956) established a four-level hierarchy of systems with Level 1 (static structure of framework) and Level 2 (predetermined motions of work) identifying closed systems and Level 3 (a control mechanism) and Level 4 (self-maintaining structure) identifying as open systems with greater external influence. The hierarchy is critical in the examination of sport and recreation organizations as Covell et al. (2007) argued that "successful sport organizations know they are open systems" because environment is a critical factor that shapes the organization's performance (p. 36). Such a systems approach requires organizations to respect external influences because they may shape the organization (Rainey, 2009). With systems theory and particularly open systems as the lens for examining a fitness center's inclusion qualities, the following research questions guided this study: (1) How does a fitness center serve people with disabilities?; (2) How does a fitness center transition special populations into independent exercise?; and (3) How does a progressive exercise program promote inclusion?

Methodology

This case study adhered to Merriam's (2009) definition of the methodology as an "in-depth description and analysis of a bounded system" (p. 40). This case study was conducted through a constructivist lens where reality was constructed through interaction with social worlds with the potential for multiple truths (Creswell, 2007; Crotty, 1998; Hatch, 2002; Merriam, 2009).

This case study examined a fitness center in the Mid-Atlantic region of the United States with the bounded system the center's service toward people with disabilities. The fitness center was corporately affiliated with a local hospital but relied mostly on the community for membership; just 2.2% of the membership mentioned their physician as a referral source upon signup (personal communication, A. Kinney). The fitness center had 6,420 members at the time of this study, 55% of which were female. Nearly 40% of members were between the ages of 50-79 years (see Table 2). The fitness center offered opportunities for individual exercise, personal training, group fitness, and aquatics.

Table 2: Fitness center’s membership age

<u>Age (in years)</u>	<u>% membership</u>
0-19	27.3%
20-29	8.6%
30-39	8.8%
40-49	9.6%
50-59	10.6%
60-69	13.1%
70-79	16.1%
80-89	5.4%
90+	0.5%

Source: Personal communication. A. Kinnev

The focus point for this study was at the fitness center’s progressive exercise program, which was designed to integrate a person from not exercising into what Rimmer (2015) called “self-managed” physical activity where the individual became a full member of the facility and exercised on their own time (p. 1). The eight-week program required a prescription from a healthcare provider and cost \$60. A fitness specialist designed a customized program that helped the client reach personal, medical, and fitness goals as well as any

recommendations set by the individual’s healthcare provider. Individuals participating in the program were given a pre-program assessment, then registered for 30-minute sessions two times per week for the eight-week program, followed by a post-program assessment. Participants of the program were given full access to the fitness center and its services. In 2015, 168 individuals participated in the progressive exercise program, 88 (52.4%) of which were men. Of those participants, 47 (28%) enrolled into a membership.

The researchers’ university institutional review board and the hospital’s institutional review board approved this study. The researchers contacted the fitness center director and gained approval from both the center and the hospital to collect data from employees. A combination of convenience and criterion sampling was used to identify participants by inviting the director of the fitness center to participate and asking what other employees may work closely with the progressive exercise program and may be interested in participating. The director agreed to participate and invited four other employees who worked closely with the progressive exercise program to participate. Other employees were not invited to participate due to their lack of involvement with the progressive exercise program.

Semi-structured interviews were conducted with five of the 23 fitness center employees (see Table 3). Participants in this study held four different position titles: director, fitness coordinator, fitness specialist, and personal trainer (two). The director represented was the highest-ranking employee at the fitness center and the participant was the only person holding that title (100% representation of the job title). The fitness coordinator managed clinical and fitness services for clients, and the participant was one of three employees holding the title (33.3% representation of the job title). The fitness specialist reported to the fitness coordinator, and the participant was one of three employees holding the title (33.3% representation of the job title); the position required an advanced designation due to certification in fitness testing and strategic programming. The title of personal trainer included certification to design personalized training programs, and the participants were two of nine positions with that title (22.2% representation of the job title). A pseudonym was assigned to each participant in an attempt to preserve confidentiality. Examples of questions asked of the participants were “How does inclusion with regard to members fit into the fitness center’s mission?” and “How does this fitness center serve people with physical disabilities?”

Table 3: Participant information

<u>Pseudonym</u>	<u>Gender</u>	<u>Race</u>	<u>Title</u>	<u>Employed</u>
Melody	Female	Caucasian	Fitness Specialist	2 years
Kathy	Female	Caucasian	Fitness Coordinator	7 years
Terri	Female	Caucasian	Personal Trainer	2 years
Wendell	Male	Caucasian	Director	12 years
Ida	Female	Caucasian	Personal Trainer	4 months

The full interview schedule is included in Table 4. Additionally, a co-author of this study who has a physical disability completed the progressive exercise program at the fitness center prior to data collection and kept a journal about the experiences during the program. All participants were age 18 years or older. The final data set included five interview transcripts and one first-person journal.

Table 4: Interview schedule

Questions asked of all participants

How long have you worked at this fitness center?
 What makes this fitness center different from others?
 How does inclusion with regard to members fit into the fitness center's mission?
 How would you define special populations?
 Did you learn this through education or working?
 Explain your history working with special populations.
 How often would you say you work with older adults?
 How often would you say you work with people with physical disabilities?
 How does this fitness center serve people with physical disabilities?
 How would you define inclusion?
 How would you describe the progressive exercise program at this fitness center?
 How do you prepare people in the progressive exercise program to transition into a more independent workout program?
 How does this type of program promote inclusion?
 With what race do you identify?
 Is there anything else you would like to add?

Data were analyzed using the constant comparative method. Transcripts of each interview were read by both researchers and segments of data were assigned emergent codes by each coder. Analysis resulted in 53 codes among the two researchers. Codes were then grouped together by similarities and transformed into themes that summarized the codes. Coders then compared their results, and disagreements within the translation of codes to themes were discussed until an agreement could be reached. Themes were customer focus, education, and fostering change. The themes were then contrasted with the four-level hierarchy of systems and characteristics of inclusion regarding disability.

Results and Discussion

Rimmer et al. (2004) identified barriers that may prevent people with disabilities from participating in physical activity at a fitness center, four of which were non-physical and policy barriers: information, emotional/psychological, knowledge/education, and perceptions/attitudes. This study focused on those four barriers by examining a progressive exercise program offered at fitness center through systems theory and the functional dimension of service quality, or how those services were delivered by staff.

The first barrier of information relates to the clinical-based nature of the program. The program was eight weeks and required a prescription from a physician. The accessibility of information (e.g., accessible brochures, etc.) was beyond the scope of this research and aligned with the environmental dimension. However, it was clear this clinical-based program targeted individuals through a medical model approach toward disability, insinuating that disability is a problem for the individual and physical activity could medically help or potentially cure a health issue or disability (Oliver, 1990).

In an internal survey conducted by the fitness center of its 6,420 members, 139 (2.2%) of them mentioned their physician as their referral source upon signup. In 2015, 168 members participated in the progressive exercise program. Data provided by the fitness center was not complete enough to determine if all 139 who mentioned their physician as the referral source were progressive exercise participants. Yet, the program required a physician referral for participation without a financial benefit. Such limitation based on a medical referral to the progressive exercise program at this fitness center presents a non-inclusive environment and suggests that individuals with health challenges or disability who are seeking to exercise should first go through their physician.

Data addressing the first research question reflected that the fitness center serves people with disabilities through a clinical approach that presents qualities of the medical model and qualities of Boulding's (1956) Level 3 open system. All five of the participants identified their academic education as a contributor to their understanding of serving and working with special populations such as people with disabilities. However, they said the fitness center's affiliation with a hospital improved their general knowledge and awareness of special populations' needs and added to their education. While the staff entered into employment with a set level of knowledge about serving and working with special populations, they noted through interviews that working in the environment expanded their education, thus displaying qualities of Boulding's Level 3 open system where the system adjusts as a control mechanism. In this way, the staff adjusts output in accordance with the client's needs although resolutions may be consistent regardless of those needs.

An emphasis was placed on a clinical approach in programming, use of the facility, and general health. Regarding programming, Kathy noted:

Our programming, you know we have a lot of clinical offerings. We have Fit Encore, which is a balance and fall risk prevention program. We have fitness classes that use chairs and yoga classes that are geared towards an aging clinical population, which is not something you find at every fitness facility.

A focus on health and safety further supported the clinical approach taken by the staff. Wendell suggested the staff offers an inclusive approach to health for all members, including those with disabilities: "Our mission is to improve health every day. So regardless of who it is we exist to make people better and to create a healthier environment for everybody." Terri suggested the staff focuses on the safety of its clients. "We want to make sure they are able to get from Point A to Point B safely, be able to do what they came here to do safely."

A clinical approach corresponded with a presence of people with disabilities exercising in the fitness center. Through journaling, the researcher with a physical disability documented multiple interactions about and with disability when exercising. During the evaluation within the progressive exercise program, the researcher noted the following about the trainer: "[She] was very understanding about disability yet without discussing it. It made me think she had worked with people with disabilities before because (1) she did not ask and (2) she focused on the abilities." In subsequent exercise sessions, the researcher identified other clients with physical disabilities. The researcher noted that people with disabilities appeared to be welcomed into the fitness center, then wrote the following about exercising alongside another person with a physical disability: "This was magnified when I realized me and Boyd [pseudonym] on the NuStep machines and [wondered] how many gyms in the United States had that scenario in any given day." The following day, the researcher exercised two machines down from a woman who

uses a wheelchair, and several journal entries later the researcher noted that four people with physical disabilities could be identified in the fitness center all exercising. Yet, interviews with staff suggested they were not familiar with preferred language for people with disabilities.

There was no common definition among the staff when asked how they would define inclusion. Some defined inclusion with regard to disability (e.g., access for people with disabilities) while others had difficulty explaining their view of the definition. Furthermore, while the staff created an educational environment for clients in equipment training and attempted to establish an inclusive environment for all abilities, there was a sense of “othering” from the language used where special populations and people with disabilities were identified as not part of the in group. Staff’s language toward clients was not examined during this study.

Wendell’s use of identity-first language (focusing on disability rather than the person; Patterson & Witten, 1987) was common among staff members, as exemplified in the following quote: “We have had people, mostly wheelchair-bound individuals, where we have asked them to help us assess certain things.” Wendell’s conversation pointed toward the fitness center’s staff consulting with people with disabilities to create a more inclusive environment. However, his language did not reflect person-first language, which views descriptions such as “wheelchair-bound” to be negatively impactful upon people with disabilities compared to the phrase “person who uses a wheelchair.” Person-first language is preferred among people with disabilities in North America but not always used (Pate, Ruihley, & Mirabito, 2014). This type of language emphasizes the person rather than the disability (Centers for Disease Control and Prevention, n.d.; Lynch, Thuli, & Groombridge, 1994; Titchkosky, 2001).

Staff also exhibited othering through their discussion of people with disabilities and how they wanted to include them into programs at the fitness center. Terri said the following about people with disabilities in the progressive exercise program:

I will say a lot of times people with more of a physical disability, we will try to tell them to do personal training. ... We try and lead them more towards personal training because we do have trainers who are a little bit more, they like that clinical population.

That trainers would push clients toward personal training due to disability connects with the notion of othering and takes some of the independence out of the client’s decision-making. Such actions may be taken with positive impact in mind, but the unintended result divides clients with disabilities from other clients without disabilities and prevents full integration.

Further connecting with the Level 3 open system characteristics, clients in the progressive exercise program often were “prescribed” similar exercise routines on the same equipment, but the repetitions, time spent on a machine, or weight added (inputs) were adjusted based on client’s needs and goals. Eliminating such medical-based requirements for referral and similarly prescribed workout routines would shift the perception of the program toward one of inclusion that diversifies the program’s clientele and potentially increases overall membership numbers. Fitness centers can tap into the market of people with disabilities through local services that touch all families, such as parks and recreation communication avenues. For example, a local parks and recreation department may send mailers that advertise community activity programming, and the fitness center may consider that route to promote programming that specifically targets a population of people with disabilities. Such focused marketing and promotion campaigns are not new to the sport and recreation industry, and this option would

eliminate a medical model approach for the more preferred social model that de-emphasizes disability as merely one of many characteristics of an individual (Shakespeare, 2013).

The fitness center under study did not identify incremental change within the staff such as accessibility training or education on special populations such as people with disabilities. However, the progressive exercise program itself places incremental change into the hands of the client, allowing the trainer to guide the process through empowering the client. Empowering the client—particularly a client with a physical disability—to take control of his or her physical activity can be a major gamble considering the barriers people with disabilities face regarding physical activity. The fitness center under study approached this by working to build confidence and relationships among the progressive exercise program's participants, and by educating the clients on equipment.

The educating of clients on equipment and the fitness center in general combats Rimmer's (2004) third barrier of knowledge and education. Cowan et al. (2013) suggested that a barrier for people with physical disabilities and their exercise is that they do not have the motivation and they do not have the education about how and where to exercise. The current study refuted part of this barrier. A fitness center has no control over the motivation of a client to exercise, although the progressive exercise program in this study required a prescription from a medical provider which could be deemed as a motivating factor. However, once a client enters the door, a fitness center does have control of educating how and where to exercise. The trainers who participated in this study said they educated their clients by providing them with a tailored workout plan based on their goals or their doctor's goals, educated them on which equipment may be best to accomplish their goals, and educated them on how to use equipment in the fitness center. The second research question asked how the fitness center transitioned people toward independent exercise, and results show it was through focused assistance and enhanced confidence.

Trainers said during the progressive exercise program they began by showing clients how to operate the machines but incrementally moved toward only checking in on the clients during their session. Staff then incrementally withdrew and challenged clients to adjust and operate equipment on their own during the program. As one staff member noted, they were always there for the clients but did not hover over them. Melody said: "I make sure to adjust the machines so they are confident and they know what to do. I am always checking in." Gradually decreasing the number of times the trainer checks on the client, the trainers said, led to independence, as Wendell noted:

We are there overseeing them. We kind of let go of their hand, but we are always there if they fall. And in that sense, by the end of the program you see people that ask you questions every single time in the beginning and they are like oh, I've got it, I know what I am doing now.

This gradual move toward independence was supported by journal entries. The researcher said the initial introduction to equipment included the trainer explaining how to adjust machines and making adjustments during the workout. The process led to the trainer pushing the researcher toward a simulated situation of independence, as described below:

I had already climbed onto the machine when Rebecca said, "OK, now change the weight to 20 pounds." I hesitated, thinking to myself, why didn't she tell me to change the weight before I got on the machine? I looked at her, and she said, "You can do it." I used

a handle on the machine for stability and reached to the side of the machine with my left hand and was able to change the weight. I felt accomplished at that moment, as if I impressed the teacher.

Moving clients toward independent exercise was a goal of the staff, and it was realized by the researcher as noted in a journal entry near the end of the progressive exercise experience: “At one point, a very short time ago ... I could not have imagined dedicating two hours a day to anything outside of what I already had going on. Now, working out is just what I do ...”

The fourth barrier related to perceptions and attitudes of professionals and people without disabilities toward accessibility. Rimmer (2015) argued that a lack of fitness centers with accessible equipment, classes, programs, or trained staff presented a barrier for people with disabilities to participate in physical activity and fitness. By educating clients about their exercise options and capabilities, the client is encouraged toward an independent exercise schedule. This push by the staff supports Rimmer’s (2015) suggestion that fitness centers offer support systems such as trained staff, accessible equipment, and social engaging environments that promote independent exercise. Independence also displays qualities of Boulding’s (1956) Level 4 open system, where the structure is self-maintaining. Clients who began managing their own exercise routines were still part of the system, but were operating within an open system where external factors (e.g., client’s goals, abilities, schedule) dictated the service provided overall because it was then up to the client to provide the input rather than the staff dictating what the client was doing during the exercise routine.

Emotional and psychological barriers were connected with this study as staff worked to build confidence and relationships among the progressive exercise participants. Staff members noted and exhibited that they worked to show the clients they knew their names and routines by making small conversation. Staff members also said clients built relationships with other clients due to their routine schedules, and this was supported by the researcher’s journaling about staff members and other fitness center members initiating conversation stemming from similar exercise schedules. The third research question asked how a progressive exercise program promotes inclusion, and results showed through bonding and establishing a routine. The positive aspect of establishing a routine contradicts results from the first research question that found negative aspects of routine were due to the clinical approach.

Asked how the fitness center and progressive exercise program promotes inclusion, the responses focused more toward including everyone as opposed to the definition of inclusion of people with disabilities. Melody noted that the program acts for some as a trial to becoming a full member, and that when they join, they are at an advantage: “... they have already done the orientations and the assessment process. They are familiar with the fitness floor. And us really, like they can get to know the staff because when they check in they are always seeing someone.” Ida explained that staff communication with clients promotes a feeling of inclusion at the fitness center: “Always out on the floor as a resource, they do not have to go find staff. We are present and interacting in the space, more than being present, interacting, as well.”

Routine was also a way inclusion was promoted at the fitness center, and it exhibited qualities of Boulding’s (1956) Level 4 open system where clients accepted control of their own networking and routine. Trainers said when clients establish an exercise routine, they tend to feel more included at the fitness center because of the relationships they establish and the results they see. Kathy best explained how routine is linked to results: “I think it is the results that they see and it is not always weight loss because it is hard to really do in that time frame.

They can see that change in their numbers or a doctor sees it. That really clicks for some people.” Wendell summarized the importance of routine in making a welcoming environment:

I think they have kind of changed their lifestyle, they have created habits. They have created a connection with your people and your facility. It has become a place where they feel comfortable and safe. I think at that point they have seen the value, they have perceived the value that health can get them.

Wendell connected health with value, suggesting that clients see the value in membership when they see their health enhanced either physically or socially through establishing communities.

Journaling revealed that the researcher also established community by making connections with other clients and by maintaining an exercise routine. The researcher journaled the following just a few weeks into the program: “I have grown accustomed to seeing people regularly. We don’t speak typically, but seeing them has made an impact on me and my view of this new community.” The researcher later noted that missing a scheduled exercise resulted in a feeling of letting down the community of people there.

The experience of community progressed to employees calling the researcher by name and other clients engaging in conversation due to similar workout schedules. The researcher wrote the following about feeling part of the fitness center’s community after three weeks in the program:

I feel like I am a member. I feel like people know me. I feel like I am part of the wellness center. The more I work out—and I have consistently been present at the center Monday-Friday for three weeks now—the more I feel like anybody else who has been there when I have been could potentially be seeing me as a consumer rather than seeing my disability.

The researcher noted feeling included in the community, but also noted the exclusion of disability as it related to fitting in at the fitness center. Regarding inclusion, the researcher’s journal entries revealed that little emphasis was placed on disability from the first assessment of the progressive exercise program until the final workout in the program, which proves to be contradictory to data from interviews that suggest disability was a primary part of assessment and that staff may even go so far as steer clients away from specific programming due to disability being present. This inconsistency reveals communication toward clients with disabilities and what may be communicated privately about clients with disabilities, which could be enhanced to establish a more consistent approach toward inclusion.

Conclusion

Rainey (2009) suggests that open systems require organizations to respect external influences because they can shape the organization. Covell et al. (2007) argued that this is vitally important for sport organizations to be successful, so this study aimed to examine a fitness center’s approach to inclusion as it relates to systems theory and more specifically the functional dimension of service quality.

Findings from this study were contradictory at times, first suggesting that this fitness center uses a clinical approach that supports an outdated medical model approach to disability. Using the medical model to serve clients with disabilities suggests that disability, in whatever form, can be

healed or corrected, in this case, through exercise. These medical model qualities were clear through the progressive exercise program's requirement of a physician's referral and even the prescribed exercise routines. However, routine became an advantage for clients as they began to establish relationships at the fitness center with both staff and other clients.

We argue that the clinical approach may not be the most appropriate way to recruit clients and expand the membership base because it maintains a perception of rehabilitation that will come to an end. Instead, we suggest recruiting clients and promoting programming for people with disabilities through community communication avenues such as local parks and recreation outreach systems. The routine does, however, have a place in maintaining memberships, establishing long-term clients, and a movement toward exercise that is independent, or self-managed as Rimmer (2015) stated. A byproduct of establishing a routine was a movement toward self-managed exercise that gives the client with a disability independence that he or she may not have in other aspects of life. Shifting clients toward independence establishes qualities of a Level 4 open system that is self-maintaining within the fitness center (Boulding, 1956).

Level 4 qualities were displayed through establishment of routine and independence, but Level 3 qualities were displayed through the fitness center's clinical approach to attracting clients. We argue that the Level 3 system qualities observed through the clinical approach to progressive exercise can be enhanced more closely to a Level 4 open system if physician referrals were eliminated and programming were advertised through community communication channels. Moving this aspect of the progressive exercise program to a more open system would enhance the inclusive qualities of the fitness center and as a result potentially expand its reach for new clientele within the population of people with disabilities.

This study was conducted with limitations that shaped the results and may prevent generalization to inclusivity of other fitness centers. One of the primary limitations of this study was staff turnover. Staff composition at the time one of the researchers experienced the progressive exercise program was not the same as when interviews were conducted, and the director of the fitness center was promoted from interim to permanent. Additionally, ownership of the fitness center's parent hospital changed hands during this study, all of which may have indirectly shaped the fitness center's approach to inclusivity and the progressive exercise program. Furthermore, service provided by a fitness center will undoubtedly be shaped by the staff composition and its knowledge of inclusion, and that will shift in accordance with the staff turnover.

Another limitation of this study was the data source. Interviews were strictly conducted with fitness center staff, and they may have been compelled to only speak about the fitness center and its programming with positive bias. We attempted to control for such bias by scheduling the co-author without a disability to conduct interview during data collection. Interviews with members and the progressive exercise program's participants would have enriched the data, but access to those individuals prevented such data from being collected at the time of this study.

Future research in the area of inclusivity, service quality, and physical activity for people with disabilities can be enhanced by exploring the environmental and technical dimensions of service quality through case study of a single fitness center or through examination of multiple fitness centers. Exploration of multiple fitness centers in a single study would add validity and reliability to research on this topic, as would investigation using participants' voices as part of the data

set. Furthermore, more research is needed in exploring the experiences of people with disabilities who exercise at a fitness center and their perceptions of inclusion.

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