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Alana R. Honigman
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within the Personal Training
Relationship

ABSTRACT

I undertook this study to expand the literature regarding connections between mental and physical health to include ways in which client mental health arises and is addressed within the personal training relationship. My research was guided by an ethical framework with the purpose of improving best care practices for clients. The four research questions I posed concerned the frequency with which mental health issues are addressed, typical interventions personal trainers utilize in response to these issues, the reasons personal trainers choose specific interventions, and the training personal trainers receive regarding client mental health.

Participants ($N = 58$) were recruited through athletic facilities, internet searches, and snowball sampling methods. They completed an online survey including demographic questions about themselves, their clients, and the facilities at which they work, as well as questions about their experiences working with clients, interventions they use, and their occupational training.

My major findings were that participants encountered a variety of mental health issues from their clients. Participants used many interventions to address these issues, some that fell within their scope of practice, such as active listening, and some that did not, such as counseling. Many participants reported making referrals to mental health professionals. For those who did not, their main obstacle was lack of referrals to provide to their clients. In many cases, participants did not receive standardized training regarding best care practices for addressing client mental health, but relied on personal experiences or independently gained knowledge.

**ADDRESSING CLIENT MENTAL HEALTH
WITHIN THE PERSONAL TRAINING RELATIONSHIP**

A project based upon an independent investigation
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2012

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CHAPTER I

Introduction

Personal training is a growing occupation (Bureau of Labor Statistics [BLS], 2012) meant to target clients' physical well-being through exercise. Despite the intrinsic focus on physical health, many aspects of clients' mental health are affected through the relationship between personal trainer and client. Clients often seek improvements in self-esteem or psychological health through their personal training experience (e.g., Gavin, 1996) and research indicates that they can achieve these improvements through physical exercise (e.g., Annesi, 2005; King, Taylor, & Haskell, 1993; Norvell & Belles, 1993). Additionally, poor physical health has been connected with stress, depression, history of trauma, and low self-esteem, (e.g., Gunstad et al., 2006; Haukkala & Uutela, 2000; Nowicka et al., 2009; Stice, Presnell, Shaw, & Rohde, 2005) suggesting these issues may be common in populations of individuals seeking fitness interventions. However, professional guidelines for personal trainers explicitly direct personal trainers to refrain from engaging in activities for which they are unqualified, such as therapy (e.g., Bryan & Green, 2010; Gavin & Gavin, 1995). The connections between mental and physical well-being make it important to explore how fitness professionals address issues that may be related to both mental and physical health while remaining within their scope of practice and providing their clients with the highest quality of care. An ethical framework will be used to guide this research.

Data are limited regarding the experience of personal trainers addressing topics connected to their clients' identities, personal histories, and mental health issues that may fall outside of their scope of practice. Personal trainers are likely to encounter situations in which their clients require interventions focusing more on their mental health than their physical health, and understanding how clients navigate these situations is ethically important. Although personal training materials often mention the mind-body connection, the topics covered can be limited in scope and often do not address specific mental health considerations.

Research regarding mental health and physical fitness has great relevance to the field of social work. There is likely a portion of the clients who seek personal training services who would benefit from mental health services, but are not currently receiving them. Individuals might not seek mental health services for many reasons, such as shame, lack of resources, or doubts that psychotherapy will be effective (e.g., Marques et al., 2010). This gap in services could be addressed through increased collaboration between social workers and physical health professionals, such as personal trainers. Additionally, social workers have developed an extensive code of ethics to inform their practice with clients. Although social workers should not impose their thinking on other professions, encouraging a respectful, dialectical, examination of ethical practices within related professions will help to improve the ethical practices across the board. Facilitating inter-professional dialogue to improve the care received by clients across various helping professions may be preferable to working in isolation to create entirely independent theoretical frameworks to guide best care practices.

The purpose of this exploratory study is to better understand the circumstances in which personal trainers are encountering issues related to mental health in their work with clients. Specifically, how often do personal trainers encounter topics regarding client mental health that

may fall outside of their scope of practice? Which interventions and responses do personal trainers typically use when clients bring up topics related to mental health that may fall outside of their scope of practice and why do they choose those interventions? What training have personal trainers received during their certification process and while practicing about the topic of client mental health?

In Chapter II, I compile the literature regarding personal training as a profession, connections between mental health and exercise, and the ethical framework that guided my research. In Chapter III, I describe the methods I used to conduct my study and analyze my data. In Chapter IV, I present my study findings. In Chapter V, I discuss my findings, the ways they add to the literature, strengths limitations, contributions to the field of social work, and recommendations for future research and practice.

CHAPTER II

Literature Review

In this chapter I review the relevant literature on personal training practice and purpose, the connections between exercise and mental health, and ethical considerations for personal trainers to provide the background information for my study. Personal trainers seek to improve their clients' lives through exercise and physical fitness. Physical health and exercise have been found to be closely related to mental health, which makes it likely that personal training clients could bring up topics related to their mental health due during sessions. As helping professionals, personal trainers have an ethical interest in providing the highest level of care to their clients. This includes remaining within their scope of practice and only engaging in behaviors and interventions for which they are qualified.

Personal Training Purpose and Practice

The fitness industry is rapidly increasing in the United States (BLS, 2010; BLS, 2012). Personal trainers are the primary profession within the fitness industry. In 2010 there were 251,400 jobs for fitness trainers and instructors in the United States of America (BLS, 2012). The personal trainer job description is defined by the Bureau of Labor Statistics (2010) as follows:

Personal trainers work one-on-one or with two or three clients, either in a gym or in the clients' homes. They help clients assess their level of physical fitness and set and reach

fitness goals. *Trainers* also demonstrate various exercises and help clients improve their exercise techniques. They may keep records of their clients' exercise sessions to monitor the clients' progress toward physical fitness. They also may advise their clients on how to modify their lifestyles outside of the gym to improve their fitness. (paragraph 2).

Employment for fitness workers overall is projected to increase by 24% from 2010 to 2010 and personal trainers will be a large part of that growth (BLS, 2012). A reason for this increase may be that the use of a personal trainer can be motivating for individuals initiating an exercise routine (Jeffery, Wing, Thorson, & Burton, 1998).

Puente and Anshel (2010) found that personal trainers can influence their clients' mental health as well as their physical health. They conducted a study to examine how a client's relationship with a fitness instructor could affect motivation to exercise. The study methodology consisted of a survey completed by 238 undergraduate students enrolled in physical education classes at a Midwestern US university. Using a Structural Equation Model design, the researchers found that participants' perceptions of their fitness instructors' interacting styles influenced their perceived competence and motivation, which positively affected the participants' self-determined regulation, consisting of four aspects of motivation to exercise (Puente & Anshel, 2010). The findings suggested a personal trainer can impact individuals in ways beyond merely their exercise behavior. This study had several methodological shortcomings. Firstly, the cross-sectional nature eliminated the researchers' ability to examine the participants' perceptions at various points in time throughout their relationship with their fitness instructors. Additionally, all of the participants in this study ranged in age from 18-26 and were enrolled in a post-secondary educational institution at the time. The results may not necessarily be applicable to other age groups or to individuals with less advanced educational

levels or limited access to socio-economic resources. The researchers did not present any data regarding either participant or instructor race and ethnicity, leaving many questions about how these factors might affect the relationship.

The findings from this study indicate that personal trainers' ability to respond appropriately to their clients can positively influence their exercise motivation (Puente & Anshel, 2010). Additionally, research suggests that there is great overlap between individuals' mental health and their physical health (e.g. Annesi, 2005; Netz & Lidor, 2003; Norvell & Belles, 1993; Sale, Guppy, & El-Sayed, 2000), such that knowledge about clients' mental health might be an important factor in personal trainers' effectiveness at supporting their clients with fitness goals.

Exercise and Mental Health

Professionals across disciplines acknowledge the strong relationship between mental and physical health. The topic is discussed commonly within a range of disciplines, such as psychology, social work, medicine, and body work (e.g., physical therapy, massage, personal training). However, these discussions often remain descriptive; authors provide details about the ways in which mental and physical health are connected without opening a dialogue or proscribing ways workers within specific disciplines can address these connections while remaining within their scope of practice. In this section I will describe the previous research on the relationship between mental and physical health and then the ways in which therapists and personal trainers have attempted to address this relationship within their professional work.

Previous research. The positive effects of exercise, beyond the physical fitness changes and weight loss with which it is commonly associated, is an area of research that has been explored extensively. Research indicates exercise is related to well-being and mood (e.g., Annesi, 2005; Norvell & Belles, 1993; Sale et al., 2000). Studies have assessed many types of

exercise, ranging from aerobic to weight training to yoga (e.g., Annesi, 2005; King, Taylor, & Haskell, 1993; Netz & Lidor, 2003). Researchers suggest that even a small amount of exercise can have positive psychological effects, with different studies using samples varied by gender, age, race, and nationality.

Cardiovascular exercise has been found to decrease levels of depression in a sample of adults with depressed mood (Annesi, 2005). Participants were 50 employees at a large south eastern US corporation, 66% female, 81% of European descent, majority of middle to higher socio-economic status, all of whom scored 1.5 standard deviations above the mean on the Depression scale of the Profile of Mood States-Short Form (POMS), none of whom engaged in a regular fitness routine. The experimental group engaged in a moderate cardiovascular exercise routine for ten weeks, while the control group did not engage in any exercise routine. Depression was measured by POMS score and cardiovascular fitness was measured by maximal oxygen consumption (VO_2 max). Results showed that participants in the experimental group significantly decreased their depression level. Cardiovascular fitness was not related to changes in depression, suggesting that the affective benefits of cardiovascular exercise were present regardless of fitness improvements. Some methodological weaknesses were present. The participants self-selected into the experimental or control groups, allowing for the possibility that another factor in this group predisposed them to improvements in mood. The sample was not diverse with respect to ethnicity or socio-economic status, limiting the ability to generalize findings to individuals who are not of European descent or of middle to upper socio-economic status.

A number of studies have examined the effects of exercise on reducing depressive symptoms in non-clinically depressed samples (Conn, 2010). Through a meta-analysis of sixty

studies of exercise effects on non-clinically depressed participants' depression symptoms, Conn (2010) found that physical activity interventions significantly reduced depression symptoms in non-clinically depressed adults. Depression symptom outcome data were collected a minimum of 1 day after the intervention, controlling for possible temporary improvements in depression symptoms directly following physical activity, and a maximum of 1,825 days later. The use of a meta-analysis method increased the external validity by drawing from studies with a variety of populations. Study samples had mean ages ranging from 31 to 81, were 65% female, and had mean body mass indexes ranging from 25 (the lowest number considered overweight) to 31 (the lowest number considered obese). However, no demographic data were presented on the race/ethnic background or socio-economic status for the participants in the studies included, which negatively affected generalizability.

Multiple forms of exercise have been found to improve participant mental health. Three exercise intervention formats were evaluated for long term effectiveness in improving stress, anxiety, and depression in a population of older adults (King et al., 1993). Participants, 357 adults aged 50-65 who were not participating in a regular exercise routine, were randomized into four groups: higher intensity group-based exercise training, higher intensity home-based exercise training, lower intensity home-based exercise training, and assessment-only control.

Physiological measures of body mass index, smoking status, and VO_2 max and psychological measures of depression, anxiety, and stress were taken at baseline, six months, and one year. Results indicated that stress and anxiety were significantly reduced in participants in the exercise training groups. Additionally, increased participation in the exercise programs was related to decreases in depression symptoms. Finally, it is important to note that changes in anxiety, stress, and depression symptoms were unrelated to improvements in fitness level, as measured by VO_2

max. Methodologically, the randomized group assignment strengthened the findings by eliminating self-selection bias in creation of the groups. However, participation in the study was still subject to self-selection bias. Additionally, participants were 89% White and had averages of 14 and 16 years of formal education for women and men, respectively, suggesting the majority of the participants attended post-secondary education. It is unclear how the results might differ in populations with more racial diversity or varying educational backgrounds.

Researchers have extended the findings regarding cardiovascular exercise to other exercise formats. One such study focused on circuit weight training (Norvell & Belles, 1993). Participants were randomly assigned to the experimental or control group; participants in the intervention group completed a 16 week program of circuit weight training. Out of 33 initial participants in the experimental group, 19 dropped out before completing the intervention. Analyses showed that the drop-outs had significantly higher scores on psychological measures such as stress, anxiety and depression, but were similar to the other participants on all other measures and characteristics. Participants who completed the intervention ($N = 43$) were American state law enforcement officers, all male, 85% White, 81% married, with a mean age of 33 years, suggesting a fairly heterogeneous sample and limiting generalizability. Results suggested that the circuit weight training intervention had significant positive effects on participants' levels of anxiety, depression, job satisfaction, and hostility, extending findings regarding the benefits of exercise beyond solely cardiovascular types. Long term follow-up was not conducted to determine the lasting impact of this intervention, so the duration of these positive effects is unknown.

A study in Israel compared the mood altering effects of mindful exercise versus aerobic exercise (Netz & Lidor, 2003). The sample of 322 Israeli female teachers enrolled in one class,

choosing between aerobic options of dance aerobics or swimming, low-exertion mindful options of yoga or Feldenkrais (a technique commonly used with senior citizens and less active individuals), or a control computer class. All four class options met weekly for 90 minute sessions for one year. Measures were taken of anxiety, depression, and subjective well-being. A baseline for all of the measures was taken on the 2nd day of class. On the 14th day of class participants completed the measures before and after their classes. The results indicated that participants in the yoga, Feldenkrais, and swimming classes improved their subjective well-being and anxiety significantly from the start of the class to the end of it. However, several methodological issues place limitations of the reliability of these findings. Participants self-selected into each class, suggesting possible differences between groups in addition to the type of class. The measures were taken before the class and within 10 minutes of the class ending, which only indicated immediate and not long-term effects of participating in the class. Finally, participants were all female and no demographics such as age, ethnicity or socio-economic status were provided to describe the sample.

Thus far, research indicates that cardiovascular, weight-training, and low-exertion mindfulness exercise can all improve affect in various ways, including depression, anxiety, stress, well-being, and job satisfaction (Annesi, 2005; King et al., 1993; Netz & Lidor, 2003; (Norvell & Belles, 1993). Overall, the research has been mainly quantitative in nature, using survey and quasi-experimental methodologies. Participants self-select into experimental groups based on their desire to initiate various exercise routines. Only one study used random assignment to assign participants to groups. Ethically, it may be undesirable to randomly place individuals into experimental groups in which health benefits may be gained or denied, because the health risks can be high. Although the lack of a true experimental design may compromise

the ability to generalize findings, it upholds the ideals of social work research not only to avoid harm to participants, but also to maximize the benefits (Bay-Cheng, 2009). Many of these studies attempt not only to add to the literature with their findings, but also to provide physical and mental health benefits to participants during and after their participation in the study.

The populations included in these studies are majority White, which is not representative of the current racial demographics of the United States as a whole, and most often researchers do not address issues of racial difference or lack thereof amongst the participants (Annesi, 2005; Conn, 2010; King et al., 1993; Norvell & Belles, 1993; Sale et al., 2000). Participants also frequently have college-level or higher educational degrees (e.g., Jeffery et al., 1998; King et al., 1993; Netz & Lidor, 2003; Norvell & Belles, 1993). Additionally, each study tends to focus on a specific population, such as university students (Sale et al., 2000), older adults (King et al., 1993), middle-aged Israeli women (Netz & Lidor, 2003), or male law enforcement personnel (Norvell & Belles, 1993). Finally, most studies use some component of self-selection either during the process of determining who will participate generally or specifically into which experimental group the participants will be placed. These limitations of the diversity in the samples bring into question whether the results can be generalized to other populations. The current study will attempt to obtain a more diverse sample size with respect to multiple identities such as race and socio-economic status to address this issue.

An important limitation to this body of literature is that the studies are mostly one-directional, focusing on the exercisers' experience of the interventions without examining the actual interventions being offered and the experience of those professionals providing the interventions. It is important to consider how the individuals providing the interventions engage in their work and interact with their clients. Learning more about the experience of personal

trainers through this study will provide new and important perspective to add to the literature thus far regarding exercise.

Mental health and exercise in practice. Both therapists and personal trainers have attempted to address the connection between mental health and exercise in their practice. For example, Dr. Kate Hays (1999) is a clinician psychologist who wrote *Working it out: Using exercise in psychotherapy* to address the many ways therapists can incorporate exercise into therapy sessions. As she explains, “Exercise allows us to resolve, that is, to work out, concerns, crises, and conflicts” (Hays, 1999, xi). In her book, she discusses the reasons exercise can be therapeutic, pragmatic details, considerations for specific populations and topics, and the ethics involved. The specific populations and topics she covers are: depression, anxiety, stress management, self-esteem, eating, substance abuse recovery, chronic mental illness, trauma survivor empowerment, recovery from mental illness, diversity issues, age, and athletes with emotional problems. In each of these chapters, she provides a synopsis of the literature regarding the intersection of exercise and the topic and gives specific practice suggestions related to the topic. Often, she includes case examples from her work incorporating exercise into therapy. She considers the particular challenges associated with each topic and makes recommendations about how best to use exercise to address those challenges. In her chapter about anxiety, she describes practice techniques to address various manifestations of anxiety:

For clients who are ruminative, forms of exercise that involve a modicum of skill acquisition or attention may prove useful in distracting them from internal processes.

Alternatively, methods of redirecting attention can be incorporated into the regular rhythm of repetitive activities... For example, clients who swim could be encouraged to

redirect their attention to the sensation of pulling their arms through water, or those who run could focus on the depth of their breathing. (Hays, 1999, p.94)

Hays is thoughtful about the ways exercise must be approached differently for clients depending on their particular challenge. Her suggestions are specific and detailed, such as that social interaction should be incorporated into exercise routines for clients with chronic mental illness or that affirmation, imagery, and controlled breathing techniques are useful to address trauma (Hays, 1999, p. 135 & p. 146). Throughout her book, Hays enumerates the many ethical considerations that arise when attempting to combine exercise and therapy. The topic of ethics will be described later in this chapter.

Fitness professionals have also given thought to how best to incorporate psychology and mental health into their practice. For example, in *Psychology for health fitness professional*, Gavin and Gavin (1995) outline the SPIRIT framework to help fitness professionals develop successful relationships with their clients. They explain, “We know that health and fitness is about the whole person, not just the body and not just the mind.” (Gavin & Gavin, 1995, p. x). The acronym SPIRIT stands for Support, Purpose, Integrity, Resolution, Inspiration, and Timing; each component contains both a theoretical framework and practical implications. Throughout the book, the authors provide practical skills based in psychology for fitness professionals to use to improve their work with clients. For example, they suggest ways fitness professionals can inspire their clients. “The triple-As of reframing negative or self-limiting beliefs as positive ones that promote self-actualization are [a]ttitude, [a]cceptance, and [a]ffirmation” (Gavin & Gavin, 1995, p. 84). About acceptance, they explain, “self-acceptance is a prerequisite for changing attitudes and beliefs. You acknowledge your feelings and resist turning them into negative, self-limiting beliefs” (Gavin & Gavin, 1995, p. 85). Although the authors provide many practice

recommendations, they do not discuss any specific mental health topics or issues to consider when implementing the SPIRIT framework with clients.

The IDEA Health & Fitness Association provides fitness professionals with education and resources and has done so for the 30 years they have been in existence. The IDEA Fitness Journal, a monthly publication available to all of their members with research, fitness and business tips, and ethical standards, is one of the major continuing education resources for personal trainers. I looked at 10 journals published in 2011 to see what types of information was provided regarding mental health (IDEA, 2012). Of the 198 pieces, there were just a few articles addressing mental health topics even indirectly. Several articles addressed the topics of motivation, working with special populations such as the elderly, and working with cancer survivors. There was one article on the way exercise affects the brain and another on stress-eating and obesity (IDEA, 2012). In each journal there was a section titled “Mind-Body-Spirit News” that focused on “Wellness news and research from around the world” (IDEA, 2012). However, this section mostly contained articles about exercise methods such as Pilates, yoga, and Tai Chi rather than mental health. The journals did not contain a single article directly addressing prevalent mental health topics such as depression or anxiety, nor did they explicitly discuss ethics or scope of practice considerations in connections with client mental health.

Ethical Framework

This study will use an ethical framework to inform the research questions, methodologies, and analyses. Ethical considerations will be drawn from theories across multiple fields, including social work, medicine, personal training, and philosophy. These theories will be applied to develop an understanding of the ethical considerations within the personal trainer-client relationship, specifically regarding the ethical implications related to scope of practice.

Best care practices. In helping professions such as social work and personal training, ethics guide practice to ensure that clients receive the best possible care. Theoretical frameworks in the ethical discourse range from Deontological theory, which asserts that individuals act ethically due to intrinsic moral obligations, to Utilitarian theory, which posits that an act is considered moral if it maximizes the good and minimizes the bad consequences, to Principlism, which focuses on the act of moral deliberation and only identifies some basic, widely held principles (Alexander & Moore, 2008; Bloch & Green, 2006; Mill, 2002; Ryan et al., 1979). Care ethics is a more recently developed theory that stresses the importance of care within relationships as the ethical guiding force and is frequently applied within the medical profession (Bloch & Green, 2006; Gilligan, 1982; Vanlaere & Gastmans, 2011). This theory is relevant to both social work and personal training because helping relationships are the basis of these professions.

Gilligan (1982) developed care ethics in response to issues she identified within the justice-focused male-dominated ethical discourse. “While an ethic of justice proceeds from the premise of equality—that everyone should be treated the same—an ethic of care rests on the premise of nonviolence—that no one should be hurt” (Gilligan, 1982, p.174). She describes caring for others within relationships as an ethical responsibility, a responsibility that is complicated by the inherent power differentials within relationships (Gilligan, 1982). This concept of care ethics has been used within many professions to conceptualize ethical care within a helping relationship.

In her examination guidelines for using exercise in therapy, Hays (1999) devotes a chapter to ethical issues. In this chapter, she recommends that therapists refer to the ethical codes established within their own profession and those established for sports psychologists, then

comply with the more stringent boundaries and expectations. One topic on which she focuses is *competence*; she states that therapists using exercise should be competent both in the use of their therapeutic techniques and in exercise science (Hays, 1999, p. 205). Typically, therapists do not receive training in exercise. Hays (1999) recommends that therapists “have some knowledge of both the physiological and social bases of exercise and sport” (p. 205).

The social work profession has an established code of ethics that outlines guidelines for engaging in ethical practice (National Association of Social Workers [NASW], 2008).

Throughout the course of the profession’s development, social workers have continued to redefine the underlying ethical framework to reflect the most current understanding of ethical practice (Reamer, 1998). In the most current version of the NASW Code of Ethics, six values are identified as integral to the mission of the social work profession: service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (NASW, 2008). The purpose of identifying these values is to establish profession-wide standards for practice and ensure that clients receive the best possible care. “Social workers’ primary responsibility is to promote the well-being of clients” (NASW, 2008, p. 7). One way professionals can ensure the best care is being provided to clients is for them to remain within their scope of practice.

Scope of practice. Within the field of social work, one of the six core values is *competence*. In the NASW Code of Ethics, competence is when “social workers practice within their areas of competence and develop and enhance their professional expertise” (NASW, 2008, p. 6). Additionally, social workers have the ethical responsibility to “prevent the unauthorized and unqualified practice of social work” (NASW, 2008, p. 25). Therefore, social workers are

called upon both to remain within their own scope of practice and ensure that other individuals are not attempting to practice social work without the qualifications.

The issue of how to clearly define scope of practice is evident across disciplines. As workplaces become increasingly more specialized, simultaneously the professionals in those workplaces seek to operate within holistic frameworks (e.g., McCabe, 2005; Wise, 2008). The struggle many professionals experience in determining and upholding their own scope of practice is described clearly by a psychiatric nurse encountering such a dilemma with a patient:

“To see my line, I need to ask her to stop being holistic, to stop having an integrated sense of her health, and to parcel herself and the story of her health out, discussions of this part with me, discussions of this part not with me.” (McCabe, 2005, p. 80).

At times, clients may be asked to withhold an aspect of their experience or identity when speaking with a professional who adheres rigidly to scope of practice guidelines. Often, negotiating these dilemmas is neither easy nor predictable.

For personal trainers, scope of practice is defined as the services that certified personal trainers are able to provide legally (e.g., Bryant & Green, 2010; IDEA, 2011). However there is no industry-wide standard, so personal trainers must look to their accrediting organizations and employers for guidance regarding scope of practice. The American Council on Exercise (ACE) training manual clearly defines scope of practice and which interventions fall within personal trainer scope of practice (Bryant & Green, 2010). The ACE guidelines require “Recognizing what is within the scope of practice and always referring clients to other healthcare professionals when appropriate” (Bryant & Green, 2010, p. 9). In the YMCA of the USA training manual, scope of practice is not mentioned (YMCA of the USA, 2000). The IDEA Health and Fitness Association, which is advertised as a resource to all fitness professionals, states that with regard

to mental health personal trainers are not allowed to “counsel,” but are able to “coach,” “provide general information,” and “refer clients to a qualified counselor or therapist” (IDEA, 2011).

Although this is clearly stated, it may be difficult in practice to differentiate between counseling and coaching and individuals may interpret those interventions in unique ways.

Gavin and Gavin (1995) provide an understanding of scope of practice through their SPIRIT framework, in which they address the many intersections between physical and mental health work (Gavin & Gavin, 1995). Integrity, for example, is described as setting and respecting boundaries in the relationship between personal trainer and client, noting that these boundaries stem from both professional requirements and personal values. When discussing implementation of this theoretical framework in practice, key points are, “If we respect the limits of our personal resources, it will be far easier to know the boundaries of our roles” (Gavin & Gavin, 1995, p. 49) and, “When in doubt, check it out. Ask what someone expects of you” (Gavin & Gavin, 1995, p. 51). The emphasis in the SPIRIT framework is on the personal trainer knowing themselves and using that knowledge as a place to begin connecting with their clients. SPIRIT provides a structured framework for personal trainers to follow when considering how to address client mental health while remaining within scope of practice.

Ethical considerations for scope of practice. Although there is no overall code of ethics for personal trainers as a profession, individual accrediting organizations and gyms have their own code of ethics and disciplinary steps to ensure that personal trainers operating under their names practice in accordance with their code of ethics. For example, the ACE Code of Ethics states that “ACE-certified Professionals will endeavor to... refer participants to more qualified health or medical professionals when appropriate” (Bryant & Green, 2010, p. 659). Additionally, Bryant and Green (2010) note that referral requirements differ by state, so personal trainers are

encouraged to learn the scope of practice for other professionals and to network with allied health professionals to facilitate referring that is competent and thoughtful. The ACE Code of Ethics is enforced through the ACE Professional Practices and Disciplinary Procedures, which includes a “three-tiered disciplinary process of review, hearing, and appeals,” and could result in a range of disciplinary actions including sanctions or revoking certification (Bryant & Green, 2010, p. 12).

Due to the close connection between physical and mental health, personal trainers often encounter challenges to maintaining their scope of practice with topics regarding mental health during work with clients (e.g., Bryant & Green, 2010; Gavin & Gavin, 1995). Despite scarcity of research on this topic, one study has examined the ethical considerations of personal trainer scope of practice, specifically inquiring about times when personal trainers act outside of their prescribed roles (Gavin, 1996). A self-selected sample of 228 personal trainers in the United States completed a survey including questions about comfort with different ways to engage with clients, some within scope of practice (e.g., “engaging in friendly, personal conversations with your client”) and some outside of it (e.g., “giving advice about personal or emotional issues”) (Gavin, 1996, p. 61). Responses indicated that although more personal trainers felt comfortable with engaging in friendly, personal conversations with their clients (74% responded they would definitely engage in this behavior and 25% responded with some reservations) some trainers also felt confident or would consider giving advice about personal or emotional issues (6% would definitely engage in this behavior and 59% responded with some reservations) (Gavin, 1996, p. 61). This study also found that women were more likely to give advice outside of the scope of practice than men.

This study was conducted through a large organization for fitness professionals; participants were recruited through a magazine published by the organization and self-selected into the study by choosing to return the survey included in the magazine (Gavin, 1996). Average age was 35 years old and participants were majority male, representing a similar make-up as the organization through which the survey was distributed. No demographic information was presented regarding race of either the personal trainers or the clients with whom they worked. Other factors describing the clientele such as socio-economic status, ethnicity, age, and gender were not addressed. Although this study represents an important starting point for research in this area, future research could include a more diverse group in terms of the personal trainers themselves, the training program from which they received their credential, and the clients they serve to more accurately capture what is happening across the field. Additionally, this research was conducted over 15 years ago and no follow-up studies have been conducted. Given the rapid growth that has occurred and is predicted to continue for the personal training occupation (BLS, 2010), it would be important to examine what changes have occurred since this study was conducted.

Synopsis

Physical health is inextricably intertwined with mental health. The majority of the studies that examined connections between physical and mental health have focused primarily on the mental health benefits of exercise. There is evidence for mental health benefits including decreased stress, anxiety, depression, improved job satisfaction, and self-concept in populations varying from university students to law enforcement personnel to older adults (Annesi, 2005; King et al., 1993; Netz & Lidor, 2003; Norvell & Belles, 1993; Sale et al., 2000). The exercise experience has been examined almost exclusively from the perspective of the client, with only

one study to date addressing the experience of personal trainers (Gavin, 1996). Despite stated requirements that personal trainers remain within their scope of practice when working with clients, specific guidelines do not exist regarding approved topics and behaviors that fall within that scope of practice (Bryant & Green, 2010; Gavin, 1996). This is an issue for ethical consideration if personal trainers are frequently engaging in unethical behaviors in an attempt to meet the needs of their clients. In general, the literature is missing the perspective of personal trainers and an examination of how scope of practice regarding mental health can affect the interventions used with clients.

Chapter III

Methodology

Formulation

The major questions addressed in this research project were: With what frequency do clients address their mental health during personal training sessions? How do personal trainers typically respond when clients address their mental health? For what reasons do personal trainers utilize those specific interventions? What types of training have personal trainers received about the topic of client mental health?

This study was an exploratory empirical investigation using a fixed method design. The purpose of this study was to better understand the ways in which clients address mental health topics with their personal trainers. A survey methodology was used to collect qualitative data from personal trainers. Smith School for Social Work Human Subjects Review Committee approved this research (See Appendix A for copies of the HSR approval letters).

Participants

The participants comprised a self-selected, non-probability sample of personal trainers in the Seattle-area. All participants were over the age of 18, held a personal training credential, worked with clients as a personal trainer currently, and had worked as a personal trainer for at least one year. Personal trainers who also had mental health degrees were excluded from this study.

Recruitment and Data Collection

Initially, I planned to use two different methods to recruit participants for this study. First, I recruited personal trainers from a variety of gyms across the Seattle area. The gyms contacted were chosen deliberately to reflect diversity in terms of size and client demographics; however, the majority of the gyms contacted did not provide consent to recruit their staff. I obtained permission to recruit personal trainers from 3 gyms with a total of 15 locations. After speaking on the phone with a contact at the gym, I provided each contact with a form letter indicating their consent for me to locate my research in their institution and to use the Smith School for Social Work Human Subjects Review Committee in lieu of an agency Human Subjects Review board (see Appendix B for the template provided to agencies). I emailed my recruitment flier to my contacts at the gyms for them to distribute to their personal training staff. The recruitment flier included eligibility criteria, the internet address for the survey, and my contact information (see Appendix C for the flier).

The second method I utilized was snowball sampling. I encouraged friends, family, and colleagues to distribute a formula recruitment message to eligible individuals (see Appendix D for the sample message I sent to contacts requesting support with snowball recruitment). I sent the message request via email and Facebook.

After two weeks of recruiting via these two methods, fewer than 20 participants had completed the survey, which was a smaller sample size than I sought. To address this problem, I added a third recruitment method. I choose several cities throughout the United States of American to represent different regions of the country (Chicago, IL; Dallas, TX; Denver, CO; Miami, FL; New York, NY; San Diego, CA; San Francisco/Bay Area, CA; and Seattle, WA). Then I conducted web searches for personal trainers located in those cities. When I was found an

email address for a personal trainer, I sent them an email message inviting them to participate in my study if eligible and encouraging them to pass my recruitment message along to other eligible individuals (see Appendix E for the sample message I sent to individuals I found through online search results).

When potential participants arrived at the SurveyMonkey web page for the survey, they encountered a welcome screen. Participants were asked to read a list of eligibility criteria (see Appendix F for welcome message and eligibility questions). If ineligible, participants were thanked for their time, informed they were ineligible, and directed to contact the researcher if they had questions about eligibility criteria. Participants who were eligible for the study were directed to the informed consent page (see Appendix G for informed consent page). At the end of that page they were informed that by clicking the “I agree” button they consented to participate in the study.

The study design was an anonymous, online survey (see Appendix H for complete survey). Participants completed demographic questions about themselves, the facility at which they work, and their client base. Participants then answered a series of 26 Likert-type questions about topics their clients may have addressed during personal training sessions (e.g., “Depression” or “Body Image”). Next, participants completed a seven-item scale of Likert-type questions regarding their opinions about the usefulness of therapy for their clients. This was followed by an open-ended question about a personal experience the participant had in which a client addressed their own mental health during session. The next section of the survey contained five questions about the interventions participants use when their clients address their mental health during session. The survey concluded with two questions about the training personal trainers received regarding mental health and an open-ended response inquiring about mental

health topics that may not have been mentioned in the survey. The survey was available online between February and March 2012.

Design

The research design was well suited for the research question for several reasons. First, because the research topic had been relatively unexplored previously, I wanted to obtain a larger sample size to provide a more representative picture of the current experiences of personal trainers. An online survey allowed for recruitment across a larger geographic area to obtain a larger sample size. Additionally, the design made the study more accessible to participants because they could complete it at any time convenient to them and it was only 15-20 minutes long. Finally, using a survey with predetermined questions provided standardized results that could be analyzed using numerical statistics, such as frequency and measures of central tendency. Thus, the final results could be presented in a way that could be easily shared with personal trainers.

Data Analysis

Descriptive statistics were used to analyze the demographic information participants provided. Individual questions were analyzed using measures of central tendency and variability (e.g., age or years of experience as a personal trainer) and absolute frequency and percentages (e.g., race/ethnicity of clients, source of personal training accreditation). This analysis was used to describe the sample generally and address generalizability and potential concerns with representativeness. The Likert-type questions, questions regarding making referrals, and questions regarding education about mental health topics were analyzed using absolute frequency and percentages. The two open ended questions were analyzed using content analysis.

Chapter IV

Findings

Participants represented a diverse group of personal trainers working across the country with diverse clientele. They encountered many mental health topics while working with their clients and utilized a range of interventions. Overall, participants agreed that some mental health topics fell outside of their scope of practice, but most felt confident addressing these topics through interventions as personal trainers and by referring to appropriate mental health professionals. Participants did not always cover mental health topics during their certification process and often learned about client mental health through a variety of other resources. In one open ended response, participants described the sometimes challenging topics their clients present in personal training sessions and the ways they attempted to support their clients while remaining within their scope of practice, which at times leads them to feel ineffective.

Participant Demographics

Of the 77 individuals who consented to participate in the survey, 58 participants completed the entire survey. Participants who completed the survey ranged in age from 23 to 66 years old ($M = 37.7$, $SD = 9.4$). The sample was 60.3 % male and 36.2% female, with 3.4% choosing not to identify and none identifying as another gender identity. Each participant was able to mark as many racial/ethnic categories with which they identified; the majority of participants identified as White (84.5%), followed by African (3.4%), East Asian (3.4%), Pacific Islander (3.4%), Southeast Asian (3.4%), Middle Eastern (1.7%), Black/African American

(1.7%) and Puerto Rican (1.7%), with 1.7% of participants choosing not to identify. Participants obtained their personal training certifications from a range of 16 different accrediting sources, with the majority coming from National Academy of Sports Medicine (43.1%), National Strength and Conditioning Association-Certified Strength and Conditioning Specialists (24.1%), American Council on Exercise (19.0%), American College of Sports Medicine (10.3%) (See Appendix I for table of all participants' accrediting agencies). More than one quarter of participants (27.6%) held two or more certifications. Participants ranged in years of experience in the field from 1 to 22 years ($M = 8.5$, $SD = 5.2$).

Participants worked in 14 different geographic areas. The area in which most participants worked was San Francisco/Bay Area, CA (29.3%), followed by New York, NY (12.1%), Seattle, WA (12.1%), Chicago, IL (8.6%), Denver/Boulder Area, CO (6.9%), San Diego, CA (6.9%), and Omaha, NE (5.2%) (See Appendix J for table of all participants' locations).

I asked for information about the cost of personal training sessions in lieu of being able to determine the socio-economic status of participants' personal training clients. The majority of participants reported that their clients spent between \$51-100 per session (74.1%), and far fewer clients paid \$50 or less (12.1%) or over \$100 (12.1%). Only 8.6% of participants stated that their gym offered financial assistance towards personal training sessions. However 53.4% reported that new members could get at least one free personal training session when they initiate membership. Of these participants, 71.0% offered one free session, 9.7% offered two, 12.9% offered three, and 6.5% offered more than three. These numbers regarding cost of personal training session indicated that the majority of participants' clients have access to funds beyond their cost of living, suggesting higher socioeconomic status. Participants' clients represented a range of ages, gender identities, and racial identities, as identified by the participants (see Table 1

for client ages, Table 2 for client gender identities, and Table 3 for client racial identities). The majority of the clients participants worked with during the past year fell in the age range of 30 to 49 years old (54.5%), were female (69.1%), and were White/Caucasian (78.6%).

Table 1

Age Group Breakdown of Participants' Clients

Age Group	<i>M</i>	<i>SD</i>	Total Clients by Age Group
13-19 year olds	0.8	3.3	44
20-29 year olds	3.2	4.6	184
30-39 year olds	6.1	6.1	352
40-49 year olds	5.6	4.7	325
50-59 year olds	3.4	3.2	199
60-69 year olds	1.6	2.1	94
70 years old and above	0.8	1.3	44

Table 2

Gender Breakdown of Participants' Clients

Gender	<i>M</i>	<i>SD</i>	Total Clients by Gender
Male	6.6	5.7	385
Female	15.0	13.6	872
Other	0.1	0.5	5

Table 3

Racial Breakdown of Participants' Clients

Racial Identity	<i>M</i>	<i>SD</i>	Total Clients by Racial Identity
Asian/Pacific Islander	1.0	1.8	60
Black/African American	0.8	2.4	46
Hispanic/Chicano/Latino	1.2	3.0	67
Mixed Race	1.0	2.3	56
Native American/American Indian	0.1	.3	3
White/Caucasian	16.1	13.5	934
I am unsure	0.4	1.5	22

Mental Health Topics

Participants reported encountering many mental health topics during their personal training sessions with clients. The most common feelings participants encountered from their clients were *stress* and *anxiety*, whereas they encountered *fear* and *grief* less often (see Figure 1 for the frequency with which personal trainers encountered each emotion from their clients). More than 75% of participants endorsed the mental health issues *food*, *work*, *body-image*, *goal-setting*, and *interpersonal relationships* as being addressed monthly or more frequently in the past year by their clients. Just one topic, *identity*, was endorsed by less than 25% of the participants as occurring monthly or more frequently in the past year (see Figure 2 for the frequency with which personal trainers encountered each issue from their clients). Participants responded that their clients addressed history of or current struggles with mental health topics less frequently than the previously discussed emotions or issues. About 50% of participants

reported that their clients addressed *eating disorders, past trauma, and substance abuse or addiction* several times in the past year or more frequently. Less than 20% of participants reported that their clients addressed *harm to self or violence towards others* once or more frequently in the past year (see Figure 3 for the frequency with which participants encountered their clients addressing a history of or current struggle with mental health issues). Participants reported that their clients did not express emotion non-verbally frequently during personal training sessions, with less than 25% of participants reporting their clients had *cried, given up and stopped the exercise/activity, or yelled* monthly or more frequently (see Figure 4 for the frequency with which participants encountered non-verbal emotion expressions from their clients).

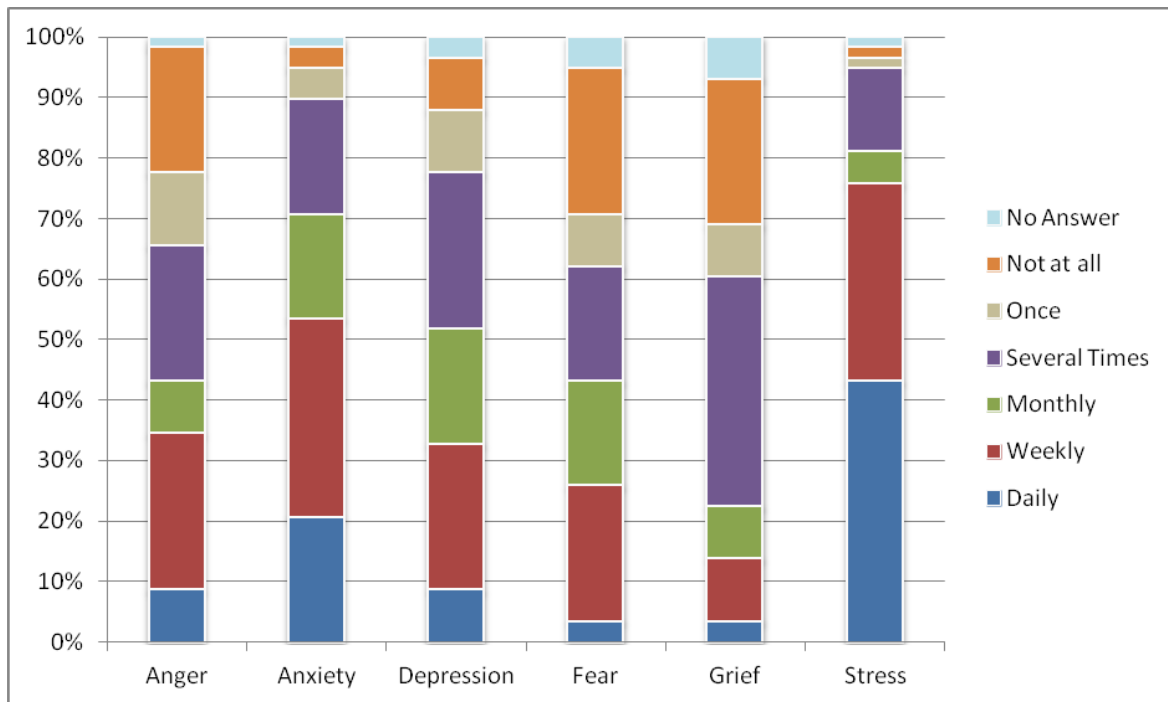


Figure 1. Participants’ estimation of the frequency with which “A client mentioned feelings of: _____” during personal training sessions in the past year.

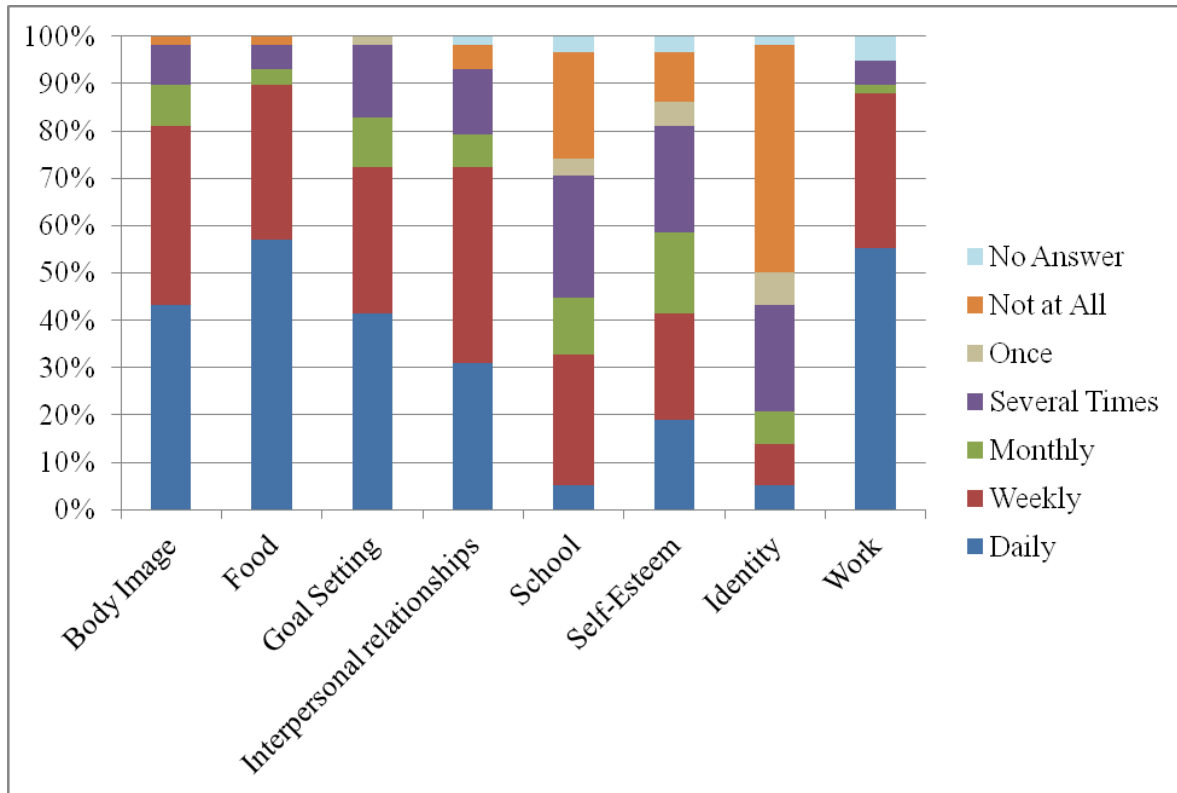


Figure 2. Participants' estimation of the frequency with which "A client discussed issues related to: _____" during personal training sessions in the past year.

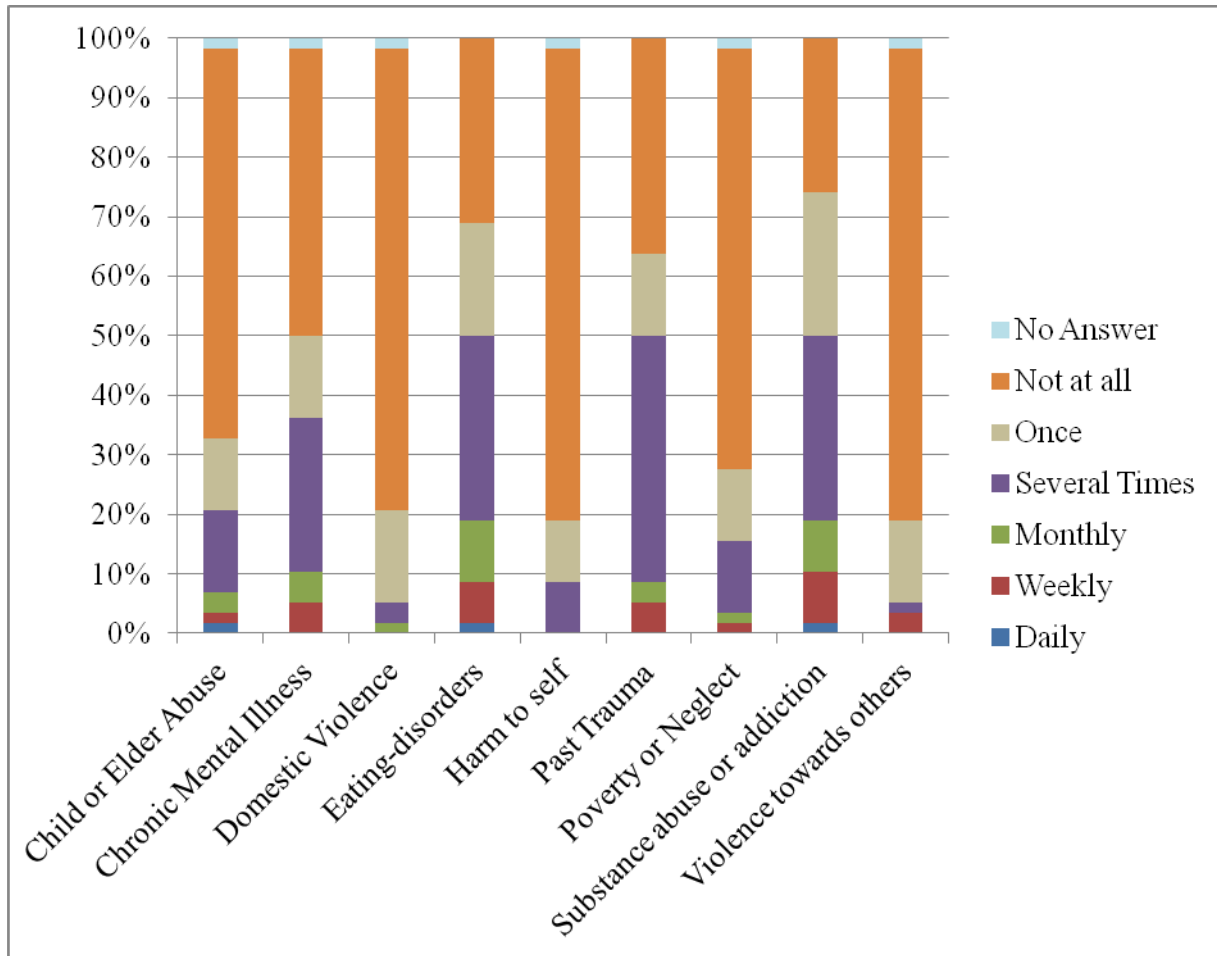


Figure 3. Participants' estimation of the frequency with which "A client spoke about a history of or current _____" during personal training sessions in the past year.

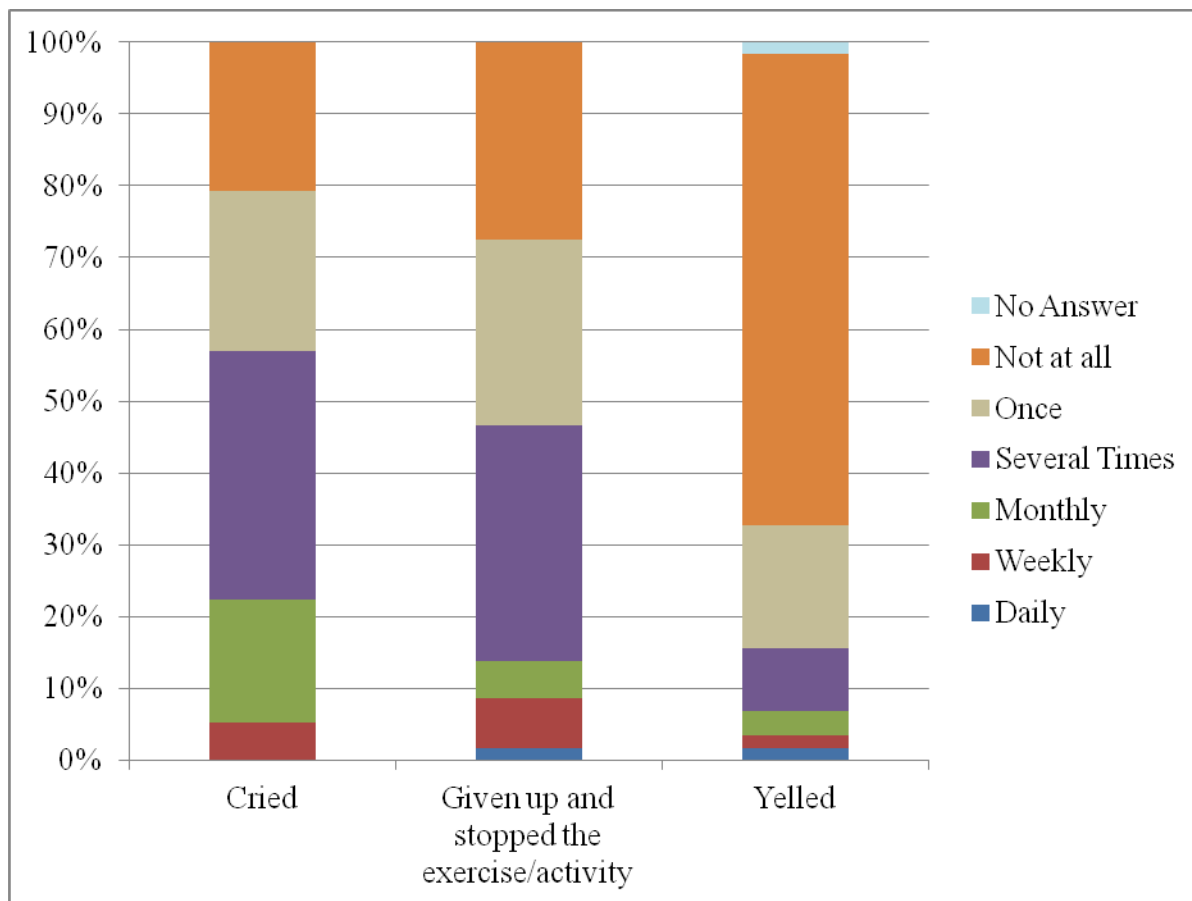


Figure 4. Participants’ estimation of the frequency with which “A client has expressed emotion non-verbally in the following ways: _____” during personal training sessions in the past year.

Beliefs about Therapy, Scope of Practice, and Interventions

On the survey items addressing beliefs about therapy and scope of practice, participants indicated they believed their clients could benefit from therapy and at times address topics that fell outside of their scope of practice. The majority of participants responded with either *Strongly Agree* or *Agree* to five of these items (see Table 4 for participant responses to beliefs about therapy and scope of practice survey items).

Next, participants indicated which interventions they typically use when clients address mental health topics (see Table 5 for list of interventions participants use). The majority of

Table 4

Participants' Responses to Mental Health Topics and Scope of Practice Survey Items

Survey Item	Strongly Agree	Agree	Disagree	Strongly Disagree	No Answer
I have worked with at least one client who would have benefited from seeing a therapist.	33	24	1	0	0
I have worked with at least one client who was struggling with issues outside of my scope of practice as a personal trainer.	23	28	7	0	0
Many of the clients I have seen could also have used support from a therapist.	20	30	8	0	0
Many of the clients I have seen struggled with issues that fell outside of my scope of practice as a personal trainer.	14	25	16	3	0
There have been times when clients discussed topics I felt were beyond my scope of practice to provide them with the necessary support.	15	33	10	0	0
I have never felt a client wanted me to provide them with support regarding a topic that was outside of my scope to practice.*	4	10	34	10	0
I feel I am able to adequately address my clients' concerns and remain within my scope of practice as a personal trainer.*	15	32	10	0	1

Note: The mode for each item is in bold.

*Responses to these items are reverse-coded, such that agreement indicates participants are able to meet client needs and remain within their scope of practice.

Table 5

Interventions Participants Used to Address Mental Health Topics Outside of Scope of Practice

Interventions	<i>n</i>	%
Listen actively	57	98.3
Encourage client to channel emotions/feelings into physical activity	39	67.2
Provide an example of when a similar thing happened to you or someone you know	39	67.2
Offer advice	35	60.3
Redirect attention to the physical activity at hand	30	51.7
Suggest the client see a therapist	29	50.0
Provide a referral to a relevant group (e.g., AA, support group, parenting skills group)	27	46.6
Provide a referral to a therapist	22	37.9
Challenge what they are saying	19	32.8
Provide a referral to a therapist with a specialty (e.g., eating disorders, depression)	15	25.9
Provide counseling on the topic	10	17.2
Set limits about what is appropriate to discuss in personal training session	10	17.2
Consult with supervisor about what to do	5	8.6
Make a report to an outside authority (e.g., police, Child Protective Services)	1	1.7

Note: A referral consists of providing the client with contact information for at least one specific individual, organization, or agency

participants (63.6%) reported having referred a client to a therapist at least once in their entire career. The participants who made at least one referral were asked to provide details about the referral process (see Table 6 for the items endorsed by participants about their referral processes). The participants who reported they had never made a referral to a therapist (46.2%) were prompted to endorse items explaining their reasons for not making any referrals (see Table 7 for the reasons participants endorsed for why they do not make referrals). Then, all participants indicated what would make them more likely to refer clients to mental health professionals (see Table 8 for results).

Education

Slightly less than half of participants (46.6%) responded that client mental health was addressed during their certification process to become a person trainer. The next largest group (40.0%) said client mental health was not addressed, and a small group (12.1%) could not remember if it was addressed or not. One participant (1.7%) did not respond to this item. Participants then indicated the ways in which they have gained knowledge about mental health topics (see Table 9 for results).

Table 6

Participants' Descriptions of Their Therapy Referral Processes

Survey Item Describing Referral Process	<i>N</i>	% ^a
I made a referral to a professional I knew personally	19	51.4
I checked in with my client later to inquire if they had followed through with the referral	19	51.4
I made a referral to a professional I felt would be a good fit for my client	16	43.2
I provided more than one referral	11	29.7
I made a referral based on a second party recommendation	9	24.3
I made a referral provided to me by my gym	3	8.1
None of the above apply	1	2.7

^aPercentage refers only to participants who responded “Yes” to the question: “In your ENTIRE career as a personal trainer, have you ever made a referral to a therapist?” (*n* = 37).

Table 7

Participants' Reasons for Never Referring a Client to a Therapist

Reason Participant Never Referred a Client to a Therapist	<i>n</i>	% ^a
I did not have any referrals to provide my client with	17	81.0
I felt uncomfortable providing a referral	8	38.1
Other	7	33.3
I have not had a client who I felt could use support from a mental health professional	5	23.8
I do not believe in referring to mental health professionals	0	0.0

^aPercentage refers only to participants who responded “No” to the question: “In your ENTIRE career as a personal trainer, have you ever made a referral to a therapist?” (*n* = 21).

Table 8

What Would Make Participants More Likely to Refer Clients to Mental Health Professionals

Participant Responses	<i>n</i>	%
If I personally knew the professional(s)	46	79.3
If I knew my client well enough	35	60.3
If I had more training about when to refer clients to mental health professionals	29	50.0
If my gym provided a list of referrals for me to use	17	29.3
Other	4	6.9

Table 9

Ways Participants Gained Knowledge about Mental Health Topics

Participant Responses	<i>n</i>	%
Personal experience	51	87.9
Read a book/article	45	77.6
Taken an academic class (e.g., Psychology)	34	58.6
Attended a training or workshop	21	36.2
Gained Continuing Education Credits towards my personal training certification	14	24.1
Other	10	17.2
Spoken with a supervisor at work	8	13.8

Participant Experiences Addressing Client Mental Health Topics

Participants responded to one open ended question: “Please describe a time a client brought up a topic you felt was RELATED TO MENTAL HEALTH and outside of your scope of practice as a personal trainer. What was the topic? How did you respond?” Nine participants responded “this has never happened to me” and three participants did not provide responses. To code the mental health topics addressed in participant responses, I used the topics from the “Mental Health Topics” section of the survey (see Appendix J for complete survey; the “Mental Health Topics” section is on pp. 9-10). I used the “Interventions” section of the survey to code the ways in which participants responded to their clients (see Appendix J for complete survey; the “Interventions” section is on p. 13). For both mental health topics and interventions, I noted all additional topics and interventions the participants addressed in their responses that had not been included in my survey.

Participants mentioned many of the mental health topics from my survey in their open responses. Interpersonal relationships were mentioned the most often—this topic appeared in nine responses. One participant wrote: “A client brought up issues regarding the difficulty of her marriage.” Eight participants wrote about struggles training clients with depression, as seen here:

The closest I ever got to what I would consider a "mental health" issue was a girl who was about 80 lbs overweight. She was a client of another trainer and he wasn't there so I trained her. I asked her about her routine and her progress. Both of which were something she knew nothing about. I asked how long she'd been training and she said "2 years". I told her that we could do better than nowhere in 2 years. We worked out a couple more times and she was visibly depressed/ low energy. After two workouts she didn't come back. I tried to contact her but she didn't respond.

The final most common topic described in participants' responses was stress, which was also mentioned eight times:

I had a client tell me that they were too stressed to train, to take good physical care of themselves; lack of sleep food etc. They were worried that this would cause a serious health problem if their job continued to provide the stress.

As seen in two previous responses, many of the personal trainers spoke about the mental health issues as impediments to success as a personal trainer. Another typical response was that participants encountered mental health issues as the motivation for clients seeking personal training services, as in this response: “[M]any clients struggle with emotional eating that stems from or trickles into other areas of their lives. [M]any bring their emotional baggage to their... sessions, as an outlet.” Participants often addressed multiple mental health topics within one response, such as in the following response about a personal training client:

Female client trying to lose weight for a bachelorette party she already felt uncomfortable going to because she looked different than the others. She said she suffered from depression and had had an eating disorder earlier in her life. She was also dealing with a new job and breaking up with her live-in boyfriend. She was getting frustrated with not being able to do what I asked in the moment and her anxiety about the bachelorette party.

In this response, the participant mentioned the topics of body image, depression, eating disorders, work, interpersonal relationships, and anxiety, both as factors leading her to seek personal training and as impediments to her success during sessions. The four topics addressed in participant responses that I had not included in my survey were sexual harassment, coping with illness, learning disabilities, and struggles with sleep.

Participants described using a range of interventions to address their clients' mental health issues. Six participants suggested their client seek support from a therapist, and another four wrote they had provided their clients with referrals to specific mental health professionals. Participants also described using active listening skills ($n = 5$), providing counseling on the topic ($n = 4$), offering advice ($n = 3$), and redirecting to the physical activity at hand ($n = 3$). Additionally, two participants mentioned collaborating with mental health professionals to provide treatment, such as in this participant's account:

One time a client came to me with cuts all over her arms [and] backs of her legs. She was a cutter. I knew right away what was going on. I talked to her about stresses in her life and things that were triggering her anger. After the session I called her therapist, who followed up.

Participants also mentioned many additional interventions that I had not mentioned in the survey, such as asking questions ($n = 2$), validating feelings ($n = 2$), encouraging ($n = 1$), reassuring ($n = 1$) and providing psychoeducation ($n = 1$). Six participants directly addressed challenges they faced as personal trainers addressing client mental health. They described feeling uncertain about how best to support their clients and noted that some topics would be better addressed by mental health professionals. Here is one participant's description of her struggles to address her client's mental health needs:

I had a client who was having a really hard time in her relationship with her partner. We would spend 3/4 of the session talking about her insecurities, feelings of anger and [jealousy], and her growing apathy for taking care of herself. I remember looking at her one day and thinking, "She's not going to be able to make any of the physical changes she wants/needs to make while she's in this relationship - I feel helpless in the face of these

larger issues. I can't do enough to help her in the ways that she needs help...I really wish she'd either go to therapy or end this unhealthy relationship!" I continued to [act] as a pseudo-therapist for as long as she continued to see me, without seeing much change in her attitude or her body. It was very frustrating.

This participant did not mention if she suggested that her client see a therapist or provide her client with any referrals.

Chapter V

Discussion

In this chapter I present how my findings extend the literature concerning the intersection of mental health and exercise, by including an exploration of how mental health issues presents within the context of the personal training relationship. First, I focus on answering the four questions I posed when I initiated this research: With what frequency do clients address their mental health during personal training sessions? How do personal trainers typically respond when clients address their mental health? For what reasons do personal trainers utilize those specific interventions? What types of training have personal trainers received about the topic of client mental health? Then I discuss additional findings beyond my initial research questions. Next, I evaluate the strengths and limitations of this study. Finally, I discuss the ways this study contributes to the social work profession and my recommendations for future action and research.

Research Questions

Mental health topics. My first question concerned the frequency with which clients address their mental health in personal training sessions. In this study I found that personal trainers do encounter mental health topics in sessions and that their clients present some topics more frequently than others. Participants endorsed every mental health topic listed in the survey as occurring within the past year of practice, suggesting that personal trainers encounter a wide range of mental health topics in their work, disregarding frequency. It was clear from participant

responses that some topics occurred with much greater frequency than others. For example, more than three-quarters of participants reported their clients mentioned feelings of stress or discussed issues related to body image on a daily or weekly basis, whereas less than one-quarter of participants reported their clients mentioned feelings of grief and less than one-twentieth reported their clients mentioned past history of or current domestic violence on a daily, weekly, or monthly basis.

It is important to note that the data tell us only how often personal trainers reported their clients mentioning topics, which is not only based on a self-report measure but also relies on participants' abilities to recognize and recall each of the mental health topics. Some topics may have been easier for participants to identify or may have been more salient and allowed them to recall times clients addressed them. For example, participants reported that clients discussed issues related to work far more often than they discussed issues related to identity. This may, in fact, reflect the frequency with which this topic is mentioned within personal training sessions, or on the other hand, it may reflect the ease with which personal trainers identify this topic or its saliency in personal trainers' minds. For example, one participant described an incident in which a client discussed sexual harassment at work: "A client recently told me she is dealing with sexual harassment from her boss at work, doesn't want to quit her job that she loves, and can't tell her husband, for fear of him making her quit her job." This is a short description of the incident from the personal trainer's perspective and memory. The personal trainer may easily identify this as an issue concerning work, but not as an issue concerning the client's identity as a female, which would affect the participant's responses to these items.

Interventions personal trainers use. My participants utilized a variety of interventions when their clients confronted them with mental health issues they identified as outside of their

scope of practice as a personal trainer. Active listening was the most common intervention used. Almost all participants used active listening and several commented on its effectiveness in their open responses. As one participant said: “I work with a lot of teens - the majority of teens need some level of help, even if it [is] just someone to talk to.” And another added, “Another client discusses family issues quite often (children with drinking, drug problems, and divorce and ex spouse) and all I do is listen. They don't seem to be looking for any answers and now are in a healthy relationship and happy.” In these examples, the participants described how they use active listening, remain within their scope of practice, and provide their clients with what they seem to be looking for from their personal trainer. Participants indicated by their responses that they have figured out numerous ways to provide support to their clients while remaining within their scope of practice. For example, more than half of the participants reported redirecting their clients or encouraging them to channel their emotions into physical activity.

Several items on this question were included to assess if personal trainers may sometimes be acting outside of their scope of practice. For example, a noteworthy portion of the participants reported providing counseling (17.2%), which the fitness organization IDEA Fitness identified as outside of personal trainer scope of practice (IDEA, 2011). Interestingly, some personal trainers spoke to being pulled into quasi-counseling attempts to meet their clients’ needs, even when they knew they were unqualified to counsel:

I remember looking at her one day and thinking, "She's not going to be able to make any of the physical changes she wants/needs to make while she's in this relationship - I feel helpless in the face of these larger issues. I can't do enough to help her in the ways that she needs help...I really wish she'd either go to therapy or end this unhealthy

relationship!" I continued to [act] as a pseudo-therapist for as long as she continued to see me, without seeing much change in her attitude or her body. It was very frustrating.

Participants endorsed having used several interventions that may fall outside of their scope of practice depending on how they were used, such as challenging what clients said or providing advice. In their open ended responses, some participants described interventions that were questionable in nature, such as in the following:

I actually do not allow clients to bring their outside issues to my sessions. I am not a therapist and don't want to be, however, I am very compassionate and WILL meet with a client outside of a session in order to console them.

This participant describes setting firm boundaries and acknowledges that the role of a personal trainer is different from that of a therapist, but then is willing to engage in those behaviors outside of the personal training session. I do not know if this choice would be approved of by the participant's accrediting agency or the facility at which the participant works, but from an ethical perspective it seems that referring these clients to qualified professionals would be the best care practice in this situation. As discussed in the literature review, operating from an ethical orientation based on care promotes practices that are within scope of practice to ensure that clients are not being harmed and are receiving the best care possible (Bloch & Green, 2006; Gilligan, 1982; NASW, 2008).

One intervention in which I was particularly interested was the rate at which personal trainers refer their clients to seek professional mental health support. Although training materials direct personal trainers to refer clients to mental health professionals when topics falls outside of personal training scope of practice (e.g., Bryant & Green, 2010, p. 659), there has been no research to date to indicate whether personal trainers use this intervention to ensure best care

practices with their clients. In my study, participants reported they provided their clients with a variety of mental health referrals. In reference to their past year of practice, 46.6% of participants reported they provided at least one referral to a relevant group (e.g., AA, support group, parenting skills group); 37.9% reported they provided at least one referral to a therapist; and 25.9% reported they provide at least one referral to a therapist with a specialty (e.g., eating disorders, depression). Over their entire careers as personal trainers, 63.6% of participants reported they made at least one referral to a therapist. These numbers are promising, because they indicate that personal trainers are using referral to qualified mental health resources as an intervention when they are confronted with mental health issues outside of their scope of practice.

Reasons personal trainers used selected interventions. Beyond knowing whether my participants made any referrals to mental health professionals, I wanted to know more about their decision-making process regarding whether to make a referral or not. The reasons personal trainers do not make referrals impact recommendations for how best to increase referrals. For example, personal trainers who do not believe their clients require additional mental health support or who do not believe in therapy would not be inclined to provide their clients with referrals. Additionally, some personal trainers might wish to refer clients to mental health professionals, but lack the names of appropriate resources. Although these scenarios would both result in a lack of referrals, mental health professionals interested in collaborating with personal trainers to improve referral rates would use different methods to address each scenario.

In my study, all participants reported that they believe in referring clients to mental health professionals as an intervention. Additionally, the vast majority of participants reported they worked with clients who were struggling with issues outside of their scope of practice as

personal trainers and with clients who would have benefited from seeing therapists. Only 8.6% of participants reported they had not worked with a client who could have used support from a mental health professional. All of this indicates that some personal trainers both believe in providing referrals and have been in situations in which it would have been appropriate to provide their clients with referrals.

I was interested in the barriers personal trainers perceive to providing their clients with referrals. Participants who reported they had never provided a client with a referral for mental health support answered one question about why they had not done so. The reason participants endorsed the most was that they did not have a referral with which to provide their client. Although this may seem to be simple and easy to address, it is the largest barrier preventing personal trainers from referring their clients to mental health services. Participants also responded that they felt uncomfortable providing the referral, which suggests that even when personal trainers believe in therapy and that their clients would benefit from seeing therapists, they might not feel comfortable suggesting their clients see therapists or providing their clients with referrals.

To most successfully address the barriers personal trainers perceive, I asked them to select from a list of items those that would make them more likely to provide their clients with referrals. Several of the items they endorsed could be facilitated by mental health professionals. For example, more than three-quarters of the participants reported they would feel more confident making a referral if they personally knew the mental health professional. Social workers and other mental health professionals could network more with athletic facilities to build relationships and increase referral rates. Almost one-third of the participants said if they had a ready-made list of referrals that would increase the likelihood they would make a referral. Again,

this is something mental health professionals could undertake in collaboration with the athletic facilities. Well over half of participants expressed they would refer at higher rates if they knew their clients better. To know their clients better, personal trainers might just need time for the relationship to develop. Additionally, many of the training materials stress the importance of rapport building and relationship development (e.g., Bryant & Green, 2010; YMCA of the USA, 2000). As personal trainers feel more competent at getting to know their clients, these results suggest they will also feel more comfortable with referring them to mental health professionals. Finally, half of participants said they would be more likely to make referrals if they had additional training about client mental health and when to make referrals. Again, this may be an area in which mental health professionals take the lead and offer support to fitness organizations or athletic facilities to provide personal trainers with education about mental health and when to make referrals.

Training regarding mental health. Participants cited numerous ways they gained knowledge about mental health topics. The clearest finding was that they disproportionately gained knowledge about mental health topics through independent methods rather than via their accrediting agencies or continuing education opportunities. The vast majority of participants gained knowledge about mental health topics through personal experience (87.9%) or by reading a book or article (77.6%). If these are the primary methods personal trainers use to guide their practice when their clients address mental health, it is likely their practices will differ widely from one another. In comparison, less than half of participants had attended a workshop or training about mental health (36.2%), gained Continuing Education Credits that address client mental health (24.1%), or even remembered addressing client mental health during their certification process (46.6%). These methods are less subjective, so increased use of these

methods could result in more standardized education and practice across the profession. It is also important to note that only 13.8% of participants had consulted with a supervisor about an issue related client mental health. Overall, participants' reports about their education sources suggest that personal trainers are relying on their own subjective personal experiences to guide their interactions with clients related to mental health, rather than following set standards from their accrediting institutions or practice training from industry approved education sources.

Although the results clearly indicate personal trainers are biased towards using more subjective rather than objective sources, they do not explain why personal trainers do not seek education through more formalized industry methods. It is possible there are few resources about client mental health offered through industry channels. For example, 40.0% of participants said they did not address client mental health at all during their accreditation process. In personal training education materials, client mental health often is not addressed at all or is touched on briefly and in broad terms (e.g., IDEA, 2012; YMCA of the USA, 2000). Another possibility is that personal trainers do not take advantage of the education opportunities that are available. For example, the online ACE Continuing Education Center contains one course that addresses nutrition and eating disorders and another course about how to use exercise to recover from psychological disorders (The American Council on Exercise, 2012). If ACE certified personal trainers are not aware that these courses exist or do not think they are as important as other continuing education topics offered, they will not choose to take them. Future research should be conducted to determine what opportunities personal trainers have to be educated about mental health, how accessible that education is, and what motivation personal trainers have to learn about these topics.

Strengths and Limitations

Sample. My goal was to recruit a large, diverse sample to improve my study's generalizability. With respect to the size of my sample, I met my goal of 50 and obtained usable responses from 58 participants. Because this is the first study of its kind, this sample size allowed me to begin to describe the situation facing personal trainers with respect to their clients' mental health. However, considering there are around 251,000 fitness trainers and instructors in the United States of America (BLS, 2012), 58 is a relatively small sample. In the future, a larger sample size would allow for greater generalizability.

The participants in my study were diverse in several ways. Both males and females were well represented within the sample. Participants ranged widely in age from 23-66 years old and had a range of 1-22 years of experience as personal trainers. Several factors made it more reasonable to generalize to the personal training industry. First, participants worked in geographic areas across the United States of America, and second, participants were accredited through many different institutions. In other ways, the sample was more homogenous. Most importantly, participants were not racially diverse—84.5% of participants identified White. The sample's racial homogeneity was likely due to the recruitment methods I used for this study, which are discussed below. However, I was unable to obtain demographic statistics about personal trainers as a group, so it is possible that the demographic breakdown of my sample is reflective of the industry overall.

I intended to obtain data from participants who worked with a diverse group of clients, as well. Again, this was only achieved in some respects. Participants worked with clients who varied widely in age. However, the vast majority of their clients were White and female. Without information about the demographic breakdown of personal training clients, it is not clear if this accurately reflects personal training clients as a group or not.

Recruitment methods. I used three different methods to recruit participants: I contacted personal trainers at several athletic facilities in Seattle via email through my contacts at the facilities, sent my recruitment message through personal and professional contacts, and contacted personal trainers I found through internet searches. Using these methods, I was able to reach personal trainers in large numbers across the country and achieve my sample size goal.

Selection bias is one of the limitations to my recruitment methods. Individuals who received the recruitment message decided to participate or not. Possibly individuals who chose to participate may have been qualitatively different in some way from those who did not. However, because I did not have demographic information about the individuals who were contacted to participate, it is not possible for me to know if any of these differences existed or what they may have been. One possibility is that individuals who were already aware of the mental health issues within their client base may have been more likely to participate.

My attempt to recruit participants through athletics facilities did not appear to be successful. It is not possible to know how participants found out about the study; however, I asked each participant to report their location, which helped me to determine that the maximum number of participants who could have been contacted initially through their athletic facility was only seven. This low response rate may have been due to any of several factors. First, I do not know how my contact at each athletic facility presented the study to the personal trainers beyond the recruitment message I sent. Second, I do not know how inundated personal trainers are with messages through their work email, and in some cases they may not pay attention to most emails they receive. Finally, individuals contacted through work had no personal interactions with me, as compared to those who received personal emails from me or who were contacted by others with a personal message. In the future, to help determine how successful each recruitment

method was, surveys should include a question asking each participant how they found out about the study.

Snowball sampling presented a unique issue that I had not expected. As my recruitment process progressed, I learned that many of my personal and professional contacts had only passed the recruitment message along to individuals they knew who were personal trainers. My hope had been for each contact to pass it along to all of their contacts, who could continue to pass it along, and that way I would reach many individuals. However, the feedback I received was that many individuals did not pass it along to everyone, but only to those they believed would qualify for the study.

Data Collection. In this study I used an online survey to collect my data. This allowed me to reach potential participants across the country and maintain participant anonymity. At the same time, it limited my personal interactions with potential participants, making the process less personal and perhaps less appealing for some individuals. It also prevented individuals without access to the internet and a computer from participating. This design appeared to be successful for the purposes of this study, but should be evaluated for its effectiveness for future research.

Recommendations

This study is one of the first to examine the phenomenon of clients addressing their mental health within sessions with personal trainers. The findings from this study can be used to help shape practice of social workers, personal trainers, fitness facilities, and personal trainer accrediting agencies. They can also be used to guide future research to add to the literature about this phenomenon.

Future research. This exploratory study provided a wealth of knowledge about the situation personal trainers find themselves in regarding their clients' mental health. However,

this study just skimmed the surface—future research should be conducted to continue to explore this topic and broaden the base of research about mental health within personal training relationships. Future researchers should target diverse populations, include additional mental health topics, and if the survey I developed is used, should slightly modify some items.

Although I attempted to obtain a diverse sample in my study, several demographic areas were fairly homogenous. Future researchers should attempt to address the weaknesses within my study to reach individuals from more diverse racial backgrounds, for example. It would be inaccurate to assume that personal trainers of color would necessarily agree with what this sample of mostly White participants reported. A more diverse sample would help to generalize findings across the fitness industry.

This study focused on the experiences of personal trainers, in part because their voices have been largely unheard and in part due to methodological ease. In future research, it would be important to find out what personal training clients identify as their mental health needs and what they think about their personal trainers' abilities to address their mental health needs. I looked at some of the literature within the personal training industry; however, it was far from comprehensive. It would be helpful for future researchers to perform a full review of the personal training literature for materials related to client mental health and personal trainer ethics and scope of practice.

In addition to the list of mental health topics included in the survey, which was developed using several resources and through informal discussions with personal trainers, participants mentioned multiple mental health topics that future researchers should consider including in future studies of this nature. Medical issues/illness was the topic most frequently mentioned by participants that had not been included as part of the survey. In fact, Hays (1999) dedicated a

chapter in her book about using exercise in therapy to the topic of addressing illness. She discussed the possibility that individuals who have experienced illness may have mental health repercussions such as depression and also the importance of exercising in the healing process (Hays, 1999, pp. 148-149). Research that follows my study would be improved by including the topic of medical illness.

Several participants also mentioned sleep issues as a common mental health topic discussed by their clients during sessions. The importance of sleep and the effects of sleep disturbances are not mentioned in the personal training materials I examined. Sleep is intricately tied to mental health, and sleep disturbance has been associated with poor mental health status (e.g., Kaneita et al., 2009; Puterbaugh, 2011). Literature exists in the mental health field about how to address clients' sleep difficulties. For example, Puterbaugh (2011) described treatment strategies mental health counselors can use to address what she called an "epidemic" of sleep problems in the United States (p. 312). Personal trainers might benefit from shared knowledge in this area, as well as psycho-education about the importance of sleep and its relevance to client mental health.

There are several slight changes I would recommend to my survey design if it were to be used in future research. Through the course of my research I learned that many personal trainers operate independent of an athletic facility or through multiple facilities and locations. The option for a personal trainer to say, "I am self-employed" or "I work in several locations" could provide relevant information for future researchers. I also learned of many institutions that offer personal trainer accreditation programs, so a future version of this study should include a more comprehensive list. Although asking about personal training session pricing was a useful way to

approximate participants' clients' socioeconomic backgrounds, I would prefer a more direct way of asking about this important demographic factor.

I felt it was important to do an exploratory quantitative study to get a general picture of the intersection of mental health and exercise within personal training because this specific topic had not been researched yet. As I conducted my study, it became clear to me that each personal trainer had a wealth of experience and knowledge about the topic of client mental health. Now that there is a basic foundation for this research, I think it would be informative to conduct qualitative interviews to obtain more details about personal trainers' experiences with their clients' mental health.

Social work and personal training practice. My first recommendation is to increase collaboration between mental health and fitness professionals to bridge the gap in expertise between disciplines and ensure clients receive the highest level of care. Education is one form this collaboration might take; social workers could provide invaluable psycho-education to fitness professionals through trainings addressing client mental health. This study could be used as a basis for developing more in-depth training and continuing education materials for personal trainers on client mental health. Education could target the topics participants reported in this study they encounter the most frequently, such as stress and anxiety. Developing trainings about scope of practice to inform personal trainers about which interventions are within their scope of practice and at which point they should refer clients to mental health professionals might also be helpful to personal trainers. Finally, training materials for personal trainer certifications could be adapted to include mention of the mental health topics that clients are likely to present during sessions, so that personal trainers have some background knowledge on each topic.

Another form of collaboration that would be fostered by establishing a relationship between social workers and fitness industry professionals is referrals. Social workers might more readily refer clients seeking fitness support to personal trainers who are able to appropriately address mental health topics and personal trainers might make more informed referrals to mental health services when clients raise topics outside of personal trainer scope of practice. Because the participants in my study identified lack of referrals as their primary reason for not providing them to their clients, this is one easy step that might greatly improve personal trainers' ability to address their clients mental health needs. Referral rates might increase if local therapists developed relationships with the athletic facilities in their area and provided materials such as business cards or fliers to make it easier for personal trainers to make referrals.

Strengthening these relationships between personal trainers and therapists would be mutually beneficial and result in better care practices for clients through collaborative services. For example, a group on depression could include two components: a support group facilitated by a social worker and an exercise class led by a personal trainer. Social workers could provide trainings for personal trainers to address important information about client mental health and personal trainers could support social workers in utilizing exercise to address clients' mental health concerns. The ideal end result would be better comprehensive care within scope of practice and appropriate referrals when needed.

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Appendix A

Smith College School for Social Work Human Subjects Review Committee Approval Letters



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

February 6, 2012

Alana Honigman

Dear Alana,

The requested revisions to your Human Subjects Review application have been reviewed and are approved. Nice job with the edits and explanations. Thank you for your professionalism.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck on your research project.

Sincerely,

A handwritten signature in black ink that reads 'David L. Burton'. The signature is written in a cursive style with a long horizontal flourish extending to the right.

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee

CC: Mary Beth Averill, Research Advisor



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

February 24, 2012

Alana Honigman
2719 E. Madison, Suite 200
Seattle, WA 98112

Dear Alana,

I have reviewed your revised Human Subjects Review application materials. I approve you adding another participant recruitment method. Thank you for keeping us informed. Nice work!

Sincerely,

A handwritten signature in black ink, reading 'David L. Burton', with a long horizontal line extending to the right.

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee

CC: Mary Beth Averill, Research Advisor

Appendix B

Agency Approval Letter Template

AGENCY LETTERHEAD PLACED HERE

Date

Smith College
School for Social Work
Lilly Hall
Northampton, MA 01063

To Whom It May Concern:

Name of agency/gym gives permission for Alana Honigman to locate her research in this institution. We do not have a Human Subjects Review Board and, therefore, request that Smith College School for Social Work's (SSW) Human Subject Review Committee (HSR) perform a review of the research proposed by Alana Honigman. Name of agency/gym will abide by the standards related to the protection of all participants in the research approved by SSW HSR Committee.

Sincerely,
Signature

Name
Position Title
Agency
Program

Appendix C

Recruitment Flier

Addressing Client Mental Health within the Personal Training Relationship

Volunteers Wanted for a Research Study!

Are you:

- ✓ 18 years of age or older?
- ✓ A certified personal trainer?
- ✓ Employed a minimum of 1 year as a personal trainer?
- ✓ Currently employed as a personal trainer?
- ✓ Not a degree holding mental health professional?

If you answered YES to ALL of the above questions, you are eligible to participate in study of personal training and client mental health.

The purpose of this study is to explore the experiences personal trainers have navigating their scope of practice concerning client mental health. Participation will consist of filling out a 15-20 minute online survey that addresses your experiences navigating your scope of practice while working with clients as a personal trainer. All information will remain anonymous.

By choosing to participate in this study, you will be providing information that will be used to develop an understanding of the challenges personal trainers face navigating scope of practice regarding client mental health. This information may be helpful in developing gym policies, training and continuing education for personal trainers.

This is an online study and can be completed anywhere you have access to a computer and the internet. Please visit <https://www.surveymonkey.com/s/9KTMWFF> to begin your participation in this research study.

This research is being conducted under the direction of Alana Honigman, Smith College School for Social Work Master's candidate. For more information, and to learn about this study, please email Alana Honigman at [EMAIL ADDRESS](#) or call (XXX) XXX-XXXX.

Appendix D

Email Message for Recruitment through Snowball Sampling

Dear Colleagues,

I am currently looking for participants to complete a survey questionnaire for my thesis research study. I am exploring the experiences of personal trainers addressing mental health topics with clients. I am looking for individuals at least 18 years of age who are certified personal trainers, currently employed as personal trainers, and have worked for a minimum of 1 year as personal trainers, but do not hold a mental health professional degree. Would you please forward this email to anyone you know who might be interested in completing my survey? The online survey takes approximately 15-20 minutes to complete. Your help would be greatly appreciated.

Please click on this link to take my survey:

<https://www.surveymonkey.com/s/9KTMWFF>

I have included a message below that you can send on to friends, family, co-workers, and professional connections who you think may be eligible to participate in the study.

Thank you for your time and help!

Alana Honigman
Master's Candidate '12
Smith College
School for Social Work

Hello,

My name is Alana Honigman and I am a second year Master's student at Smith College School for Social Work. I am currently working on my thesis and conducting a research study exploring the experiences of personal trainers addressing mental health topics with clients. I am hoping that you will participate and help to inform my research. To participate, you must meet the following criteria:

- 18 years of age or older
- A certified personal trainer
- Employed a minimum of 1 year as a personal trainer
- Currently employed as a personal trainer
- Not a degree holding mental health professional

Participation consists of completing an online survey about your experiences working with clients. The survey takes approximately 15-20 minutes to complete. Your help would be greatly

appreciated. There will be no identifying information asked on the survey and all information will remain anonymous.

Please click on this link to take my survey:

<https://www.surveymonkey.com/s/9KTMWFF>

Feel free to contact me with any questions you may have. Thank you for your time.

Alana Honigman
Master's Candidate '12
Smith College School for Social Work
[EMAIL ADDRESS](#)
(XXX) XXX-XXXX

Appendix E

Recruitment Letter to Individual Personal Trainers

Dear (Personal Trainer's Name Here),

I found you listed as a personal trainer (how I found their name goes here (e.g., “through the X database” or “on X website”)). My name is Alana Honigman and I am a second year Master's student at Smith College School for Social Work. I am currently working on my thesis and conducting a research study exploring the experiences of personal trainers addressing mental health topics with clients. I am hoping that you will participate and help to inform my research. To participate, you must meet the following criteria:

- 18 years of age or older
- A certified personal trainer
- Employed a minimum of 1 year as a personal trainer
- Currently employed as a personal trainer
- Not a degree holding mental health professional

Participation consists of completing an online survey about your experiences working with clients. The survey takes approximately 15-20 minutes to complete. Your help would be greatly appreciated. There will be no identifying information asked on the survey and all information will remain anonymous.

Please click on this link to take my survey:

<https://www.surveymonkey.com/s/9KTMWFF>

Finally, if you know of anyone else who might qualify for this study, I would appreciate it if you could forward this message to them. Feel free to contact me with any questions you may have. Thank you for your time.

Alana Honigman
Master's Candidate '12
Smith College School for Social Work
[EMAIL ADDRESS](#)
(XXX) XXX-XXXX

Appendix F

Welcome Message, Eligibility Criteria, and Notice of Ineligibility

Addressing Client Mental Health within the Personal Training Relationship

Welcome Page

Thank you for taking the time to participate in this study. Your involvement is very important and greatly appreciated. Please look over following criteria to determine if you are eligible to participate:

- You MUST be 18 years of age or older.
- You MUST be a certified personal trainer.
- You MUST be currently employed as a personal trainer.
- You MUST have been working as a personal trainer for 1 year or longer.
- You MUST NOT be a degree-holding Mental Health professional.

If you meet these criteria, you are welcome to continue on to the next page.

If you do not meet these criteria, thank you for your interest in participating, but you are not eligible. If you have any questions about this study or eligibility criteria, please contact the researcher, Alana Honigman, at [EMAIL ADDRESS](#) or (XXX) XXX-XXXX

Appendix G

Informed Consent Form

Addressing Client Mental Health within the Personal Training Relationship

Informed Consent Form

Dear Study Participant,

I am a Masters student at Smith College School for Social Work and I am conducting a research study exploring personal trainers' experiences working with clients regarding mental health topics that may fall outside of personal training scope of practice. I am curious about which topics come up during personal training sessions, the interventions personal trainers typically use, and what training they have. The purpose of this study is to understand personal trainers' experiences navigating situations in which their clients require support with mental health topics that may fall outside of the prescribed scope of practice. This study will provide descriptive information about personal trainers and their experience addressing mental health related issues with clients to fill an area that has not yet been researched. This area of research will help to identify useful ways in which social workers and personal trainers can collaborate to provide better support and treatment to clients and areas of training for personal trainers. The data from this study will be used for my Master's thesis, in professional publications, and presentations on this topic.

I invite you to participate in an anonymous online survey for the purpose of sharing your experiences working with clients, specifically about situations in which mental health topics were addressed. All participants should be over the age of 18, hold a personal training credential, currently work with clients as a personal trainer, and have worked as a personal trainer for at least one year. You cannot hold a mental health degree or certification. The survey is in English.

The survey will consist of some demographic questions about you (such as your age), your workplace (such as where it is located generally), and your clients (such as the races represented in your client base). It will then ask a series of questions about your experiences with your clients. The questions will inquire about topics your clients have brought up, your comfort level with discussing the topics or offering interventions, and how you respond. The survey should take from 15-20 minutes to complete.

Minimal risk from participation is anticipated. You may experience distress when reflecting on times in which your clients brought up difficult or serious topics. The survey may also raise ethical considerations regarding scope of practice when discussing certain topics with clients. A list of referrals to mental health agencies is provided at the bottom of this Informed Consent Form. You may gain new insight into your work as a personal trainer. You may identify areas in which you would like more information or training to be more effective. You may remember times in which you were helpful and supportive to clients. You will not receive compensation for your participation in this study.

Because this survey is being conducted online, your responses will be anonymous. The researcher will have no way to identify participants. Survey Monkey will provide no identifying information to the researcher. Please do not identify any clients in your answers to this survey. All survey data will be kept securely on a password protected computer in a password protected database. All data will be kept secure for 3 years in accordance with Federal Regulations. If data are kept after the 3 years, they will continue to be stored securely until they are no longer needed, at which point they will be destroyed.

Addressing Client Mental Health within the Personal Training Relationship

Your participation in this study is voluntary. You may withdraw at any point while completing the survey by leaving the survey website or closing the browser window. Any responses provided before you withdraw will be deleted. However, due to the anonymous nature of the survey, it will not be possible to remove the responses you have given after you click the final submit button. There is no penalty for withdrawal from the study. You may contact me at the email or phone listed below for questions or concerns about this study before, while, or after completing the survey. You may also contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

CLICKING "I AGREE" INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Please print or save a copy of this page to keep for your records.

Thank you for your participation!

Researcher's Contact:

Alana Honigman

Mailing Address
Goes Here
EMAIL ADDRESS
(XXX) XXX-XXXX

Referral List:

NASW-WA State Chapter
522 N. 85th St., #B100
Seattle, WA 98103
206-706-7084

King County Crisis Clinic
24 Hour Crisis Line
1-866-4-CRISIS
Community Information Line (8am-6pm M-F)
1-800-621-4636

National Suicide Prevention Lifeline
24 Hour Crisis Line
1-800-273-TALK

***1. CLICKING "I AGREE" INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.**

I AGREE

I DISAGREE

Appendix H

Survey

Addressing Client Mental Health within the Personal Training Relationship

Participant Demographics

2. What is your age?

3. What is your gender identity?

- Male
- Female
- Other (please specify)

4. What is your race/ethnicity? Please check all that apply.

- African
- Afro-Caribbean
- American Indian
- Black/ African American
- Chicano
- East Asian
- Latino-Central American
- Latino-South American
- Middle Eastern
- Pacific Islander
- Southeast Asian
- White
- Other (please specify)

Addressing Client Mental Health within the Personal Training Relationship

Personal Trainer Information

5. Where did you get your personal training certification?

- NASM (National Academy of Sports Medicine)
- ACE (American Council on Exercise)
- AFAA (Aerobics and Fitness Association of America)
- ACT (Athletic Certification Training Commission)
- ACSM (American College of Sports Medicine)
- Other (please specify)

6. How many years of experience do you have as a personal trainer?

Addressing Client Mental Health within the Personal Training Relationship

Facility Information

The following are several questions about the facility at which you work. If you work at several different gyms, please describe the gym at which you work most frequently.

7. In which city and state is the gym at which you most frequently work located? (example: Seattle, WA)

8. How much do your clients pay (on average) for each personal training session?

- Under \$25
- \$26-\$50
- \$51-75
- \$76-100
- \$101-125
- Over \$125
- I don't know

9. Does your gym offer financial aid or assistance towards personal training sessions?

- Yes
- No

***10. Does your gym offer any initial free personal training sessions to new members?**

- Yes
- No
- I don't know

Addressing Client Mental Health within the Personal Training Relationship

Free Personal Training Session Follow-Up Question

11. How many free training sessions do new members receive?

- 1
- 2
- 3
- More than 3

Addressing Client Mental Health within the Personal Training Relationship

Client Demographics

12. Please estimate the number of clients you currently see in each of the following age categories:

13-19 year olds	<input type="text"/>
20-29 year olds	<input type="text"/>
30-39 year olds	<input type="text"/>
40-49 year olds	<input type="text"/>
50-59 year olds	<input type="text"/>
60-69 year olds	<input type="text"/>
70 years old and older	<input type="text"/>

13. Please estimate the number of clients you currently see in each of the following gender categories:

Male	<input type="text"/>
Female	<input type="text"/>
Other (e.g., transgendered, intersex)	<input type="text"/>

14. Please estimate the number of clients you currently see in each of the following racial categories:

Asian/Pacific Islander	<input type="text"/>
Black/African/African-American	<input type="text"/>
Hispanic/Chicano/Latino	<input type="text"/>
Mixed Racial Heritage	<input type="text"/>
Native American/American Indian	<input type="text"/>
White/Caucasian, non-Hispanic	<input type="text"/>
I am unsure of their racial heritage	<input type="text"/>

Addressing Client Mental Health within the Personal Training Relationship

Mental Health Topics

Please think about your PAST YEAR working as a person trainer. Make your best estimate about how often you encountered each of the following situations during the past year during your work as a personal trainer.

15. A client mentioned feelings of:

	Daily	Weekly	Monthly	Several times	Once	Not at all
Anger	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grief	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

16. A client discussed issues related to:

	Daily	Weekly	Monthly	Several times	Once	Not at all
Body Image	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Food	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Goal Setting and Motivation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interpersonal relationships	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
School	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Self-esteem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sense of Identity (e.g., race, gender, age, sexual orientation)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Addressing Client Mental Health within the Personal Training Relationship

17. A client spoke about a history of or current:

	Daily	Weekly	Monthly	Several times	Once	Not at all
Child or Elder Abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic Mental Illness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Domestic Violence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eating-disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Harm to self (suicide or self-harm)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Past Trauma (e.g., physical or sexual assault, life threatening injury or illness, death)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poverty or Neglect	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Substance abuse or addiction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Violence towards others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

18. A client has expressed emotion non-verbally in the following ways:

	Daily	Weekly	Monthly	Several times	Once	Not at all
Cried	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Given up and stopped the exercise/activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yelled	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Addressing Client Mental Health within the Personal Training Relationship

Therapy Scale

19. Please indicate how much you agree with the following statements:

	Strongly Agree	Agree	Disagree	Strongly Disagree
I have never felt a client wanted me to provide them with support regarding a topic that was outside of my scope to practice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There have been times when clients discussed topics I felt were beyond my scope of practice to provide them with the necessary support.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Many of the clients I have seen could also have used support from a therapist.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have worked with at least one client who was struggling with issues outside of my scope of practice as a personal trainer.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Many of the clients I have seen struggled with issues that fell outside of my scope of practice as a personal trainer.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel I am able to adequately address my clients' concerns and remain within my scope of practice as a personal trainer.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have worked with at least one client who would have benefited from seeing a therapist.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Addressing Client Mental Health within the Personal Training Relationship

Example from Personal Experience

20. Please describe a time a client brought up a topic you felt was RELATED TO MENTAL HEALTH and outside of your scope of practice as a personal trainer. What was the topic? How did you respond? Please do not provide identifying information (for example name or place of employment) about your client. If you cannot think of a time this has happened to you, please respond with, "This has never happened to me."

Addressing Client Mental Health within the Personal Training Relationship

Interventions

21. Please indicate ALL of the following interventions you have used in the PAST YEAR when clients have brought up topics that you felt were at all outside of your scope of practice concerning your clients' MENTAL HEALTH:

- Challenge what they are saying
- Consult with supervisor about what to do
- Encourage client to channel emotions/feelings into physical activity
- Listen actively
- Make a report to an outside authority (e.g., police, Child Protective Services)
- Offer advice
- Provide counseling on the topic
- Provide an example of when a similar thing happened to you or someone you know
- Provide a referral to a relevant group (e.g., AA, support group, parenting skills group)
- Provide a referral to a therapist (a referral consists of providing the client with contact information for at least one specific individual, organization, or agency)
- Provide a referral to a therapist with a specialty (e.g., eating disorders, depression)
- Redirect attention to the physical activity at hand
- Set limits about what is appropriate to discuss in personal training session
- Suggest the client see a therapist
- Other (please list other interventions you have used)

Addressing Client Mental Health within the Personal Training Relationship

Referral 1

***22. Making a referral to a client consists of providing the client with contact information for at least one specific individual, organization, or agency. In your ENTIRE career as a personal trainer, have you ever made a referral to a therapist?**

- Yes
- No
- I can't remember

Addressing Client Mental Health within the Personal Training Relationship

Referral 2A

23. If you have provided at least one client with a referral to a therapist, please check ALL of the following that apply:

- I made a referral to a professional I knew personally
- I made a referral provided to me by my gym
- I made a referral based on a second party recommendation
- I made a referral to a professional I felt would be a good fit for my client
- I provided more than one referral
- I checked in with my client later to inquire if they had followed through with the referral
- None of the above apply
- Other relevant information about my referral:

Addressing Client Mental Health within the Personal Training Relationship

Referral 2B

24. If you have never provided a client with a referral to a therapist, why not?

- I have not had a client who I felt could use support from a mental health professional
- I did not have any referrals to provide my client with
- I felt uncomfortable providing a referral
- I do not believe in referring to mental health professionals
- Other (please specify)

Addressing Client Mental Health within the Personal Training Relationship

Referral 3

25. Please check ALL of the following that would make you more likely to refer a client to a mental health professional in the future

- If I knew my client well enough
- If I personally knew the professional(s)
- If I had more training about when to refer clients to mental health professionals
- If my gym provided a list of referrals for me to use
- Other (please specify)

Addressing Client Mental Health within the Personal Training Relationship

Training

26. Was the topic of client mental health mentioned during your certification process?

- Yes
- No
- I can't remember

27. In what ways have you gained knowledge or experience about topics related to mental health? Please select all that apply.

- Attended a training or workshop
- Gained Continuing Education Credits towards my personal training certification
- Personal experience
- Read a book/article
- Spoken with a supervisor at work
- Taken an academic class (e.g., Psychology)
- Other (please specify)

Addressing Client Mental Health within the Personal Training Relationship

Final Question

28. Are there any topics related to client mental health that were not addressed in this survey that you feel are important to consider or are brought up frequently in your personal training sessions?

Addressing Client Mental Health within the Personal Training Relationship

Thank You

Thank you for supporting my research. If you have any further questions, feel free to contact me at [EMAIL ADDRESS](#) or (XXX) XXX-XXXX

If you are experiencing distress due to participation in this survey, the following are a list of resources in the Seattle area and nation-wide from whom you can seek support:

NASW-WA State Chapter
522 N. 85th St., #B100
Seattle, WA 98103
206-706-7084

King County Crisis Clinic
24 Hour Crisis Line
1-866-4-CRISIS
Community Information Line (8am-6pm M-F)
1-800-621-4636

National Suicide Prevention Lifeline
24 Hour Crisis Line
1-800-273-TALK

Appendix I

Table 1A. *Agencies from Which Participants Received Credentials*

Table 1A

Agencies from Which Participants Received Credentials

Accrediting Agencies	<i>n</i>	%
National Academy of Sports Medicine (NASM)	25	43.1
National Strength and Conditioning Association-Certified Strength and Conditioning Specialists (NSCA-CSCS)	14	24.1
American Council on Exercise (ACE)	11	19.0
American College of Sports Medicine (ACSM)	6	10.3
Aerobics and Fitness Association of American (AFAA)	4	6.9
Corrective Holistic Exercise Kinesiology (CHEK)	3	5.2
National Council on Strength and Fitness (NCSF)	3	5.2
National Exercise and Sports Trainers Association (NESTA)	2	3.4
National Personal Trainer Institute (NPTI)	2	3.4
Other, not defined	2	3.4
World Instructor Training Schools (WITS)	2	3.4
Cross-fit	1	1.7
NACM ^a	1	1.7
National Federation of Professional Trainers (NFPT)	1	1.7
No Answer	1	1.7
Personal Training Academy Global (PTAG)	1	1.7

^aA web-search did not produce any results indicating the agency to which this acronym refers

Appendix J

Table 2A. *Geographic Areas in Which Participants Work*

Table 2A

Geographic Areas in Which Participants Work

Geographic Area	<i>N</i>	%
San Francisco/Bay Area, CA	17	29.3
New York, NY	7	12.1
Seattle, WA	7	12.1
Chicago, IL	5	8.6
Denver/Boulder Area, CO	4	6.9
San Diego, CA	4	6.9
Omaha, NE	3	5.2
Miami, FL	2	3.4
No Answer	2	3.4
Wahiawa, HI	1	1.7
Washington, DC	1	1.7
Dallas, TX	1	1.7
Grand Rapids, MI	1	1.7
Durham, NC	1	1.7
Boston, MA	1	1.7