ATHLETIC TRAINING EDUCATION JOURNAL

www.natajournals.org
ISSN: 1947-380X
DOI: 10.4085/1947-380X-21-052

ORIGINAL RESEARCH

DIVERSITY, EQUITY, INCLUSION & ACCESS

The Experiences of Professional Master's Athletic Training Students with Sexual Harassment During Clinical Education

Chaselyn M. Trentley, BS, ATC*; Debbie A. Bradney, DPE, ATC*; Stephanie M. Singe, PhD, ATC‡; Thomas G. Bowman, PhD, ATC*
*Athletic Training, University of Lynchburg, VA; †Athletic Training Program, University of Connecticut, Storrs

Context: Sexual harassment is a concern in health care professions and on college campuses nationwide. Athletic trainers are health care professionals who work in close conjunction with athletes, coaches, officials, and other stakeholders, predisposing them to potential sexual harassment occurrences.

Objective: To examine the experiences of sexual harassment of professional master's ATSs during their clinical education experiences.

Design: Mixed-method study.

Setting: Online questionnaire.

Patients or Other Participants: Eighty-seven athletic training students (68 women, 19 males; age = 23.40 ± 1.85 years; 44 first-year students, 43 second-year students) currently enrolled in Commission on Accreditation of Athletic Training Education (CAATE)–accredited professional master's athletic training programs.

Data Collection and Analysis: We sent an online questionnaire to CAATE-accredited professional master's athletic training program directors, along with a recruitment email encouraging program directors to send the questionnaire to students currently enrolled in the programs they lead. We validated the questionnaire using expert and peer review. We used a general inductive approach to analyze the results and used multi-analyst triangulation and peer review to ensure credibility.

Results: Our study revealed that 28.70% of participants reported they felt as though they were subjected to sexual harassment behaviors during clinical education. Themes reported through recipients' accounts of sexual harassment defined a timeline that started when sexual harassment most commonly manifested through *inappropriate comments*, followed by ATSs having to *adjust after incidents* instead of the perpetrators, and finally ended with *insufficient resolution* in which victims felt the situations should have been handled differently.

Conclusions: Sexual harassment affects some professional master's ATSs in clinical education settings. Athletic training program administrators should educate students on clearly defined policies and procedures that will lead to resolution when sexual harassment occurs during athletic training clinical education.

Key Words: Gender bias, discrimination, collegiate athletics, Commission on Accreditation of Athletic Training Education

Ms Trentley is currently an athletic trainer at Sentara. Please address correspondence to Thomas G. Bowman, PhD, ATC, University of Lynchburg, Athletic Training, 1501 Lakeside Drive, Lynchburg, VA 24501. bowman.t@lynchburg.edu.

Full Citation:
Trentley CM, Bradney DA, Singe SM, Bowman TG. The experiences of professional master's athletic training students (ATSs) with sexual harassment during clinical education. *Athl Train Educ J.* 2022;17(4):293–301.

The Experiences of Professional Master's Athletic Training Students with Sexual Harassment During Clinical Education

Chaselyn M. Trentley, BS, ATC; Debbie A. Bradney, DPE, ATC; Stephanie M. Singe, PhD, ATC; Thomas G. Bowman, PhD, ATC

KEY POINTS

- Some athletic training students felt they were victims of sexual harassment during clinical education experiences and often did not know how to handle the situations.
- Participants noted inappropriate comments from a variety of perpetrators, including athletes, coaches, and umpires/officials, as the most common form of sexual harassment.
- Athletic training program administrators should educate students on clearly defined policies and procedures that will lead to resolution when sexual harassment occurs during athletic training clinical education.

INTRODUCTION

Although Title IX of the Education Amendments of 1972 prohibits sex discrimination in places receiving federal funding, sexual harassment continues to exist.[1] Sexual harassment has many definitions; some behavioral and verbal examples may include unwanted sexual advances, appeals for sexual favors, and other comments or physical conduct of a sexual nature.[1–3] Sexual harassment is a concern among health care professions and on college campuses nationwide. Health care providers tend to be at higher risk of experiencing these behaviors because of the unique nature of the patient-provider relationship.[1–11] Athletic trainers (ATs) are health care professionals who work in close conjunction with athletes, coaches, officials, and other stakeholders, predisposing them to potential sexual harassment occurrences.[1,4,12] Collegiate ATs tend to be in a position to build trust with stakeholders because of the amount of time they spend together. ATs also function as a reliable resource for stakeholders regarding a multitude of topics. Therefore, often a close relationship is established as athletes and coaches gain a sense of comfort with ATs.

Workplace bullying,[13,14] organizational conflict,[15,16] and external pressures when making clinical decisions[17] have been reported among ATs at the collegiate setting, suggesting a hostile working environment. Previous studies have revealed that approximately 29% of undergraduate athletic training students (ATSs) had experienced some type of sexual harassment (ie, sexual humor or unwanted sexual advances),[18] and 25% of the entire athletic training population (students and professionals)[19] has been sexually harassed. Further, 40% of ATSs and professionals reported being victims of sexual harassment, and 59% reported witnessing sexual harassment.[12] Shingles and Smith[3] found that 64% of a sample of female ATs had been sexually harassed at one point during their education or professional career. Sexual harassment training also occurred for less than half of ATSs, leading to situations in which many did not know how to report incidents of sexual harassment.[1] In addition, over 31% of students felt discriminated against based on their gender,[18] and gender discrimination has also been found to affect the career trajectory of female ATs at the National Collegiate Athletic Association Division 1,[2] 2,[20] and 3[20] levels. Finally, gender bias has also been reported[21] for those females working in professional sports settings.

However, to date there has been no research that explores how frequently professional master's ATSs experience sexual harassment while engaged in clinical education. With the recent changes to the educational pathway to certification, more research is warranted, as findings for undergraduate students and working professionals may not translate to professional master's students. Therefore, the purpose of our study was to examine the experience of sexual harassment and gender bias of professional master's ATSs while they were engaged in their clinical education settings. Our guiding research questions focused on descriptions of sexual harassment occurrences, frequencies of different types of sexual harassment, and the resolutions that occurred after the transgressions were identified.

METHODS

Research Design

We used a concurrent mixed-method design[22,23] to collect exploratory data on the experiences of ATSs regarding sexual harassment and gender bias. We created an online questionnaire to collect quantitative and qualitative data through closed and open-ended questions. The concurrent mixed-method design allowed for the collection of qualitative and quantitative data at the same data collection time point, providing a more holistic understanding of the phenomenon being studied,[22,23] and it facilitated data collection via an online medium, allowing responses from a broad group of participants. We created an instrument that could both quantify and qualify the experiences of our participants with sexual harassment in an exploratory way. The quantitative and qualitative data had equal priority in our design, as both related directly to our research questions. We consulted a previous study[24] as a quality assessment tool to ensure we addressed the necessary elements of our design.

Participants

Eighty-seven ATSs (age = 23.40 ± 1.85 years) who were currently enrolled in a Commission on Accreditation of Athletic Training Education (CAATE)–accredited professional master's athletic training program within the United States at the time of data collection volunteered to participate. Additional demographic data for participants can be found in Table 1. To ensure the anonymity of participants, we did not capture the name of the institutions the participants attended, and, therefore, the number of programs represented by participants is unknown. Inclusion criteria included enrollment in a CAATE-accredited professional master's program and engagement in clinical education at the time of data collection.

Table 1. Participant Demographic Data

	Frequency (%)
Sex	
Male	19 (21.8)
Female	68 (78.2)
Year in athletic training program	
First	44 (50.6)
Second	43 (49.4)
Race	
African American	11 (12.6)
Asian	3 (3.4)
Hispanic	5 (5.7)
Mexican American	1 (1.1)
Native American	2 (2.3)
White/Caucasian	65 (74.7)

Instrument Development

We created a mixed-method questionnaire based on previous literature studying sexual harassment in athletic training and athletics[1–5] to meet our purpose. The quantitative data collected were used to produce percentages of ATSs who experienced sexual harassment in the collegiate setting through questions inquiring about the frequency of sexual harassment situations, the number of respondents who were aware of sexual harassment policy, and the frequency of sexual harassment being perpetrated by either athletes, coaches, or co-workers. We felt this was important to quantify the participants' experiences with sexual harassment. Demographic information such as race, age, gender, and first or second year as a master's student was also displayed quantitatively.

The qualitative data collected allowed for a greater understanding of the specific instances of sexual harassment that occurred. We asked the participants to explain in detail, if applicable, the sexual harassment or gender-biasing behavior that they had witnessed or experienced. Finally, questions inquired about the response to the incident and any adverse effects resulting from sexual harassment. The qualitative questions allowed for collection of in-depth stories, which was essential to understanding sexual harassment of ATSs in the collegiate setting. Using the open-ended questions was a means to qualify the experiences of our respondents, to allow them a chance to share their experiences and expand on the quantification of their experiences.

We validated the questionnaire through expert review and pilot testing[25] before data collection occurred. The expert review provided content and face validity for the instrument, a common first step in the development of an instrument designed to explore an unknown topic.[25] We had 2 experts outside of the research team with extensive experience in qualitative research methods and athletic training clinical education review the questionnaire for comprehensiveness, clarity, flow, appropriateness, content validity, and face validity for the given research purposes.[25]

We edited the questionnaire based on the experts' feedback until they had no further suggestions and the questions were considered relevant to the research questions, clear, and important to obtaining the study's objectives by scoring at least a 3 out of 4 for each metric (relevance, clarity, and importance).[26] After expert review, we pilot tested the questionnaire with 2 students to further attest to comprehensiveness, clarity, flow, and appropriateness for answering the research questions. The pilot testing process served to secure both content and face validity.[25] We finalized the questionnaire after both the 2 experts and the 2 students had no additional suggestions for improvement.

Procedure

The Figure provides an overview of the procedures used for this study. Our study was approved by the University of Lynchburg Institutional Review Board for Human Subjects Research. After approval, we used a criterion sampling strategy for participant recruitment. A recruitment email containing a link to an online questionnaire was sent out to every CAATE-accredited professional master's athletic training program director ($N = 138$) at the time of data collection using the contact information provided by the CAATE Web site. The recruitment email encouraged program directors to forward the questionnaire to students currently enrolled in the programs they lead. We sent 2 reminder emails at 1-week increments asking the program directors to re-forward our recruitment email to all ATSs to improve recruitment and reach saturation for the qualitative data. Participants clicked on the link to the questionnaire in the email, provided informed consent, and completed the electronic questionnaire. We utilized Google Forms (Google LLC) as our platform for distribution of the questionnaire and data collection.

Analysis Strategies

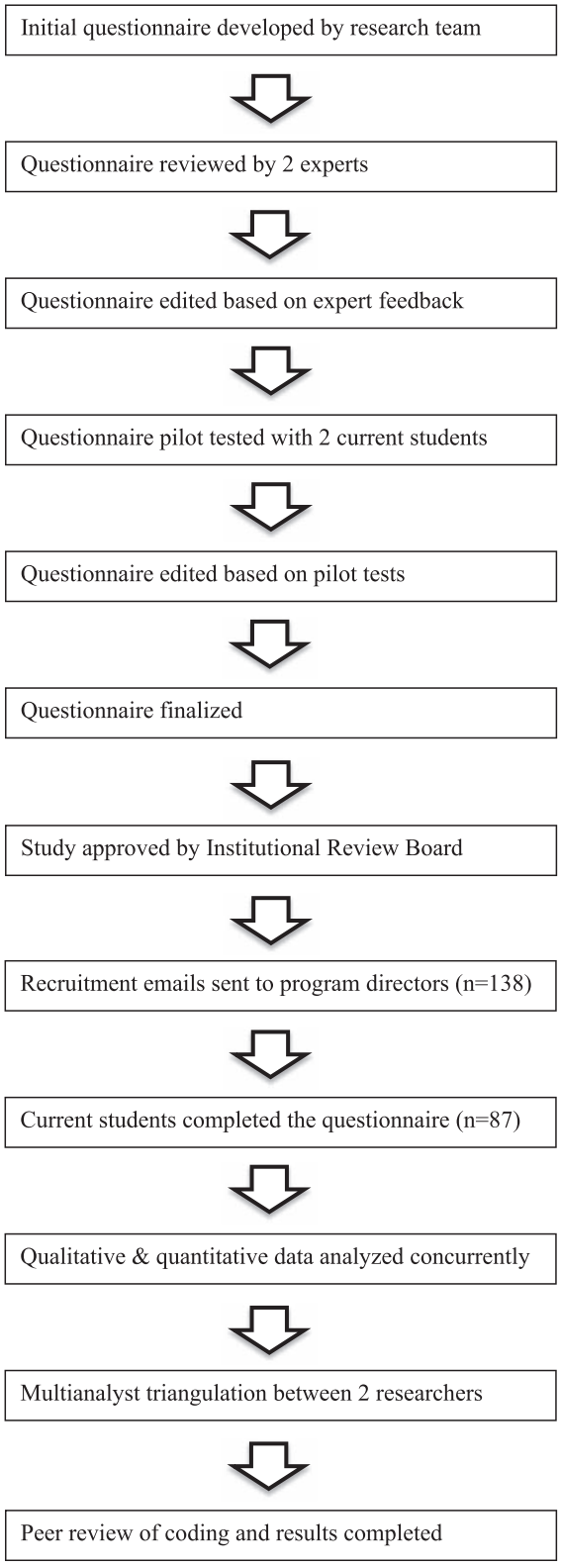
We calculated descriptive statistics for the demographic data and used nonparametric Mann-Whitney *U*-tests to determine sex differences in Likert scale data ($0 = \textit{never}, 5 = \textit{daily}$) asking the frequency of acts of sexual harassment perpetrated by athletes, coaches, or coworkers ($\alpha \leq 0.05$, a priori). We used a general inductive approach to analyze the qualitative data.[27] The purposes for using an inductive approach were to condense extensive and varied raw text data into a brief summary format, to establish clear links between the research objectives and the summary findings derived from the raw data, and to develop a model or theory about the underlying structure of experiences or processes that are evident in the raw data.[27] We ensured credibility of the data through multi-analyst triangulation and peer review. Two research team members (C.M.T. and T.G.B.) coded the data independently and discussed the coding scheme and presentation of the results during multi-analyst triangulation. The 2 primary coders came to full agreement after negotiating over the specific names of the themes. After finalizing the multi-analyst triangulation process, we shared the coded responses and presentation of the results with another member of the research team (S.M.S.) and asked her to validate the coding structure and results. After the peer's approval, we finalized our written presentation of the results.

RESULTS

Quantitative Results

Sex differences in dichotomous question responses can be seen in Table 2. Participants from both sexes stated that they had been subjected to sexual harassment behaviors (female: $n = 24$,

Figure. Flow diagram of study procedures.



35.3%; male: n = 1, 5.3%). Several females (n = 23, 33.8%) reported witnessing sexual harassment during clinical practice, while 15.8% (n = 3) of males reported the same. Most female participants (n = 62, 91.2%) and almost half of the male participants (n = 9, 47.4%) thought their sex contributed to job-related challenges. More than half of females (n = 48, 70.6%) and males (n = 11, 57.9%) were aware of current sexual harassment policy at their clinical sites but had not seen it put into practice (females: n = 49, 72.1%; males: n = 15, 78.9%). When comparing the experience of females and males with different types of sexual harassment, the only significant difference found was in the case of unwanted advances outside of the clinical setting, or through social media, from athletes (females: median = 0, range = 0–5; males: median = 0, range = 0–2; $P = .05$). Sex differences in Likert scale question responses can be seen in Table 3.

Qualitative Results

Themes seen through recipients' accounts of sexual harassment defined a timeline that started when sexual harassment most commonly manifested through *inappropriate comments*, followed by ATSs having to *adjust after incidents* (instead of the perpetrators), and finally ended with events leading to *insufficient resolution* in which victims felt the situations should have been handled differently.

Inappropriate Comments. The first theme identified was sexual harassment most commonly manifesting through *inappropriate comments*. Comments deemed "inappropriate" were the most commonly reported form of sexual harassment. For example, one participant stated,

> *At a high school rotation working with football, certain athletes would make sexual comments to me directly and about me to the male student who was also placed there. These comments included nicknames, comments about my body, and general sexual comments.*

Similarly, another student explained, "While working in the high school setting with boy's football, I was often in the room when inappropriate hand gestures were made, or boys would make comments about me wanting to touch them while performing treatments such as muscle releases and e-stim."

One participant dealt with inappropriate comments and ensured it did not happen again. She explained,

> *There have been multiple situations. I immediately shut-it-down. I tell them [patients] that they will treat me with the same respect they would show male health care professionals or their mothers. If they wouldn't say it to their moms, they don't get to say it to me.*

Not all comments came from athletes. One participant was notified that an umpire had made inappropriate comments about her. She provided the following details:

> *I was an intern for a summer collegiate baseball league. This particular umpire worked a lot of the games and was known for being very "close" with the players. I was professional and did my job despite knowing he [the umpire] had made some comments to the catcher about my legs and other parts of my physical appearance. At the end of the season he was texting with a player and made an incredibly inappropriate comment about wanting to perform oral sex on me. The screenshot was sent to me and I immediately reported it . . . I was shocked to hear that someone (an adult official) would speak about me in such an inappropriate way.*

Multiple respondents were affected by comments with sexual connotations made by various individuals. Simply put, "They

Table 2. Sex Differences in Dichotomous Question Responses

Question	Women, n (%)		Men, n (%)	
	Yes	No	Yes	No
Do you feel as if you have been subjected to any sexual harassment behaviors?	24 (35.3)	43 (63.2)	1 (5.3)	18 (94.7)
Have you witnessed sexual harassment of an athletic trainer in any athletic training setting (practice, athletic training clinic, road trips, etc)?	23 (33.8)	45 (66.2)	3 (15.8)	16 (84.2)
Does your sex contribute to challenges in the athletic training field?	62 (91.2)	6 (8.8)	9 (47.4)	10 (52.6)
Do you command the same respect as your colleagues of the opposite sex?	61 (89.7)	7 (10.3)	18 (94.7)	1 (5.3)
Are your experiences similar working with men's teams compared to women's teams?	28 (41.2)	40 (58.8)	11 (57.9)	8 (42.1)
In your experience, have you felt as though you are looked upon as a distraction rather than an asset in the eyes of coaches of the opposite sex?	32 (47.1)	36 (52.9)	0 (0)	19 (100)
As an athletic trainer, have you felt hesitant to apply to a career in sports leagues dominated by the opposite sex due to the assumption your sex may affect your eligibility for employment?	44 (64.7)	24 (35.3)	1 (5.3)	18 (94.7)
Do you know your institution's current policy for dealing with sexual harassment?	48 (70.6)	20 (29.4)	11 (57.9)	8 (42.1)
If you are aware of your current policy, have you witnessed the policy be put into effect when an issue with sexual harassment has arisen?	10 (14.7)	49 (72.1)	2 (10.5)	15 (78.9)

[perpetrators] think it's a harmless joke but it undermines professionalism." However, others stated that they viewed inappropriate comments as playful or harmless at times. One participant attempted to downgrade the seriousness by stating,

> *I've had and heard some male athletes make sexual comments occasionally, but I have never felt like they are sexual harassment. I think they are just joking and teasing and don't actually mean what they say.*

Finally, one respondent did not report the comments she was told because,

> *I told them this kind of talk is not allowed and it ended there. It was a small comment that did not warrant action or attention as an "incident."*

Most inappropriate incidents our participants noted entailed verbal comments, but not all participants described these comments as sexual harassment requiring reporting.

Table 3. Sex Comparisons in Likert Scale Questions

Question	Women, Median (Range)	Male, Median (Range)	*U*	*P* Value
How often do you experience inappropriate comments of a sexual nature from athletes?	1 (0–5)	1 (0–5)	518.5	.18
How often do you experience inappropriate comments of a sexual nature from coaches?	0 (0–3)	0 (0–1)	490.0	.06
How often do you experience inappropriate comments of a sexual nature from coworkers?	0 (0–3)	0 (0–3)	632.5	.87
How often do you experience unwelcome physical conduct from athletes?	0 (0–4)	0 (0–5)	614.0	.64
How often do you experience unwelcome physical conduct from coaches?	0 (0–3)	0 (0–1)	601.5	.39
How often do you experience unwelcome physical conduct from coworkers?	0 (0–2)	0 (0–1)	630.5	.72
How often do you experience requests for sexual favors from athletes?	0 (0–5)	0 (0–1)	601.5	.39
How often do you experience requests for sexual favors from coaches?	0 (0–3)	0 (0–0)	608.0	.28
How often do you experience requests for sexual favors from coworkers?	0 (0–2)	0 (0–0)	617.5	.35
How often do you experience unwanted advances outside of the clinical setting, or through social media from athletes?	0 (0–5)	0 (0–2)	483.5	.05[a]
How often do you experience unwanted advances outside of the clinical setting, or through social media from coaches?	0 (0–5)	0 (0–1)	631.5	.73
How often do you experience unwanted advances outside of the clinical setting, or through social media from coworkers?	0 (0–3)	0 (0–1)	592.5	.32

[a] $P \leq .05$.

Adjust After Incidents. The second theme we identified was ATSs having to *adjust after incidents,* versus their perpetrators needing to change. After a sexual harassment incident, the victim (ATS) was the one who compensated for the incident rather than the perpetrator. For example, students had to "switch clinical sites," "avoid" certain athletes or coaches, or have a coworker take over treating a patient completely. One participant noted, "a few days afterward, I asked to be removed from the site." Another said, "I completely avoided all contact with him [perpetrator] at all costs, including pretending that I had to stock something so I couldn't be in the AT room at the same time as him." One participant "just allowed the male staff to deal with them [perpetrators]." Similarly, others also shifted care: "Whenever the athlete came in it was awkward and I would have someone else work with him." One student felt she had no options to deal with the predicament. She responded, "Avoidance of this individual was the only way to deal with the situation."

Interestingly, one participant did not seek a change but only because her rotation was almost over. She explained,

> *The only time I ever felt uncomfortable enough to switch clinical sites, I had one week left in the rotation. I stuck it out and avoided that individual.*

Finally, one participant noted the fact that she needed a chaperon present when treating perpetrators. She stated, "It made it difficult to treat them [perpetrators] and I found it harder to allow myself to treat them without another male staff present."

Insufficient Resolution. The third theme we found defined how the victims found *insufficient resolution* after reporting sexual harassment. One participant stated,

> *Honestly, I should have made a bigger deal about some of them. Most of the time people get a slap on the wrist, or nothing would happen. I wish that when the events took place, they would be properly documented, and the individual sent to a residual training (if a coach/co-worker).*

Others agreed with the fact that the actions taken did not do enough. A student stated, "I would've liked for someone to have talked to the athlete to ensure that he knew what expectations and standards we have." Similarly, another agreed, "I would have liked an authority figure to have spoken to this athlete to stop the behavior." Finally, "Some type of disciplinary action taken by the coaches or athletics department, or something" should have occurred.

At times, sexual harassment situations were ignored completely, depending on the status of the perpetrator (coaches, preceptors, or officials). For example, one participant stated the following regarding her preceptor:

> *I was placed at a physical therapy clinic with an older male as a preceptor (ATC and DPT). He [preceptor] made comments about me being a woman: "so you can't really do much but laundry," and "when you start having babies you won't be an AT anymore." Apparently, he has been saying it to female students for years and no action has been taken.*

Another student was harassed by a coach during her first clinical education rotation. She had an athletic director at a high school start calling me and my preceptor "the lesbians." It was my very first clinical rotation. I literally had no idea what to do or say …. He didn't even apologize.

Finally, another respondent discussed comments a coworker made about one of the coaches. The participant explained,

> *A coworker made inappropriate comments to me about one of the coaches and it made it hard to work with that coworker and coach at the same time. It felt as if it was getting worse as I got to know the coach by working the same position as him.*

Unfortunately, resolution often did not occur as participants would have liked. One situation, "wasn't resolved at all, just kind of ignored." Indeed, administrators should "involve the victim in the plan of action and decisions that are made." Several participants noted the fact that educational efforts should be included. For example, situations should be dealt with "by educating the athletes and informing them on how to respect female athletic trainers" or by having "coaches discuss what is appropriate regarding students during clinical rotations." Finally, one participant noted, "Most of my experiences I feel the athlete/coach was not aware that they were being inappropriate, so I just want them to realize their actions are not wanted." An apology would also go a long way in the thoughts of our participants: "The kid should have been talked to by the head coach and apologized to me."

However, at times situations were not reported and participants told "no one" or only told "close friends, other students about a week or so after" the event. Fear was one reason why incidents were not properly reported. For example, "I never reported the experiences to proper authorities mostly to avoid any conflict or loss of rapport with my athletes/co-workers." Others handled the situations themselves, and "after I told him [perpetrator] to stop once, he stopped." Finally, some incidents happened in "a clinic with lots of people around so people were aware of the situation." In the last circumstance, the participant did not see the need to formally report the incident, as those who needed to be told were present when the incident happened. Although a lack of formal reporting caused some situations to not be addressed, most participants were not satisfied with responses to sexual harassment when they were formally reported.

DISCUSSION

Before our study was conducted, few researchers[1,12,18] had examined sexual harassment of ATSs while in their clinical setting. Professional socialization[28,29] plays a large role in helping students become inducted into the field, as well as prepared to manage any situation that may arise, including a case of harassment. Understanding cases of harassment can help program administrators develop educational interventions to help students prepare for and mange a potential case of harassment. Our study attempted to fill the gap in the literature to gain an understanding of the frequency and types of sexual harassment behaviors that professional master's ATSs may experience while in the clinical setting. Our results revealed that participants of both sexes stated that they had been subjected to sexual harassment behaviors (females: n = 24, 35.3%; males: n = 1, 5.3%, overall: n = 25/87, 28.7%). Our results (28.7%) are similar to (29%[18] and 25%[19]) or lower than (64%[3] and 40%[12]) those of previous studies examining sexual

harassment in athletic training settings. However, even though some of these studies provided a baseline of sexual harassment in athletic training, they lacked external peer review.[12,18,19] The rate of harassment we found is similar to the rate found previously for nurses (25%[6]) but substantially lower than the rate for nurses and nursing students (91%[10]), physical therapists (86%[7]), and physical therapists and physical therapy students (80.9%[8]).

Previously, sexual harassment has been defined as being exposed to "inappropriate comments," including unwanted compliments and comments about sexual tendencies.[12] In addition, being inappropriately touched, unwanted sexual advances, sexual gestures, or hostile working environments have also been identified as constituting harassment.[3,12] Unfortunately, many have neglected to view situations as harassment because they did not perceive them as creating a threatening environment.[3,12] Therefore, as was the case with some of our participants, victims failed to report the incidents.[3,12] Interestingly, the most common inappropriate incidents our participants noted entailed *inappropriate comments* by student athletes (Table 3). However, not all participants described the comments as sexual harassment that required reporting, as was the case in a previous study[10] with nurses and nursing students. Often sexual harassment through inappropriate comments was interpreted as "joking and teasing" and was downplayed rather than being reported. Our participants noted similar experiences of "joking and teasing" but seemed to be more willing to bring complaints forward. Unfortunately, our participants were frustrated that complaints were not handled appropriately, from their perspective. Similarly, previous researchers[12] reported that 48% of respondents were not satisfied with the way instances of sexual harassment were handled.

Most females (n = 48, 70.6%) and males (n = 11, 57.9%) were aware of current sexual harassment policy at the location of their clinical education experiences, as was the case in previous work.[12,18] However, many perceived that policy was not put into practice after sexual harassment occurrences (females: n = 49, 72.1%; males: n = 15, 78.9%) in our study, a much higher percentage than was reported previously.[12] Interestingly, more males felt policy was not followed, which may align with a previous study[12] that suggested males' experiences with sexual harassment might be overlooked. We found the finding regarding following of policy interesting since only 59 participants responded that they were aware of current policy, but 64 responded that they had not seen the policy put into place. We are unsure how participants felt policy was not initiated if they failed to know what the policy was. The finding may indicate that although there are sexual harassment policies in place, the policies are not explained to stakeholders during orientation sessions or might not be enforced or implemented after some sexual harassment occurrences. The lack of implementation of sexual harassment policies was also shown in themes seen through recipients' accounts of sexual harassment. Our finding was demonstrated in multiple responses and stemmed from organizational administrators overlooking and/or ignoring some perpetrator actions rather than disciplining the perpetrators. Perhaps improved onboarding experiences would provide students with an improved understanding of organizational policy and interventions, as has been suggested for young professionals.[30,31] However, it is important to note that victims are not notified of perpetrator punishment status because of privacy issues. Therefore, perhaps punishments were handed down in some situations and our participants were simply not aware of them which lead to their perception that the situations were not dealt with appropriately. Regardless, organizational administrators should show victims they are responsive to complaints, thoroughly conduct investigations promptly, and utilize accountability measures in place for perpetrators.[32]

Previous researchers[12] found that 59% of participants stated that they had observed sexual harassment of another ATS or AT by student athletes. Our results revealed that 29.9% of participants (33.8% [n = 23] of females and 15.8% [n = 3] of males) reported witnessing sexual harassment during clinical practice. The population used in the study by Simmons[12] included certified ATs (in addition to students) and incidents that occurred within their career experiences, which could have influenced a higher percentage of witness accounts due to a vague timeframe of occurrences with variations in career experience. However, it is possible that occurrences of sexual harassment are on the decline because of educational interventions. Nevertheless, our results are concerning, as sexual harassment appears to be a relatively common occurrence.

Most female participants (n = 62, 91.2%) and almost half of male participants (n = 9, 47.4%) thought their sex contributed to job-related challenges. In a study completed in 2016,[20] organizational and personal factors had emerged as 2 major themes that described challenges for females assuming head AT roles. Organizational barriers were defined as *gender stereotyping* and the *"good old boys" network,* while personal influences included a *lack of leadership aspirations, motherhood and family,* and a *lack of mentors*.[20] The large percentage of males who thought their sex contributed to job-related challenges may have thought so because they were providing care for female patients. However, specific details on why our participants felt they would face job-related challenges remain unknown. We believe exploring the perceptions of students and clinicians regarding job-related challenges based on sex is an area ripe for exploration.

Based on our findings, we believe sexual harassment needs to be addressed within the educational process to help students understand their rights and responsibilities as well as the resources available to them when harassment does occur. Program administrators are encouraged to address professional conflicts, including sources of harassment and management strategies, to mitigate occurrences and their impact. We recommend that athletic training program administrators develop policies with all preceptors for reporting sexual harassment during clinical education and potential courses of action for dealing with perpetrators. Perhaps clinical education coordinators can provide sexual harassment education to preceptors during training sessions, and preceptors could provide input into policies that govern sexual harassment. Furthermore, sexual harassment education should be provided to coaches, patients, and others with whom ATSs may interact, and all stakeholders should be provided with bystander intervention training. We believe the actions of organizational administrators are critical, as previous literature[33] has shown that the organizational climate surrounding harassment can facilitate or deter occurrences. Eliminating sexual harassment is critical, as occurrences can cause multiple negative outcomes, including decreased job satisfaction, lower

organizational commitment, work withdrawal, physical and mental health decline, and post-traumatic stress disorder.[33]

Limitations and Future Research

Our study had limitations that could have influenced our results and are important to consider. For example, given the sensitivity of our study's topic, participants may not have been willing to answer questions regarding their experiences, despite the anonymity the study offered. All responses were also based completely on the account of the recipient; there is no way to confirm or deny the accounts reported. There were also limitations with recruitment. Program directors may have overlooked our recruitment email or not have had an interest in the study, which would have resulted in them likely not forwarding the questionnaire to the students in the programs they lead. We are unaware of the email "open" and "forward" rate from the program directors to prospective participants, and we do not know how many programs were represented by participants. However, no database for students exists, and using program directors as gatekeepers to recruit students is a common practice. The timing of our study may have also hindered recruitment as program directors and students prepared for the end of the semester. We also had more females than males respond to the questionnaire, which may have influenced our results. For future research, it may be beneficial to examine best practices for sexual harassment training or to conduct further studies examining the sexual harassment of ATs to gain a better understanding of the frequency of these behaviors. We also suggest interviewing victims to help clarify issues related to reporting, outcomes, and culture and how they might be overcome. Finally, future research should investigate the impact of sexual harassment on students, with a focus on the implications to their entrance into the field as well as how harassment impacted their ability to cope with workplace conflicts.

CONCLUSIONS

Sexual harassment affects some professional master's athletic training students during clinical education experiences. Unfortunately, many respondents did not know how to handle the situations when they arose. Teaching students how to handle unprofessional situations, such as sexual harassment, is an important part of the socialization process. Participants identified inappropriate comments from a variety of perpetrators, including athletes, coaches, and umpires/officials, as the most common form of sexual harassment experienced during clinical education. Athletic training program administrators should educate students on clearly defined policies and procedures that will lead to resolution when sexual harassment occurs during athletic training clinical education.

REFERENCES

1. Mansell J, Moffit DM, Russ AC, Thorpe JN. Sexual harassment training and reporting in athletic training students. *Athl Train Educ J*. 2017;12(1):3–9. doi:10.4085/12013
2. Burton LJ, Borland J, Mazerolle SM. "They cannot seem to get past the gender issue": experiences of young female athletic trainers in NCAA Division I intercollegiate athletics. *Sport Manag Rev*. 2012;15(3):304–317. doi:10.1016/j.smr.2012.01.001
3. Shingles RR, Smith Y. Perceptions of sexual harassment in athletic training. *Athl Train Educ J*. 2008;3(3):102–107. doi:10.4085/1947-380X-3.3.102
4. Velasquez BJ. Sexual harassment: a concern for the athletic trainer. *J Athl Train*. 1998;33(2):171–176.
5. Velasquez BJ, Drummond J. Sexual harassment in the athletic training room: implications for athletic trainers. *Int J Athl Ther Train*. 2003;8(2):20–23. doi:10.1123/att.8.2.20
6. Spector PE, Zhou ZE, Che XX. Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: a quantitative review. *Int J Nurs Stud*. 2014;51(1):72–84. doi:10.1016/j.ijnurstu.2013.01.010
7. deMayo RA. Patient sexual behaviors and sexual harassment: a national survey of physical therapists. *Phys Ther*. 1997;77(7):739–744. doi:10.1093/ptj/77.7.739
8. McComas J, Hébert C, Giacomin C, Kaplan D, Dulberg C. Experiences of student and practicing physical therapists with inappropriate patient sexual behavior. *Phys Ther*. 1993;73(11):762–769. doi:10.1093/ptj/73.11.762
9. deMayo RA. Patients' sexual behavior and sexual harassment: a survey of clinical supervisors. *Prof Psychol Res Pract*. 2000;31(6):706–709. doi:10.1037/0735-7028.31.6.706
10. Bronner G, Peretz C, Ehrenfeld M. Sexual harassment of nurses and nursing students. *J Adv Nurs*. 2003;42(6):637–644. doi:10.1046/j.1365-2648.2003.02667.x
11. Robbins I, Bender MP, Finnis SJ. Sexual harassment in nursing. *J Adv Nurs*. 1997;25(1):163–169. doi:10.1046/j.1365-2648.1997.1997025163.x
12. Simmons AM. *Athletic Trainers' or Athletic Training Students' Perceptions of Sexual Harassment by Student-Athletes in the Collegiate Setting*. Master's thesis. James Madison University; 2016.
13. Weuve C, Pitney WA, Martin M, Mazerolle SM. Experiences with workplace bullying among athletic trainers in the collegiate setting. *J Athl Train*. 2014;49(5):696–705. doi:10.4085/1062-6050-49.3.16
14. Weuve C, Pitney WA, Martin M, Mazerolle SM. Perceptions of workplace bullying among athletic trainers in the collegiate setting. *J Athl Train*. 2014;49(5):706–718. doi:10.4085/1062-6050-49.3.13
15. Lacy AMP, Bowman TG, Singe SM. Challenges faced by collegiate athletic trainers, part I: organizational conflict and clinical decision making. *J Athl Train*. 2020;55(3):303–311. doi:10.4085/1062-6050-84-19
16. Bowman TG, Singe SM, Pike Lacy AM, Register-Mihalik JK. Challenges faced by collegiate athletic trainers, part II: treating concussed student-athletes. *J Athl Train*. 2020;55(3):312–318. doi:10.4085/1062-6050-85-19
17. Pike Lacy AM, Singe SM, Bowman TG. Collegiate athletic trainers' experiences with external pressures faced during decision making. *J Athl Train*. 2020;55(4):409–415. doi:10.4085/1062-6050-165-19
18. Gillette CJ. *Perceptions of Discrimination in Athletic Training Education Programs*. Master's thesis. University of Wisconsin La Crosse; 2000.
19. Velasquez B. *Study of Sexual Harassment Issues in Physical Education and Athletics at Colleges and Universities*. Dissertation. Middle Tennessee State; 1996.
20. Mazerolle SM, Eason CM. Barriers to the role of the head athletic trainer for women in National Collegiate Athletic Association Division II and III settings. *J Athl Train*. 2016;51(7):557–565. doi:10.4085/1062-6050-51.9.08

21. Lovse S, Mazerolle SS, Paloncy KA, Carr WD. Perception of gender bias in the professional sport setting from the female athletic trainer's perspective. *Athl Train Sports Health Care*. 2020;12(5):221–226. doi:10.3928/19425864-20190621-01
22. Östlund U, Kidd L, Wengström Y, Rowa-Dewar N. Combining qualitative and quantitative research within mixed method research designs: a methodological review. *Int J Nurs Stud*. 2011;48(3):369–383. doi:10.1016/j.ijnurstu.2010.10.005
23. Terrell SR. Mixed-methods research methodologies. *Qual Rep*. 2012;17(1):254–280.
24. O'Cathain A, Murphy E, Nicholl J. The quality of mixed methods studies in health services research. *J Health Serv Res Policy*. 2008;13(2):92–98. doi:10.1258/jhsrp.2007.007074
25. Turocy PS. Survey research in athletic training: the scientific method of development and implementation. *J Athl Train*. 2002;37(suppl 4):S-174–S-179.
26. Lynn MR. Determination and quantification of content validity. *Nurs Res*. 1986;35(6):382–385. doi:10.1097/00006199-198611000-00017
27. Thomas DR. A general inductive approach for analyzing qualitative evaluation data. *Am J Eval*. 2006;27(2):237–246. doi:10.1177/1098214005283748
28. Mazerolle SM, Bowman TG, Dodge TM. Athletic training student socialization, part I: socializing students in undergraduate athletic training programs. *Athl Train Educ J*. 2014;9(2):72–79. doi:10.4085/090272
29. Mazerolle SM, Bowman TG, Dodge TM. Athletic training student socialization, part II: socializing the professional master's athletic training student. *Athl Train Educ J*. 2014;9(2):80–86. doi:10.4085/090280
30. Eberman L, Mazerolle Singe S, Eason CM. Formal and informal work-life balance practices of athletic trainers in collegiate and university settings. *J Athl Train*. 2019;54(5):556–561. doi:10.4085/1062-6050-245-17
31. Mazerolle SM, Eason CM, Eberman LE. Perceptions of work-life balance practices offered in the collegiate practice setting. *J Athl Train*. 2017;52(12):1131–1139. doi:10.4085/1062-6050-52.11.28
32. Kabat-Farr D, Crumley ET. Sexual harassment in healthcare: a psychological perspective. *Online J Issues Nurs*. 2019;24(1):Manuscript 4. doi:10.1016/j.ijnurstu.2017.02.018
33. Willness CR, Steel P, Lee K. A meta-analysis of the antecedents and consequences of workplace sexual harassment. *Pers Psychol*. 2007;60(1):127–162. doi:10.1111/j.1744-6570.2007.00067.x