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Organizational Infrastructure in the Collegiate Athletic Training Setting, Part II: Benefits of and Barriers in the Athletics Model

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Context: The athletics model, in which athletic training clinical programs are part of the athletics department, is the predominant model in the collegiate athletic training setting. Little is known about athletic trainers' (ATs') perceptions of this model, particularly as it relates to organizational hierarchy.

Objective: To explore the perceived benefits of and barriers in the athletics model.

Design: Qualitative study.

Setting: National Collegiate Athletic Association Divisions I and III.

Patients or Other Participants: Eight full-time ATs (5 men, 3 women; age = 41 ± 13 years, time employed at the current institution = 14 ± 14 years, experience as a certified AT = 18 ± 13 years) working in the collegiate setting using the athletics model.

Data Collection and Analysis: We conducted semistructured interviews via telephone or in person and used a general inductive approach to analyze the qualitative data. Multiple-analyst triangulation and peer review established trustworthiness.

Results: Two benefits and 3 barriers emerged from the data. Role identity emerged as a benefit that occurred with role clarity, validation, and acceptance of the collegiate AT personality. Role congruence emerged as a benefit of the athletics model that occurred with 2 lower-order themes: relationship building and physician alignment and support. Role strain, staffing concerns, and work-life conflict emerged as barriers in the athletics model. Role strain occurred with 2 primary lower-order themes: role incongruity and role conflict.

Conclusions: The athletics model is the most common infrastructure for employing ATs in collegiate athletics. Participants expressed positive experiences via character identity, support, trust relationships, and longevity. However, common barriers remain. To reduce role strain, misaligning values, and work-life conflict, ATs working in the athletics model are encouraged to evaluate their relationships with coaches and their supervisor and consider team physician alignment. Moreover, measures to increase quality athletic training staff from a care rather than a coverage standpoint should be considered.

Key Words: congruence, role strain, work-life conflict, staffing

Key Points

- Benefits of the athletics model included identifying with the collegiate athletic trainer (AT) role and role congruence.
- University-employed team physicians and supervising athletics directors with medical experience were a benefit to role congruence.
- Barriers in the athletics model included role strain, staffing concerns, and work-life conflict.
- Collegiate ATs in the athletics model who experience these barriers should evaluate their relationships with athletics department personnel and supervisors and assess team physician alignment within the organizational hierarchy.
- To mitigate role strain and work-life conflict, ATs should consider increasing quality staff to move from a coverage to a care approach.

The athletic training profession began in colleges and universities.[1] Whereas the profession has expanded its practice settings over the years, these institutions have remained a primary employment setting for athletic trainers (ATs).[2] Today, the collegiate setting still offers desired athletic training jobs in the demanding, high-profile arena of collegiate athletics. Attractors are widespread and often include the competitive setting, the opportunity to work with elite student-athletes, and a fit with or love of the workplace.[3–5] Detractors include time demands, salary concerns, limited autonomy over work schedules, and competing expectations and conflicts with coaches.[3,6–8] Common among these factors is the platform, which is driven and founded by the organizational infrastructure within collegiate athletics. These organizational components largely express the atmosphere and culture of collegiate athletics, which include the devotion of time, diligent work, and sacrifice to experience success.

The collegiate/university athletic training setting is well known for its challenging, high-profile, fast-paced atmo-

sphere, and the collegiate AT role has evolved with the increasing drive for athletic success. Extensive literature exists on professional topics in this setting, including quality-of-life concerns[9]; work-life conflict[7,10–12]; and role strain,[6,13] primarily comprising role conflict and role overload (ie, long work hours), job satisfaction,[14] lack of promotion,[8] lack of value,[15] and turnover or attrition.[3,8] Researchers have also observed that ATs persist and thrive within the collegiate setting when they identify or connect with the collegiate atmosphere[3–5,16]; have supervisory, coworker, and social support[3,4,17,18]; and have autonomy in decision making.[3] All of these factors, again, are linked to the organizational climate and subculture within collegiate athletics.

Collegiate/university athletic training has largely operated via an athletics model since the early 20th century.[1] In this model, athletic training clinical staff are hired or fired by the athletics department. Athletic training (eg, salaries, athletic training equipment and supplies, medical expenses, and insurance) is funded through the athletics' budget. Reported advantages of this model include closer relationships and enhanced communication between sports medicine and athletic department personnel.[19] Reported disadvantages include potential conflicts of interest regarding control of patients' medical care and potential role conflict for ATs who manage multiple roles (eg, clinical, administrative, and teaching responsibilities).[19] Whereas some programs have experienced long-term alignment with either academics (ie, academic model) or campus student health services (ie, medical model), the most common model used in collegiate athletic training clinical programs is the athletics model. The hierarchy generally is as follows: (1) staff ATs report to a head AT or director of athletic training or sports medicine and (2) the head AT or director of athletic training or sports medicine often reports to a team physician and yet ultimately reports to an athletics director. In some institutions, this athletics director is a health care professional (eg, a physician, AT, or physical therapist). However, in most cases, he or she is an administrator and often a former coach with no medical experience. At some larger institutions, an AT's contract may include 2 supervisors: the athletics director and the head coach.[19,20]

The pressure to win has been tangible since the first collegiate contest in 1852.[1] However, collegiate athletics has evolved into a multibillion-dollar business of amateur sport. High-dollar contracts fuel enormous pressure on coaches to win and have long-term successful programs to avoid termination.[20] Collegiate ATs are often wedged into high-pressure, challenging situations in which their ethical duty to provide proper medical care is confronted by pressure from athletics personnel to return patients to participation so they can contribute to the program's and coach's success.[21] Conflicts of interest in the medical wellbeing of the patient arise when ATs' decisions are challenged or overridden by individuals who are not in the medical profession or through external second opinions from favored physicians, with medical decisions being made for nonmedical reasons.[20] Reports of ATs being fired because of conflicts with coaches over medical treatment or a coaching staff change are common.[20,22]

In recent years, ATs have entered the national spotlight because of disputes over player injuries, especially concussion, and return-to-play decision making.[20,23] In light of these conflicts, a 2014 interassociation statement on best practices for sports medicine management in colleges and secondary schools highlighted the advantages and disadvantages of sports medicine supervisory relationships.[19] Recently, Kroshus et al[24] reported that not only did sports medicine clinicians perceive pressure to prematurely return concussed patients to participation, but clinicians employed through the athletics department also experienced greater pressure. Such evidence and dialogue fuels the debate over the proper alignment of athletic training services within collegiate athletics.

As the athletic training profession has developed, advancement has come through the desire to be recognized and respected. The debate over collegiate athletic training independence from the athletics department is at the forefront. However, we need to examine the opinions of ATs in the athletics model about what does and does not work with athletics department alignment. Whereas the athletics model is the most common organizational infrastructure in collegiate athletics, little to no research exists on collegiate ATs' perceptions of this model. Therefore, the purpose of our study was to explore the perceived benefits and barriers collegiate ATs experienced within the athletics model and the alignment with the college's or university's athletics department. The following research questions guided our study: (1) What were ATs' opinions of the athletics model? and (2) What were ATs' perceptions of their role in the athletics model and their relationships with coworkers?

METHODS

Research Design

This paper is part of a larger, mixed-methods study in which we examined professional topics and organizational infrastructure in the collegiate setting.[25] The larger, mixed-methods study included a survey instrument (phase I) and telephone interviews (phase II). This paper focuses on phase II. We used an exploratory qualitative design with semi-structured interviews to investigate the "lived experiences" of ATs employed in the athletics model and the perceived benefits of and barriers in having the athletic training staff aligned with the athletics department.[26,27] The designs of phase I and II of the larger study are described in part I.[25]

Theoretical Framework

Role theories are commonly used to examine organizational relationships. These role theories guided our exploratory study of perceptions of the athletics model. Role congruency theory states that a group will be positively evaluated when its characteristics and values are recognized as aligning with its typical social roles.[28] The theory of role strain was introduced by Goode[29] and has been a framework for research on athletic training professional concerns.[6,13] In this theory, roles are viewed as units of social structures, and in general, individuals want to fulfill the expectations placed on them in these roles. *Role strain* is the difficulty of fulfilling role expectations and demands. Other operational terms include *role set* and *role obligations. Role set* is the group of relationships associated with a particular role (eg, relationships with patients,

Table 1. Participant Demographic Data and Assigned Pseudonyms

Pseudonym	Sex	Age, y	Social Status	No. of Children	National Collegiate Athletic Association Division	Position Title	Time in Position, y	Time Certified, y
Bruce	Male	40	Single	0	I	Director of Athletic Training	6.0	15
Chloe	Female	40	Single	0	I	Director of Sports Medicine	4.0	20
Edward	Male	29	Married	0	I	Interim Director of Athletic Training	3.5	6
Grant	Male	64	Married	2	III	Head Athletic Trainer	41.0	41
Jacob	Male	32	Married	2	I	Assistant Athletic Trainer	2.5	9
Jared	Male	57	Married	2	I	Director of Athletic Training	27.0	35
Jessica	Female	27	Engaged	0	I	Assistant Athletic Trainer	3.0	4
Melissa	Female	42	Married	2	I	Assistant Athletic Trainer	9.0	18

physicians, coaches, and administration). *Role obligations* are the expectations associated with a certain role and are defined by the members of a role set.[13] Role strain has 5 subscales: *role ambiguity*, *role conflict*, *role incompetence*, *role incongruity*, and *role overload*.[29,30] Pertinent role strain subscales are operationally defined and discussed in the Results and Discussion sections.

Participants

Eight ATs (5 men, 3 women; age = 41 ± 13 years old, time employed at the current institution = 14 ± 14 years, experience as a certified AT = 18 ± 13 years) participated in our study. Seven participants were employed at National Collegiate Athletic Association (NCAA) Division I schools; 1, Division III. Four were married with children, 1 was married without children, 1 was engaged, and 2 were single without children. Three participants were directors of sports medicine or athletic training, 1 was an interim director of athletic training, 1 was a head AT, and 3 were assistant ATs. Demographic information and assigned pseudonyms are provided in Table 1.

Completion of the survey implied informed consent, and the study was approved by the University of Connecticut–Storrs Institutional Review Board.

Data-Collection Procedures

Inclusion criteria for our study were full-time employment as a collegiate AT and salary received from the college's or university's athletics department budget. Participants were recruited using 2 avenues. First, participants who completed the Web-based survey in phase I of the larger study were instructed to share their contact information at the end of the survey if they wanted to participate in an interview. Second, we incorporated criterion and snowball sampling: at the end of an interview, participants would voluntarily provide the names of potential ATs who fit the inclusion criteria. Data saturation also guided our final participant sample.

We contacted participants via e-mail, and telephone (n = 5) or in-person (n = 3) interviews were scheduled at their convenience. We used a previously described semistructured interview guide.[25] One researcher (A.G.) conducted all interviews to ensure consistency of data collection. Interviews lasted an average of 45 minutes, were recorded digitally, and were transcribed verbatim.

Data Analysis

We analyzed data via a general inductive approach.[26] All 3 researchers evaluated the transcribed interviews and conducted multiple readings of the data. During the first reading, we examined the transcripts with a holistic lens for an overall impression of the findings. The process highlighted the visible findings and trends in the data as described by the participants. The second reading involved the memoing process, in which field notes were drafted in the margins of the transcripts. This process allowed us to demonstrate the similarities and group them on the third reading. Inductive codes were also assigned during this reading, and on the final examination, all common findings were categorized together and assigned a conceptual tag.

Whereas we analyzed the entire interview, we focused on the participants' answers to specific questions from the interview guide that were related to organizational infrastructure and their opinions and perceptions of their role in the athletics model. Selected interview guide items are listed in Table 2.

Trustworthiness of the Data

Peer review and multiple-analyst triangulation established trustworthiness of the data. Researcher bias is often a concern in qualitative inquiries, and although we are content experts and well trained in qualitative methods, conducting a peer review allowed us to gain a fresh perspective and guarantee rigor in data collection and accuracy in analysis. Our peer, a seasoned scholar and expert in qualitative methods and quality-of-life topics, reviewed the survey instrument and interview guide for content, clarity, and flow. Peer feedback was considered and changes were made to the study's instruments. A peer also confirmed the emerging theories or themes identified in the multiple-analyst triangulation. As described, the researchers completed data analysis after the stepwise procedures. Multiple-analyst triangulation, as peer review, ensures that the analysis process will capture the emergent themes.

RESULTS

Two benefits and 3 barriers emerged as higher-order themes from our data analysis of athletics model perceptions (Figure). Role identity emerged as a benefit, with participants expressing their connection with the collegiate setting. Role congruence also emerged as a benefit that occurred with 2 lower-order themes: relationship building and physician alignment and support. Role strain, staffing concerns, and work-life conflict emerged as barriers in the athletics model. Role incongruity and role conflict emerged as the primary lower-order themes of role strain. Each theme is presented with supporting quotations.

Table 2. Selected Questions From the Semistructured Interview Guide[a]

1. Explain the model your athletic training program is currently operating under:
   a. Where and how is athletic training aligned (ie, under athletics, campus health services, or the athletic training education program)?
   b. Explain how your "model or system" works.
   c. What is your opinion of the current model you are under?
   d. Elaborate on your relationships with the people you work with (ie, medical director, coaches, athletics administration).
      i. Describe your role.
      ii. Are your job expectations clear?
      iii. To what extent do your job expectations/demands compete with the expectations/demands of others (coaches, administration, etc)?
2. Describe an ideal working environment in athletic training? Is it obtainable in your current work environment or another work setting?
3. What do you feel is, or has been, your greatest challenge as an athletic trainer?
4. Reflect on the challenges that you have faced and describe what you have done to effectively deal with those challenges.

[a] All interview questions are provided in the Appendix of part I of this study.[25]

Benefits

Role Identity. At the grassroots, role identity is a common reason for becoming an AT, as Grant shared: "First of all, we become athletic trainers because we care about people." A greater level of role identity reflects an AT's sense of self-formation and belonging within the collegiate athletics setting; specifically, assuming the role of the AT within this setting and organizational infrastructure met their professional needs. Jared had worked in the collegiate setting for more than 35 years, with 27 of those at his current institution. His love for the job was evident in his comments and mantra about coming to work daily:

> I subscribe to Dick Butkus … he said they paid him to practice, but he played for free. And being a collegiate [AT] I'm kind of the same way, they pay me to be here from Sunday through Friday. I'll go work Saturdays for free because I love it.

Jacob illustrated the idea of role identity when discussing his attraction to the collegiate setting and his passion for his job:

> I wanted to work in college athletics, and to be honest with you, [it is] the setting that I found most enjoyable and desirable … [and] see myself continuing to stay in and having a future with it. … I tell every individual that I've ever worked with that is either interested in athletic training or very young in the profession, whatever you do, you have to love.

Bruce stated the following about his role and professional development:

> I actually enjoy what I'm doing … my free time is actually an educational read. To me, that's more

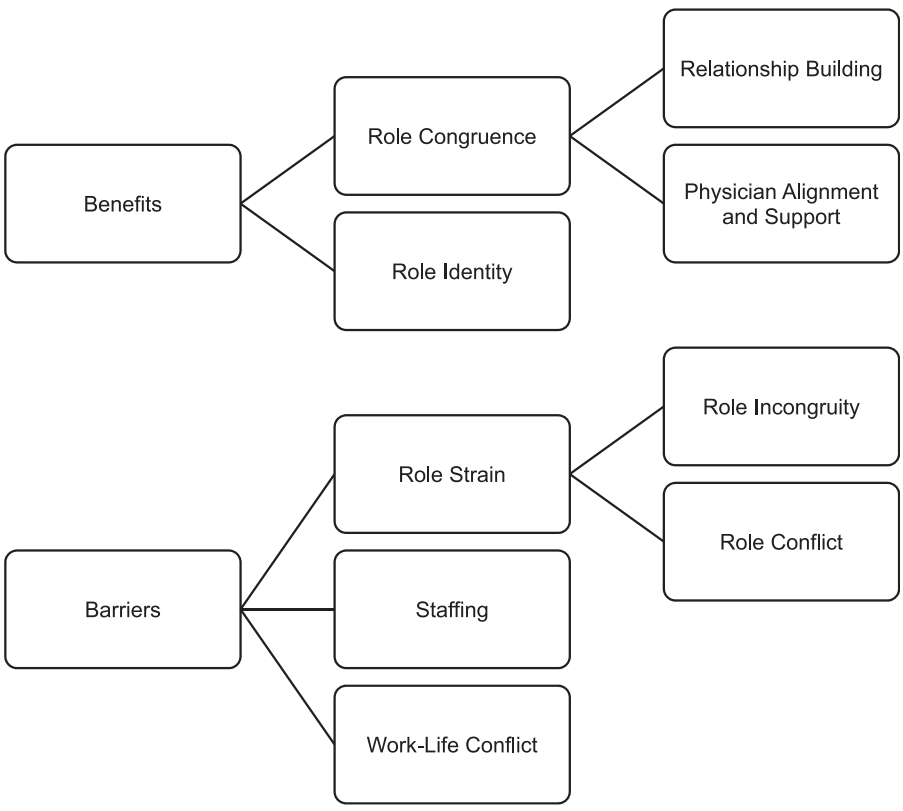

Figure. Benefits of and barriers in the athletics model.

enjoyable. I am relaxing because I'm reading something that I want, yet it's making me better as a professional. I don't come to work every day thinking, oh my … I've got to go to work.

Participants' identification as collegiate ATs allowed a better fit in and commitment to their setting and the organization.

Role Congruence. Role congruence emerged as a benefit in the athletics model when participants who viewed their program and the model in a positive light portrayed a sense of shared values, attitudes, and goals with their supervisors, coaches, physicians, and AT coworkers. Hence, their hard work and role in the athletics department were valued. This congruency was established using relationship-building strategies or physician alignment and support.

Relationship Building. Role congruence occurred when participants worked hard to establish strong trust relationships with their supervising athletics director and coaches. Relationship building created a better alignment in values, in which all parties understood their shared goal: working for what was best for the student-athlete. Longevity at their institution and in their position also helped several participants build these relationships. Jared was the director of athletic training at his institution, where he has been employed for 27 years. He elaborated on longevity and relationships with administration and coaches:

> I've outlived 7 [athletics directors], 9 football coaches, 10 basketball coaches, 5 presidents, … I don't get mad at them, I just outlive them … as long as you're doing the right thing, and doing a good job, [longevity] creates an environment where [they say] "He knows what he's doing, don't screw with him." I think once you can demonstrate that you have the best interests of the student-athlete at heart and the best interests of the university, you're doing the right thing for [everyone]. And sometimes it takes time to establish that … I joke every time I have a new football coach, "Well, it'll take 2 years to convince this guy I know what I'm doing." … it's just part of the gig.

Chloe has been the director of sports medicine for 4 years at a large Division I institution, where she has been employed for 18 years. She spoke at length about how building trust relationships with coaches has been her greatest challenge. However, through understanding their point of view and building trust, she has experienced positive outcomes:

> I think that's always the biggest challenge for any athletic trainer … it's building those relationships with coaches … making the coaches feel heard … But … feeling like you're having to jump through hoops to do it, too, can be frustrating … we've had some issues with coaches, where a coach wanted to hire someone for a position who was married to one of his staff members. We [said], "No, that's not a great fit … Let's find someone that's even better that we both like." … So we understood there was kind of a balance there … And I do know there's a lot of money at stake, and their jobs, and then supporting their families … I get that wins and losses affect their livelihood.

She elaborated on building positive relationships with coaches:

> The perfect environment would be where the coaches have 100% trust that we're going to bring in the best person for them and for us. … Coaches [have] said: "If we're here to meet these [young ATs], we know you're going to hire the best person." … Coaches, just by nature, most of them are going to be kind of micromanagers and are going to need to build some of that trust when their job depends on us doing our job … I think we just keep working, let the coaches have the confidence in our department, and in me … that I do have their best interests at heart … obviously what I've done to build a relationship with them has worked.

Grant, who has been employed at a Division III institution for 41 years, summed up the importance of building good relationships: "I don't care how many pieces of legislation they pass, respect is something you earn day after day after day."

Building strong trust relationships with fellow athletic training staff members was also an important aspect of role congruence. Melissa discussed her longevity in the athletics model and the longevity and unity of her athletic training staff in a positive light:

> I guess I don't know any different because I've been doing it for so long and we haven't had a problem with it … it's all I know … [most of the staff have] been here so long … So everybody knows each other well, and kind of picks ideas off each other.

Chloe echoed the importance of staff relationship building and unity:

> …making sure that everyone knows that WE are the important part in the sports medicine program … looking out for each other … it's everybody … we need to chip in … that was one thing that was pretty important in hiring people, is people that bought into that, we're not hiring you to work a sport, or be associated with a certain coach. We're hiring you to be a part of our staff, and oh, by the way, your assignment will be this sport.

Physician Alignment and Support. Support from team physicians also facilitated role congruence. However, the alignment of these physicians with the college or university was also important to creating congruency for the AT in the athletics department. On-campus physicians, through student health services or the university's medical school, were involved in staffing, decision making, and communicating with athletics directors. For instance, Jacob was employed at a large Division I university where the athletic training staff was supervised by a senior associate athletics director who was an AT and a physical therapist and by the medical director. He said the following about the access, support, and alignment of their medical director:

> . . .with [our team physician] being housed under student health, it provides consistency, and . . . helps negate any controversy that may occur within the health of the student-athletes . . . there can be some controversial issues that arise: "Was the health of the student-athlete really thought about, or did you want to just see him on the field?" . . . having him housed out of student health kind of eliminates [this controversy] . . . it also allows more access to the nurses, to the facilities . . . it helps to solidify the fact that he's here for the student first, athlete second.

Melissa discussed "great support" with having all on-campus physicians, including their medical director, who was an orthopaedic surgeon with the university's school of medicine and involved in the chain of command with her director of sports medicine and the associate athletics director. Chloe's general medical team physicians were aligned with student health services. She noted the following about physician involvement and support:

> . . .in terms of the doctors, we have a fantastic relationship. I think we're really fortunate that we all have such great support from them, and they really get what we do and respect what we do . . . they were very supportive of everything we were doing this summer, and the hires, and they were very actively involved in it too.

Participants whose physicians were not aligned with on-campus medical providers worked diligently to develop relationships with these health care professionals. Over 40 years at the Division III level, Grant had developed a network of "go-to people," or health care professionals, whom he believed provided a consistently high level of care for his patients. Jared noted that, in addition to staffing quality ATs, the most important characteristic of an ideal working environment was "the relationships with your specialists, and other allied health professionals within the community . . . to gain that timely access, to gain the expertise of others when needed."

Barriers

Role Strain. Role strain emerged as a barrier in the athletics model. Two components of role strain, role incongruity and role conflict, emerged as lower-order themes.

Role Incongruity. *Role incongruity* is defined as the degree to which expectations for one's performance in a role are misaligned with the individual's disposition, attitudes, self-perception, and values.[13] It occurred with participants who perceived a misalignment between their values and their role as ATs and the overarching goals and values of the athletics department. Some participants believed that aligning their program with health care professionals would improve health care access for their patients and advance the athletic training profession. Bruce, a director of athletic training, said:

> I think just the separation from the athletics, putting us in the medical model would give the profession itself a little more credibility . . . [it] would actually help with our salaries as well, and [with] some of the hours that we work . . . [coaches will give] some resistance because obviously any type of change will get resistance, but I think the coaches will have a better understanding of what we're truly here for and know that every action we do is backed by a physician.

Grant stated the following about incongruity with the athletics administration: "We need to get the administrators to understand that we too, are people; we're not a wrench on the wall. We're not to use as they see fit." Edward expressed incongruity with his supervisor:

> Our supervisor is an athletic administrator with no medical experience. The person who signs off on our protocols is our team orthopaedist, so he's not actually employed by [our university]. I think there are benefits to both [medical and athletics models] . . . I wish that the person who was the athletic administrator had medical experience . . . for instance, last week, I had to answer a question from our budget person on why we had spent so much on EpiPens . . . you wouldn't have to worry about [it] if it was a medical person who was in charge of us.

Whereas Jacob was satisfied with his supervisor and physician support, he mentioned:

> I would actually like to see more of a student health model with athletic training. I think it would solidify the profession. I think that you would have, again, more access to other health care professionals.

Role incongruity also occurred when coaches' expectations of ATs were misaligned with the ATs' values and personal expectations to care for and protect their patients. Jessica said:

> [Coaches] would want to do workouts that definitely pushed the girls to their physical limits . . . [I struggled] with what I would ideally want to do as an athletic trainer . . . [and] sometimes having girls sit out at practice . . . there was some pushback from that.

Grant added, "So, of course, coaches get a little excited . . . Eventually, unless you have a really, really strong [athletics director], you wind up with 18 different bosses, which is essentially what we've got here." Bruce elaborated on his struggles with coaches:

> I report directly to one of the associate directors of athletics . . . [yet] there's a lot of affiliation with the coaches. I have to make sure that I remind them that we work with them . . . a lot of the decisions that we make, we may be pressured by coaches . . . in terms of getting somebody back out onto the field . . . I know that the coaches and the athletic directors have desires to have everybody playing so you can win . . . but as medical professionals, we're here to look after the best interests of the athlete. And I think that we should be removed from any type of pressure like that. There's been situations where, I had a [medical emergency] . . . I tried to get somebody to call for an ambulance, and everybody was afraid to call . . . because the coach didn't think that

> an ambulance at the scene would be good for the team's morale … [Recently] I've had coaches pressure me [to return] athletes with heart conditions … So I think that we're hindered by what we do … they're all [trying to make] medical decisions that none of them are qualified to make.

We concluded that the expectations, attitudes, and values of athletics department personnel (primarily coaches but athletics directors as well) were misaligned with the ATs' self-perceptions, attitudes, and values. Whereas this struggle within the athletics model emerged from the data, Chloe offered an interesting summation on incongruity and the struggle to find the organizational model that fit her program:

> [A former coworker] and I had kind of gone back and forth on [switching to a medical model], and he was like: "I don't know that it would necessarily be different with a different model." [I spoke with a colleague who is an AT in a medical model] and a lot of the things I was going through, they'd had to deal with too, and I was kind of surprised, honestly. He said: "Yeah, we hired someone, and the coach didn't like him, and basically made him miserable, and the guy quit." … So it was interesting, but I can see there being pros and cons with either [model].

Role Conflict. *Role conflict* is a component of role strain and is the presence of clear but opposing or incompatible expectations.[29] Participants experienced *intersender conflict*, which is a subset of role conflict and the degree to which the demands of 1 member of a person's role set conflict with the demands of another person or persons within the role set.[13] They also expressed how the expectations for a collegiate student-athlete (ie, the specialization and year-round training) conflicted with their role to care for their patients. Melissa stated this was her greatest challenge as an AT because

> it's getting harder and harder to keep the kids healthy because they are going all year long … Especially … [my sport], our freshmen that come in, they're playing club all summer, and then they come in here in July and work out, and then we start preseason [and] they get no break … there's no turning them around … these chronic injuries just don't have time to heal.

When describing the ideal work situation in athletic training and if it was attainable in his current environment, Grant said:

> I don't know if in today's expectations, the athletes and their parents … if it's ever going to be attainable … Because any time they're hurt, they don't play. When they don't play, obviously they don't get any good … So you can only tell Johnny and Suzy that you had a good experience for so long before it sinks in that they haven't yet.

Interrole conflict occurs when an individual has membership in 2 groups and the demands of one role conflict with the demands of the other.[13] Participants with heavy administrative duties expressed their struggle to juggle all of their roles and responsibilities. Chloe elaborated on the challenges of managing administrative and clinical responsibilities:

> Finding the time, especially with my position … some time in the middle of basketball season … [to] make sure I'm stopping by baseball practice, and going to see the coach over there … [showing that] she actually cares … I think that's been the biggest thing for me is balancing the [administrative and clinical] time and making sure my student-athletes are getting the right support they need for the team that I directly work with and then also, just as a department, trying to make all of the rest of the teams feel … important.

Grant, an AT at a small Division III institution, provided an important perspective on interrole conflict. When asked about the athletics model, he stated:

> It works … It's not perfect. In our situation where funds are so short, we've got 425 athletes, with myself 75% athletic trainer, 25% instructor. [My 1 full-time] athletic trainer, and I hate to use the word "assistant," because she's so good, she's our senior women's administrator, assistant athletic director, and [also] 50% athletic training.

Staffing

Staffing was a consistent barrier that emerged from the participants' experiences. Whereas chronic understaffing was a constant challenge, quality control and conflicts with athletics department administrators were also discussed. Jared, who had more than 20 years of experience as director of athletic training, said that his greatest challenge as an AT was

> Staffing … you've got to have the right person … I feel very fortunate, my staff [have been] loyal, good athletic trainers … But you know, unfortunately when you're hiring good people, they leave because they're going to go get better jobs … So there's that turnover. But staffing is the biggest thing, and when the administration believes that, "Well, let's just hire [graduate assistants]," and they don't understand the difference between care and coverage. [Graduate assistants] are great for providing coverage, but they don't provide an increased level of care.

Jared added that the ideal working environment would be

> [an environment where] my staff is appropriate … [and] meets or exceeds the AMCIA [Appropriate Medical Coverage of Intercollegiate Athletics] … consistent staff to provide the level of care that the student-athletes deserve and expect.

Grant also expressed that, in 41 years of employment at a Division III institution, his greatest challenge was, "Finding help … we don't have near enough help … That's a constant battle for us … Understaffing, it's just constant."

In his efforts to increase his staff and provide an appropriate level of care, he commented:

> Well, we keep trying to tell them. [Actually,] tomorrow we have a meeting with the provost of finance here on campus because we [have had so much turnover] … they've got … to come up with a new position, [they've] got to figure it out. You can't have 2 and a half people and expect them to be in 5 places at once; it doesn't work.

Grant expressed his frustration about the barriers he faces, primarily with staffing:

> So it's all you can do. I don't want to leave angry … So many of my colleagues [here], when they leave, they're so angry, then they just won't even step foot back on campus. I would like to not leave like that.

Bruce had experience in various athletic training settings and has 6 years of experience as director of sports medicine in the collegiate setting. He noted the following about staffing challenges:

> …the biggest thing is having the adequate personnel. And when you look at a medical model … they understand how many patients a doctor sees … Well, maybe if we had help through the medical model and people who understand seeing patients and things like that, we would have better staffing.

Jared's opinion of the different models in the collegiate athletic training setting provided a good summation of the importance of having quality staff: "You can have the perfect model, and if you don't have the right people within that model, it's a bad situation."

Work-Life Conflict

Managing both work and life commitments was a challenge for many participants. They expressed work-life conflict in several ways. Newly certified and experienced ATs discussed their current struggles and the effect of increased summer care and reflected on their regret over family time they had missed. Jessica, who had been certified for 4 years, viewed her greatest challenge as a young AT as

> …definitely the time commitment, for me. And I feel confident in my skills … doing rehab[ilitation]s, managing patients, that kind of thing … It's just the time that I spend here, that's probably the biggest challenge … explaining to other people why I can't do things. Like, "Oh, I have to work."

Jacob, who was married with 2 young children, also noted that time commitment was his greatest challenge:

> …the biggest thing is just trying to manage the family life with the work … working in a job where I'm traveling 4 days out of the week, if not more … especially in the spring. [So] I try to manage as much family time as I can in the fall [and summer] to kind of compensate for the amount of time that I miss in the in-season. So I think that's been kind of the biggest struggle that I've had.

Edward, who was married without children, said:

> My greatest challenge is that my wife also has a busy schedule, and it's conflicting … a lot of athletic trainer couples, they understand each other's schedule … [work-life balance] is important, and I would say that my wife and I both understand, at this point, that it might not be possible.

Participants shared their concern about the effect of increased summer activities on work-life balance. Chloe explained:

> [Work-life balance is] very important, and I do a terrible job at it … there's no summer … because now basketball can do workouts … you'll be up there for hours … It used to be, when I got into it, that it was injured athletes and people with bad grades that needed to stay and make up classes. Other than that, we'd cover camps, and have some time off, and now it's … crazy.

Jared reflected on raising 2 children and the changes in summer activities:

> [my wife] was a stay-at-home mom … we decided to homeschool, so when I did have time, I was able to interact … back [in] those first 10, 12 years … we had the summers off … We had 160 student-athletes on campus last summer. So that has been a significant change, and if I had young children at home, that would create an issue … I'm not sure how I'd handle it as a youngster right now. Again, there it comes down to the staffing number, or that the expectations keep rising, but the staffing and some of the support areas haven't.

Grant also described his struggle to balance work and personal responsibilities during his long career as a collegiate AT:

> I look around at athletic trainers [today]; many … are divorced. Well, I'm not; fortunately I've got a wife who stayed with me … I don't know honestly if I'd do it again because I missed too much. You know, now, when you just take time off, some of the coaches and athletic directors say, "Well, you didn't do that before." Well, I didn't get to some of the stuff I should have with my children; I'm not going to miss it with my grandchildren. Then they're angry or upset. Well … That's something we have to do in our profession. We have to start figuring this out.

Grant's comments about his struggles to find work-life balance within the traditional model of athletic training speak to organizational constraints as well as role incongruity. That is, his administrator's unawareness of the role an AT plays can lead to greater conflict. Bruce's statements about work-life balance appeared to mirror Grant's comments. He was concerned about coaches being

blinded by their own needs and not understanding the big picture, which put a strain on the AT:

> We . . . need to help the coaches understand that there are other teams, and there are only so many hours within the day. Like cheerleading, for instance, they want to go from 7:00 PM to 10:00 PM. Okay, let's not extend the day, and it's a matter of [letting] them know you have to [practice] when we're here, during our hours.

Work-life balance was a struggle for our participants. Conflicts manifested because of the nature of the job, understaffing, and organizational factors.

DISCUSSION

The professional discourse on the best organizational hierarchy for collegiate athletic training has recently increased.[22,31,32] Specifically, it has raised the following question: Which model best fits the collegiate athletic training setting for providing quality care to patients and ensuring that ATs remain healthy, committed, and able to provide optimal care? In 2010, Laursen[22] suggested that the traditional, or athletics-centered, model does not allow for optimal patient care, as the potential for conflict is inherent. In other words, coaches and ATs can have different views, values, and beliefs on management and return to participation after injury. Our examination of collegiate ATs' perceptions of the athletics model was driven by this debate and revealed that role identity and role congruence are perceived benefits of the model. Role congruence was present when trust relationships with athletic training, athletics, and medical personnel were nurtured and participants perceived support from their team physicians. Barriers in the athletics model included role strain, primarily as role incongruity and role conflict. Staffing challenges and work-life conflict also emerged as barriers.

Role Identity

Role identity describes the idea that persons can relate and distinguish themselves in a particular role. Through social interactions, individuals validate the role they undertake.[33] A person can develop a self-concept through these interactions and learn the behavioral expectations of society and the organization for that role.[34] Our participants discussed developing their AT role in the athletics model and this role aligning with their values as a person. For ATs, role identity has emerged as an important aspect of developing organizational and professional commitment.[35] It involves identifying with the work and the role played in the collegiate setting.[3,4] Personal fit and locating a role that aligns with one's personal skills and strengths can assist in retention, and ATs can find satisfaction and worth in their role.[36]

Role Congruence

Congruence[37] and person-environment fit[38] have been positively related to job satisfaction, organizational commitment, and career success. Veage et al[39] demonstrated that mental health employees whose values were congruent with the values of their employer experienced greater perceived work accomplishments and personal wellbeing and less burnout. In our study, congruence within the organizational infrastructure of the athletics department arose through relationship building and team physician alignment and support.

Relationship Building. Our participants who experienced role congruence through relationship building shared a common trait: longevity in athletic training and their respective institutions or positions. Whereas longevity concerns in athletic training are documented,[40] our participants who have persisted, over time and with patience and hard work, built and nurtured trust relationships with coaches, athletics administrators, team physicians, and coworkers to create a positive environment in which these organizational members share common goals and attitudes for the population they serve. Trust relationships in the workplace involve respectful interactions and fair treatment among organizational members.[41] Okello and Gilson[41] demonstrated that these trust relationships not only enabled cooperation among organizational members and patients but also affected the intrinsic motivation of health workers. A positive effect on intrinsic motivation can influence retention (ie, longevity), organizational performance, and quality of patient care.[41]

Physician Alignment and Support. Winterstein[42] called the AT-physician relationship the cornerstone of the sports medicine team, and our results highlight the importance of this relationship and its effect on role congruence for ATs. A notable finding in our study was the perceived congruence not only with team physician support, involvement, and communication but also when the physician was employed within the university's health care system. Recently, researchers[19,22,31,32] have advocated for this physician alignment or at least for the athletics director to have a medical background. Rural and smaller institutions (eg, non–Division I schools) may not have access to substantial campus health services or diversified health care providers. However, over time, some of our participants developed a network of health care providers to assist in providing quality care for their patients.

Role Strain

Role Incongruity. Role strain in collegiate athletic training has been well documented.[6,13,20,24] Role overload and role conflict are reported factors in ATs leaving the collegiate setting.[3,8] Brumels and Beach[6] studied role complexity in collegiate ATs and found that role incongruity was the only subscale of role strain that negatively predicted all measured variables: job satisfaction, intent to leave the current position, and intent to leave the athletic training profession. Henning and Weidner[13] reported that collegiate ATs who were also preceptors did not have congruency in their jobs, and a quarter of participants reported complete incongruence.

Role conflict focuses on incompatible and competing demands and expectations from members in a role set, whereas role incongruity focuses on the misalignment of values, ethics, dispositions, and attitudes of members in a role set.[13,29,30] These constructs are similar, as a difference in perceived values can fuel competing expectations. For example, values related to maintaining a successful (ie, winning) collegiate program can fiercely compete with values related to the mental and physical wellbeing of the program's student-athletes, which drives incompatible

expectations for participation. In our study, ATs voiced role strain through role incongruity with coaches or supervising athletics directors. The values and disposition of athletics department personnel were misaligned with their own values, disposition, goals, and ethical responsibilities as ATs. Over time, the bureaucratic aspects of the collegiate athletics culture can create an unsettling environment that devalues the AT's role.[9] Whereas our results differed slightly from the literature in which researchers[3,8,20] have expressed this stress as role conflict for collegiate ATs, they support the evidence of role strain between ATs and athletics department personnel. However, our finding of role incongruity in the athletics model contrasts with the research of Eason et al,[43] who found perceived role conflict but no role incongruity.

Misalignment of values and beliefs and incompatible expectations between collegiate coaches and sports medicine clinicians is evident in the literature, as Wolverton[20] recently reported that more than half of the collegiate football ATs surveyed (53 of 101 participants) perceived pressure from coaches to return concussed student-athletes to participation before they were medically cleared. Qualitative results from this study demonstrated the stark realities of incongruity, conflict, demotion, and even job termination that collegiate ATs can experience. More recently, Kroshus et al[24] surveyed ATs and team physicians from 530 institutions and found that more than half experienced pressure from both coaches and patients to prematurely return concussed athletes to activity. Furthermore, participants working in an athletics model perceived greater pressure than those in a medical model.

In our study, participants who spoke at length about role incongruity in an athletics model, in which the supervising athletics director had no medical expertise. Incongruity was expressed not only in medical decision making but also in purchasing and hiring. Whereas most states recommend[19] and even mandate[44] that ATs report directly to a physician, this was not the reported hierarchy for 6 of 8 participants' athletic training staffs. Reporting to a university-employed team physician, who is also the medical director for the sports medicine department (ie, supervising all sports medicine decisions, including athletic training, general medical, and orthopaedic decisions), may reduce role incongruity between ATs and athletics department personnel.[19,24]

Role Conflict. Coaches now have increased access to student-athletes[45] and year-round performance expectations. These expectations are often incompatible with ATs' goals to provide quality care and protect patients' wellbeing in an environment that offers little time to rest and recover from injuries. Our findings of intersender role conflict support recent research[46] on the growing concern ATs have about the effect of increased training, especially increased summer activities, on their patients' mental and physical wellbeing.

Our participants experienced interrole conflict while managing multiple roles, including clinical, administrative, and academic responsibilities. Furthermore, building relationships with staff and coaches also competed for professional time. Managing administrative or teaching roles; a demanding patient care load; and practice, conditioning, events and games, and travel responsibilities can weigh on ATs. As discussed in this section, the conflict can intensify when an athletic training staff does not have adequate and quality personnel. The conflicts that ATs working in the athletics model experienced are somewhat comparable with those in the academic model.[43] That is, juggling multiple competing roles was deemed challenging, as it reduced the time available for personal interests, obligations, and responsibilities. The interrole conflict that this group and ATs in the academic model[43] experienced illustrates the potential problem of reporting to a supervisor who is not fully aware of the complexity of the AT's role and the value ATs bring to the workplace.

Staffing Concerns

A major challenge for many of our participants was staffing, both the quantity and quality of athletic training staff. This challenge of appropriate staffing is not new,[47] as it expresses the nature of collegiate athletics that often results in not enough full-time or even part-time ATs being available to provide appropriate medical care. Participants, particularly at smaller schools, discussed chronic understaffing. This problem stimulated work-life conflict for ATs in the non–Division I setting, as the staff size was frequently 2 to 3 ATs for more than 200 student-athletes.[48] Researchers[47,49] have demonstrated the collegiate AT's workload is gradually increasing, especially during nontraditional and summer seasons,[46] but creating and hiring for new positions to offset this increasing workload is less common. The AMCIA document was drafted in 1998 and last revised in 2007.[50] However, little empirical evidence is available on whether institutions are meeting these recommendations. The quality-of-staffing concerns that participants expressed also involve the coverage-versus-care discussion and the quality of care that the athletic training staff can provide its patients. The National Athletic Trainers' Association[51,52] has advocated for using the term *care* rather than *coverage* to improve the perceived value, status, and quality of life for ATs.

Work-Life Conflict

Work-life conflict in the collegiate setting has been well documented[3,7,8,10–12,36]; thus, the finding that our participants struggled with this is not surprising. The antecedents were comparable with those described by Mazerolle et al[7,18] and continue to highlight the organizational challenges presented to ATs, including long work hours, travel, and inflexible work schedules. Work-life conflict also emerged from the growing expectations and requirement for summer medical care, which has recently become a new challenge for ATs in the collegiate setting.[46] The NCAA changes in summer activities for student-athletes have increased the workload for collegiate ATs to the point that the summer workload mimics the nontraditional season workload. This increase in summer medical care can negatively affect work-life balance, schedule flexibility, and rejuvenation.

LIMITATIONS AND FUTURE RESEARCH DIRECTIONS

Our study was exploratory and cross-sectional and only included the perceptions of ATs. Therefore, future researchers should focus on larger, mixed-methods investigations of ATs' perceptions of the athletics model,

including all NCAA divisions. Furthermore, the attitudes and opinions of other members of the role set (eg, coaches, athletics department personnel, and team physicians) should be examined. Investigators should also compare role and value congruence; staffing, including compliance with the AMCIA[50] document; and work-life conflict among the athletics, medical, and academic models. Our study represents only 1 point in time and cannot begin to fully explain the effect that time of year may have on ATs and their ability to successfully navigate their work-related responsibilities. Future researchers need to longitudinally examine the workloads of ATs and how organizational infrastructure may influence medical access, patient care, and outcomes.

CONCLUSIONS

The alignment of athletic training with the athletics department is the common infrastructure in collegiate athletics today. Benefits of this alignment include identifying with the collegiate AT role and role congruence. Role congruence occurred through building trust relationships and through physician alignment and support. University-employed team physicians and supervising athletics directors with medical experience were also viewed as benefits to congruence. Barriers in the athletics model included role strain via role incongruity and role conflict, staffing concerns, and work-life conflict. Collegiate athletic training staffs who are aligned with the athletics department and experience these barriers are encouraged to evaluate their relationships with athletics department personnel and their supervisor as well as the alignment of their team physician within the organizational hierarchy. In addition, measures to increase quality staff from the standpoint of care rather than coverage should be considered to mitigate role strain and work-life conflict.

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