January 2019

Welcome To The Neighborhood: Communities Of Practice And Identity Development Of Athletic Training Students

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WELCOME TO THE NEIGHBORHOOD: COMMUNITIES OF PRACTICE AND IDENTITY DEVELOPMENT OF ATHLETIC TRAINING STUDENTS

by

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A Dissertation

Submitted to the Graduate Faculty

of the

University of North Dakota

in partial fulfilment of the requirements

for the degree of

Doctor of Philosophy

Grand Forks, North Dakota

December
2019

This dissertation, submitted by Alicia Champagne in partial fulfillment of the requirements for the Degree of Philosophy in Educational Foundations and Research from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.

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Date

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Department Educational Foundations and Research

Degree Doctor of Philosophy

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Alicia Dionne Champagne
11/20/19

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ACKNOWLEDGEMENTS

I would first like to express my sincere appreciation and gratitude to the members of my advisory committee for their guidance throughout this entire process. Although it took a little re-shaping at the beginning, there is no way I would have put together a finished project like I did without their insight along the way. The stumbling really was where the greatness was found and it allowed me to appreciate the rest of the path even more. Second, I would like to thank the athletic training students and fellow athletic trainers for their participation and continued support over the years. Each of the conversations I have had with these individuals provided inspiration for this work. My parents, family, and friends all help to keep life in perspective and I could not ask for a better support network. Their encouragement has never ceased and they have continued to be some of the most understanding people in my life. Lastly, the UND Women's Soccer players have always been my cheerleaders along the way and their investment in my journey continues to fill my heart with joy. I continue to be thankful for the time I get to spend with them day in and day out. Each of these groups provide different reasons for why I continue to love my job and they all motivate me to be better every day.

Now, as my Advisor Josh Hunter would say, it's time to get some other eyes on it.

ABSTRACT

Clinical education is a large component of athletic training education and is centered on social learning. Students learn how an athletic trainer functions through exposure to a community of practice. As students transition towards full participants in the clinical environment, they get to practice their skills and begin developing their professional identity. As the profession prepares to transition to solely entry-level master's degrees in 2022, many athletic training programs will need to alter and re-evaluate the clinical experiences available for students. This phenomenological study explored social learning within the clinical environment with an emphasis on how interactions within these communities of practice influenced professional identity development. Data collection consisted of athletic training students, each completing two interviews, and preceptor focus groups. The results of this study found through collaboration with others and exposure to competent members within the community students learn what it entails to be an athletic trainer. The students slowly developed instances where they identified as an athletic trainer through a variety of social pressures, communication factors, and by building relationships. Understanding these interactions is beneficial for the upcoming transition and the development of updated policies and procedures geared toward providing quality anticipatory socialization for athletic training students.

Keywords: communities of practice, clinical education, athletic training

Chapter I: Introduction

Athletic trainers are a commonly misunderstood group of professionals. Either confused with personal trainers or often boiled down to the "water boys/girls" on the sidelines of football games, athletic training is more in depth than many people understand. In actuality, athletic trainers are in the service of helping people while providing prevention, examination, diagnosis, treatment and rehabilitation of emergent, acute or chronic injuries and medical conditions (National Athletic Trainers' Association [NATA], 2019). Athletic trainers represent a community of practice of healthcare professionals who understand the broad scope of care they provide on a daily basis. Yes, hydration is one component; however, this is far from the extent of care athletic trainers provide when working with patients. The education of future athletic trainers is a comprehensive experience to ensure students are prepared to join this community of practice and is predicated on a variety of social experiences and learning.

Situated Learning in the Clinical Setting

Clinical experiences are used as a primary educational experience for health professions including athletic training. These experiences provide an actual patient population for the students to learn and to practice skills from the classroom. More importantly, these experiences revolve around social learning during the exposure to a community of practice. Clinical experiences are situated learning activities that present opportunities for students to be introduced as legitimate peripheral participants. The concept of situated learning emphasizes the comprehensive understanding of the whole person, how they are active in the world, and that each of those parts' entail mutual involvement (Lave & Wenger, 1991). It encompasses the relationships students build with others in their environment and understands how learning is

fueled through these active, social encounters. Learning can be situated in any number of environments, it just depends on how the experience is framed.

Throughout this study, situated learning is framed as any learning taking place in the clinical environment. The clinical environments provide access to athletic trainers as a community of practice. In the education of athletic training students, it is not enough to just teach them the factual knowledge. The students need to understand the social world and learn their role within that world. Access to clinical experiences provides first-hand opportunities to learn the skills athletic trainers use daily within their community of practice to provide care. As students are exposed to a community of practice, they can start to build their professional identity as they better understand the expectations of their role as a future athletic trainer.

Legitimate peripheral participation allows newcomers to become a part of a community of practice (Lave & Wenger, 1991). As newcomers, the opportunity to participate in simple, low-risk tasks is a way to be introduced into a community of practice. Access to these basic tasks is one way to describe legitimate peripheral participation. This often begins through observation experiences which leads to helping with daily athletic training room operating tasks such as organization and preparing for practices or games. Further access and instruction result in centripetal participation, which occurs as the students continue to learn technical knowledge in the classroom. The students are given more opportunities to practice skills from the classroom with patients in the clinical setting, such as evaluating injuries and constructing rehabilitation plans, with each new experience representing centripetal participation. Becoming a more central participant represents a shift, when continued skill development and understanding of a community of practice occurs within the student. There is a transition from newcomer to oldtimer. Apprentice to master. Athletic training student to athletic trainer. The goal: to prepare

students to join the community of practice upon completion of their education and to foster this transition. One piece of this goal is the development of a professional identity as students become central participants and gain legitimacy within the community, all of which is based on social learning experiences.

Communities of Practice

Intentional or not, legitimate peripheral participation is one way to understand how learning takes place. It is not a specific type of educational technique or something that requires a specific context, rather, legitimate peripheral participation is a different way of analyzing learning (Lave & Wenger, 1991). Newcomers are introduced to the social world and what it takes to be a part of this world as they transition from the periphery to the center of the community. Inherent to situated learning are these communities of practice which "imply participation in an activity system about which participants share understandings concerning what they are doing and what that means in their lives and for their communities" (Lave & Wenger, 1991, p. 98). In this study, clinical education provided students access to a community of athletic trainers, which occurred once students were admitted into the athletic training program. When the students entered the clinical setting, they became legitimate peripheral participants. The athletic trainers who worked with the students on a daily basis served as preceptors and represent a community of practice. This community of practice provided a guide for the students to aspire towards upon graduation as they prepare to become professionals in the field.

When describing these communities, the concept of practice is something which should be articulated. Practice connotes doing, but more specifically, doing in a historical and social context which provides structure and meaning to how things are done (Wenger, 1998). In this

way, practice is always social and includes the explicit and the tacit aspects of a community. Things such as language, procedures, tools, and regulations are made explicit when describing practice. On day one, many of these explicit items are covered and made clear right from the start. The tacit components, the subtle cues, the untold rules of thumb, and the underlying assumptions may never be articulated but are some of the unmistakable signs of membership in a community (Wenger, 1998). Knowing the best time to approach a coach with bad news, how to act on concerns of a parent regarding their child's mental health, and understanding how roles may shift when working alongside other healthcare professionals are just a few examples of social components which may never be articulated to an athletic training student. Often fading into the background, the tacit pieces are often thought of as common sense by those oldtimers of the community, but for newcomers they are no more natural than the explicit. The explicit components are only one piece of what it means to practice within a community. Being situated within these communities provides a window into these social encounters as they happen in real-time.

Creating an identity. Membership into a community requires mutual engagement, where practice exists when people are engaged in action whose meanings are negotiated between its members (Wenger, 1998). There should be an awareness of the community's language, role-definitions, and values (Handley, Sturdy, Fincham, & Clark, 2006). Being provided access to become legitimate peripheral participants, students are doing more than just observing. They are absorbing and being absorbed into the "culture of practice," gradually creating a general idea of what that community of practice looks like (Lave & Wenger, 1991, p. 95). Rather than learning static subject matter, students are engaged in and participating in developing an ongoing practice. Clinical education provides an opportunity to join these communities of practice and through the

daily social interactions, begin developing their professional identity as the students slowly learn from the more experienced members of the community.

As outsiders of the community, students need to learn what it means to be a member. During the socialization process students are exposed to values the profession holds in high esteem, which requires the new members to evaluate how their own sets of values and beliefs fit within this new community (Ajjaawi & Higgs, 2008). Identity is developed through layering events of participation which helps make abstract concepts more concrete or real. Together these experiences and social interpretations inform each other to create an identity (Wenger, 1998). There are internal and external factors that play a role in the development process as members find their place within the community. Identity "manifests as a tendency to come up with certain interpretations, to engage in certain actions, to make certain choices, to value certain experiences" in relation to the accountability to an enterprise or community (Wenger, 1998, p. 153). As an enterprise, athletic training is a community which gives the focus; as an identity, it gives perspective. Different experiences will provide different perspectives, but the accountability to the community is where the manifestation of tendencies comes into play. As members develop, their experience gives them perspective, as the internal and external forces help shape their identity.

Currently, athletic training students participate in the traditional classroom and the clinical setting to help build their identity. These education experiences are about to embark on a shift as a new mandate requires students desiring to become an athletic trainer to obtain an entry-level master's degree starting in 2022 (Commission of Accreditation of Athletic Training Education [CAATE], 2015). This transition represents a shift away from the current options of completing either a bachelor's or an entry-level master's degree to become an athletic trainer.

Along with this change comes a new set of educational standards (CAATE, 2018), which will require educational programs to re-evaluate their current strategies. The new standards broaden the scope of what students are required to be exposed to and seeks to ensure students understand the role social, psychological, and physical factors play in management and treatment of patients. Due to the informal nature of the organizational socialization in athletic training (Pitney, 2002) and the upcoming change in athletic training program delivery style, the aim of this study was to explore how undergraduate athletic training students experienced their exposure to a community of practice and how it shaped their development of a professional identity. An understanding of these student experiences aims to help educators make necessary changes to policies and procedures which would create positive social experiences during their situated learning in the clinical environment.

Problem Statement

Clinical education in athletic training provides social learning experiences for students to learn and practice the skills required of an athletic trainer. Athletic training students who are obtaining their undergraduate degree typically have three years (Cavallario & Van Lunen, 2015) of these situated, social learning experiences to create relationships, move from peripheral to central participants, and become full members within the community of practice. Students' opportunities for communication with a variety of stakeholders during their education are impacted by the length of their educational program (Carr, Volberding, & Timson, 2016). Each of these communication opportunities provides a chance for students to slowly build their professional identity. However, as the profession moves to the entry-level master's degree, the length of the programs will likely decrease (Cavallario & Van Lunen, 2015). Not only will there be less time to help students develop a professional identity over the length of their program, but

the increased requirements dictated by the educational standards will likely result in alterations in the time within a specific clinical environment.

During these clinical rotations, the mentor/mentee relationship has been identified as a determining factor in learning (Marañón & Pera, 2015). For athletic trainers serving as preceptors, role strain has been identified due to the struggle of providing service to patients while simultaneously providing quality educational experiences for students (Henning & Weidner, 2008). It is unknown how this upcoming degree change will alter the mentor/mentee relationship and if role strain will be affected, but preparing for the transition requires understanding the current state of the social interactions. An understanding of these social interactions will be helpful to determine whether specific policies and procedures can be implemented to assist identity development to prepare students for the workforce.

Conceptual Framework

Learning how to assess a patient's injury is one thing; knowing how to treat the whole patient is a much more difficult skill to comprehend and implement. During the three year reporting period from 2015-2017, the national average first attempt pass rate on the Board of Certification exam was eighty-three percent for bachelor's programs (CAATE, 2018). Based on this above-average passing rate on the first attempt, it is clear that athletic training students are able to clearly understand the foundational knowledge required to be an athletic trainer. Employers have mirrored this statement, as they are satisfied with entry-level athletic trainers' technical skills and knowledge, however there has been a desire for improved interpersonal skills (Massie, Strang, & Ward, 2009). One of the most important skills identified by a panel of experts was communication and the role it plays in a variety of other skills and attributes (Aldret, 2018). These statements, by members within the community of practice, identify communication and

interpersonal skills as desirable traits. Clinical education presents an environment to build these communication skills and a community of practice to learn from, but graduates seem to be missing something essential to their professional development when they enter the workforce. The gap athletic training programs need to understand is why the students are not prepared for the totality of skills necessary and how social learning within a community of practice influences students' development of their professional identity.

Professional socialization occurs during participation in these communities of practice. Typically described as a two-part developmental process, professional socialization includes the experiences which occur prior to entering the workforce (anticipatory socialization) and experiences after entering the workplace (organizational socialization) (Teirney & Rhodes, 1993; Pitney, 2002). Therefore, students' anticipatory socialization would occur during these clinical and didactic education experiences. Anticipatory socialization exposes students to a community of practice which is made up of different types of role models and mentors. Through conscious reflection and unconscious acquisition, mentors play an influential role in the socialization process of students (Cruess, Cruess, Bourdreau, Snell, & Steinert, 2015). A primary component of anticipatory socialization is the social learning that occurs in the clinical environment and the mentors the students are exposed to within these different clinical settings.

Situated learning focuses on how the increasing participation of newcomers, or students, shapes their gradual transformation into oldtimers (Lave, 1991). The anticipatory socialization through situated practice allows for the transition from legitimate peripheral participation to centripetal participation (Harris, 2011). This transition occurs through the observation of role models, reflection on practice, and practice opportunities which allow for feedback. Together this view of learning combines the mind, culture, history, and the social world as interrelated

components (Lave, 1991). Mentors in the clinical environment are vital to students' learning as they help shape students' professional identities (Marañón & Pera, 2015).

Anticipatory socialization helps build awareness of the community of athletic trainers. Participation in the community helps students understand the skills, language, roles, implicit relations, tacit conventions, and underlying assumptions and values (Handley et al., 2006). Organizational socialization in a variety of athletic training settings has been described as an informal process, often occurring via trial and error experiences as there are minimal to no formal induction processes outside of administrative duties (Pitney, 2002; Pitney, Ilsley, & Rintala, 2002). New graduate assistants at the National Collegiate Athletic Association Division I (NCAA DI) were overwhelmed by the sheer volume of work and had to informally rely on colleagues to better understand their roles (Pitney, 2002). The informal nature of organizational socialization speaks to the importance of quality anticipatory socialization. If much of organizational socialization is independent, it would befit athletic training programs to pay more attention to the anticipatory socialization experiences students are obtaining prior to graduation. This is of increased importance during a time of transition for the profession, as the available time to create strong mentor/mentee relationships will likely change after the transition.

Situated learning theory suggests that learning is embedded within activity, context, and culture (Lave, 1991). Students are placed in environments where they are able to practice the skills required of an athletic trainer while being supervised by individuals modeling these professional behaviors. Through this situated learning, students begin the process of becoming a member of the community of practice. As students enter this community of practice, they begin the professional socialization process (Harris, 2011) and it is through this process that students are exposed to opportunities to create a professional identity. Exposure to a community of

practice allows students to learn through the eyes of those who are already a part of that community and thus understand the expectations.

What is unknown is the role of social interactions in students' situated learning experiences and how exposure to a community of practice influences professional identity development. Students have exhibited they know the information needed to pass the certification exam, but employers identify weaknesses in the interpersonal skills (Massie et al., 2009). Without opportunities to act as central participants within a community of practice, students are not exposed to moments where they can begin their development of a professional identity. Without these moments, students miss out on chances to practice their interpersonal skills and get feedback from the preceptors who are supervising those experiences. This gap in the anticipatory socialization represents a concern for athletic training programs who want to produce high quality graduates. An understanding of how students are being exposed to a community of practice and the role this plays in creating a professional identity is required to help address this gap.

Study Purpose

The purpose of this study was to use qualitative inquiry to better understand social learning in the clinical environment. Using phenomenology as a basis for exploration, the intent was to explore how students are experiencing the community of practice they are situated within during their undergraduate athletic training education.

Primary research question:

1. How do athletic training students develop a professional identity through social learning?

Other research questions:

a. How does the athletic training students' role within their community of practice evolve throughout their undergraduate education?
b. How are athletic training students experiencing the mentor/mentee relationship during their situated learning in the clinical environment?

The focus of phenomenology is not to determine reactions to situations, but to have a more intentional purpose; the focus is placed on how the same phenomena manifests itself to different individuals (Giorgi, 1975). By gathering concrete examples of experiences from people who are experiencing the phenomena, a picture of what the holistic experience looks like from an insider's perspective was put together. Once the students' experiences were laced together to represent their experience within a community of practice, outsiders can start to appreciate the students' composite perspective. In addition to gathering the student perspective, the preceptors' point of view was explored as a secondary component. Although the primary focus was on the students, the preceptors were able to provide insight on their role within the mentor/mentee relationship and as central members within the community of practice. Exploring both perspectives within the relationship provided depth to the findings. Together, the experiences give ways to optimize learning in the future and address the gap in anticipatory socialization as students begin creating their professional identity.

Overview of Remainder of the Study

Chapter Two will provide an overview of the literature regarding historical aspects of athletic training education, followed with how situated learning and communities of practice influence the professional socialization of athletic trainers. In Chapter Three, an introduction to phenomenology and the methodological approaches used in this current study will be presented.

The results of the study will be presented in Chapter Four followed by Chapter Five and a discussion of implications for the future of all stakeholders in athletic training education.

Chapter II: Literature Review

In the relatively short history of athletic training education, there have been numerous changes to develop a more uniformed profession. A brief exploration of the changes which have helped shape the profession will be evaluated first. Then the role of communities of practice will be introduced with focus on how mentors and peers influence athletic training students' education. Lastly, it is important to understand professional socialization in athletic training and the role of the social components in situated learning experiences. Together each of these components will help clarify the necessity of anticipatory socialization and why research in this area will help the profession move forward.

Athletic Training Education

Prior to looking where athletic training education is going, it is helpful to look at where it began. A brief historical review of the changes that have shaped the profession will provide a backdrop for the upcoming changes. The profession continues to work towards gaining the status of other healthcare professions such as physical and occupational therapy, which is why adjustments to education continue to take place. Learning how clinical education has changed over the years will provide more insight into the upcoming degree change.

Historical Foundations

Compared to the history of higher education as a whole, athletic training education is still in its youth. The first athletic trainers were often educated primarily as secondary school teachers, with the first athletic training curriculums developed in 1959 (Delforge & Behnke, 1999). At the time, there was a need to get more athletic trainers working in the high school setting. Due to the new nature of the profession, the best way to employ these individuals was in a dual role. Most often these first athletic trainers worked as a health or physical education

teacher during the day and covered sporting events after school. Ten years after the first programs were forming, the NATA officially recognized undergraduate athletic training programs.

A national certification exam was created in 1970 in order to help unify minimum expectations of practicing athletic trainers. At this point there were four paths to take the certification exam: an athletic training education program, the apprenticeship program, graduation from a school of physical therapy, or the special consideration route which consisted of at least five years as an "actively engaged" athletic trainer (Delforge & Behnke, 1999). Each of these routes had slightly different ways of qualifying for the certification exam.

In 1990, the American Medical Association officially recognized athletic training as an allied healthcare field (NATA, 1990). The recognition represented a large step for the profession. To better align with other healthcare fields and to ensure proper preparation of athletic trainers, the first set of athletic training education standards was created in 1991 (CAATE, 1991; Delforge & Behnke, 1999). Over the years the other routes to certification were eliminated, with the athletic training program route being the sole option as of 2004. The primary reason the other routes were eliminated was to standardize the education of future athletic trainers. A secondary reason was to help clarify the profession to lawmakers and other healthcare professions (McMullan, 1996). As the profession was just being recognized as an allied healthcare field and various states were working to create licensure laws, it was difficult to explain how to become an athletic trainer when there were multiple routes to certification. Ultimately, each of these steps worked to create unification in the process to become an athletic trainer.

One component with continued emphasis is clinical education requirements of students during their athletic training program. Clinical experience is beneficial for students to help

ensure they have had hands-on exposure to a variety of aspects of athletic training. Prior to the unifying route to certification, the number of hours in the clinical setting varied between 800 and 1,500 hours. This range was the difference between completing an athletic training program or taking the apprenticeship route. The large range of required hours was one key point of concern when it came to standardizing the education routes, as students who chose to take the internship route were expected to complete almost twice the number of hours as other students (McMullan, 1996). The clinical education hour requirement has continued to change over the years as the profession has evolved (Delforge & Behnke, 1999).

Initially during these clinical experiences there were few regulations regarding what these students could or could not do while in the clinical setting. This often resulted in students working on their own to help provide coverage to areas without athletic trainers. The athletic training students would travel on their own to away events, cover practices on their own, and essentially function as an athletic trainer without actually being certified (Weidner, Noble, & Pipkin, 2006). The thought was that this type of anticipatory socialization was an adequate way to prepare students for their future role as an athletic trainer. Athletic training students were responsible for a variety of advanced skills which added invaluable experience to their education. During experiences such as these, throughout their entire education they were being informally socialized and prepared to work on their own. The concern with this process was that students with no certification and minimal experience were providing athletic training services. These experiences helped students gain independence and feel like full members of the community of practice prior to graduation. However, the reality was that allied health profession students viewed their experience as providing a labor force and being socialized as the only means of clinical education experience (Weidner & Henning, 2002; Thrasher, Walker, & Hankemeier,

2018). Students did not feel like they were receiving the clinical instruction that would help them learn more from their experiences. There was not the same transition from legitimate peripheral participant to central participant. This led to the alterations in the education standards regarding clinical education and supervision requirements. Implementation of the educational standards greatly altered clinical education experiences for students. With the updated standards, students were able to slowly build experience as a peripheral participant.

Current standards. As the educational standards have changed over the years, this lack of instruction has continued to be a point of emphasis to help ensure students were having appropriate clinical learning experiences. Students must now be supervised by a clinical preceptor who is typically an athletic trainer, however other health professionals sometimes serve in this role depending on the setting. The primary role of preceptors is to "supervise and engage students in clinical education" (CAATE, 2018, p. 20). Currently there are no specific hour requirements to qualify for the certification exam, with more emphasis being placed on the variety of experiences as opposed to a specific amount of time in the athletic training room. Quality over quantity of clinical experiences has been the new focus, with a goal that this will help improve the athletic training students' education.

Clinical education requirements vary, but most occur throughout a student's education program. Most athletic training programs range from two to three years, with clinical education spanning a minimum of two academic years (Cavallario & Van Lunen, 2015; CAATE, 2018;). With the transition to a master's degree, comes a new component: immersive clinical experience. This new standard, aimed at providing students a chance to "experience the totality of care provided by athletic trainers," requires students to work alongside their preceptor for at least one continuous four-week period (CAATE, 2018, p. 3). Essentially the students will be required to

do whatever their clinical preceptor does on a day-to-day basis, without having formal class sessions impeding the student's availability. This presents a shift in the way clinical education is designed and will require a change in how athletic training programs are approaching the clinical environment. The immersive experience lends itself well to exposing students to a community of practice and identity development, however without addressing the current issues in the clinical setting, the intended outcomes of immersion could just be well intentioned ideas that do not come to fruition.

There needs to be anticipatory socialization to the profession while also providing an environment conducive to learning. Athletic training and other health professions require both of these types of experiences when it comes to education. Recently, there has been an improved emphasis on instruction and how to create a positive learning culture to improve students' clinical experiences (Mazerolle, Bowman, & Benes, 2014; Mazerolle, Bowman, & Benes; 2015). This emphasis requires the help of the clinical preceptors to make these learning experiences a reality. The upcoming change in degree programs will require athletic training programs to re-evaluate how they are creating these experiences and the roles that all involved members play.

Role of Clinical Education

Teachers are some of the fundamental influencers in creating a learning environment conducive to student development (Bandura, 1989). The teacher's talents and self-efficacy are going to help set the tone. Without an effective presence to lead a particular setting, learning opportunities will not be optimized. Students view the presence of a skilled and knowledgeable educator as beneficial to effectively assist the learning process (Lubin & Hamlin, 2017). In the traditional setting this may be the professors or instructors teaching in the athletic training programs; in the clinical setting this teaching is left up to the clinical preceptors.

There are two primary learning environments for athletic training students, didactic and clinical. The didactic setting comprises the students' formal classroom instruction; the clinical setting allows opportunities to practice in a real-life setting. This combination is described as the clinical integration model and is the most commonly used model in athletic training education (Edler, Eberman, & Walker, 2017). In this type of model, roughly 50-75% of their course load is engaged in the didactic setting, while the remaining amount of their course load is at clinical sites. Incorporation of both settings allows students an opportunity to situate technical knowledge to reinforce what they are learning in the classroom. However, the transition from a bachelor's degree to entry-level master's could challenge this commonly utilized model. Currently there is limited research on the students' perspectives of their clinical education experiences and this transition presents a call for research to ensure educators are addressing the necessary factors associated with these changes.

In the didactic setting, instructors have to work to create learning experiences that mimic real-life scenarios. The clinical setting has these opportunities readily available, but it is up to the preceptor to acknowledge the learning potential of each of these experiences. There can be gaps and missteps in both of these settings. Taking students' perceptions into account can be a useful tool to help modify or improve the quality of these experiences (Dunne, McAleer, & Roff, 2006). When addressing the clinical setting specifically, preceptors believed that creating a respectful environment was helpful for students' learning (Nottingham & Kasamatsu, 2018). Students mirrored these remarks and added the preceptor's approachability influenced the perception of a positive learning environment. High levels of respect between students and preceptors help create a dynamic that supports growth, whether that be specific to the student's development or

the working relationship as a whole. Without respect, the learning environment will suffer and learning opportunities will be stunted.

Learning environments have been described as major factors in persistence to graduation within an athletic training program (Bowman & Dodge, 2011). It is essential that both traditional and clinical environments be taken into consideration, but the focus for this study was limited to the clinical environment. For example, male nursing students pointed out areas where the clinical experience was not as favorable to their learning as it could have been, such as when they were working in the maternal wards (Meadus & Twoley, 2011). This particular group of students felt there were conditions or societal factors that hindered their clinical education. Other groups of students and socio-cultural factors should be explored in depth to better understand the role of social interactions within clinical environment.

There are numerous aspects of the profession that are best taught and learned while situated in the athletic training room. When instructors, preceptors, peers, students, and patients understand their role in the learning process, everyone can benefit from the experience. The social agents in the athletic training environments are what make the learning particularly meaningful for professional identity development and need to be further explored to ensure they are continually being addressed. There have been significant changes to clinical education in athletic training over the past two decades. Although the key concepts and ideas are still very similar, the modes and styles of learning have changed with new technology and changes to clinical experiences (Weidner & Henning, 2002). For this reason, it was essential to re-evaluate from a pure phenomenological perspective the experiences the students in athletic training programs are having in the clinical environment. As the previously mentioned articles discovered, there was a social aspect described in many of the experiences which prompts the

questions for how students experience these situated learning experiences. In the current study, learning situated in the clinical environment was evaluated to explore students' experiences of informal educational opportunities and how they transition to a central participant within a community of practice.

Communities of Practice

Similar to many other health professions, students in athletic training cohorts spend time working and learning from each other. Learning together in these experiences builds a feeling of community or a sense of belonging which can help protect against feelings of isolation (Given, 2002). Students in athletic training programs typically spend three years together which provides an opportunity for these communities of learning to develop (Cavallario & Van Lunen, 2015). These interpersonal relationships, interactions, and group dynamics help influence education significantly (Goodenow, 1992).

These communities are essential for students throughout the learning process. An environment that helps students engage, discover, explore, and develop is necessary to help build these communities (Lubin & Hamlin, 2017). One area of concern for many students during their education is an appropriate support system during times of stress. Feelings of isolation increase stress hormones in the body and although low levels of stress can be beneficial for performance; when levels increase to the point of becoming chronic stress, there can be negative effects on learning (Ratey & Hagerman, 2008). Feelings of isolation can be minimized when students, peers, instructors, preceptors, and other staff members understand their individual role in the learning and support process. Using peers as tutors or mentors, paired with an increase in approachability and accessibility of school staff are some ways suggested to help address these concerns (Dunne et al., 2006). Throughout their time in school, participation in this community

of learners helps their progress. Influential to this community and progress are the mentors the students work with as they learn what it means to be a member within the community.

Mentor Relationships

There are a variety of individuals who athletic training students might consider a mentor. Within these communities of practice, the students are exposed to instructors, preceptors, and peers with experience who can all provide the necessary support and guidance expected of a mentor. A mentor is there to help encourage students to reach their greatest potential, while also addressing the students' emotional needs (Given, 2002). Every student is going to need a little something different during their education, which is why different figures might fill this mentor role.

For some students an advisor and a mentor might be the same person, but they often serve different roles. An advisor is there to provide advice or to direct students; a mentor is typically one who provides guidance and support as the student makes their own decisions (Slayback, 2017). Advisors serve a more formal role in development, as they have more expertise and are there to provide advice. Mentors on the other hand can be formal or informal, but often provide the wisdom a student might be searching for as they navigate whatever journey they are currently taking. Whether the mentor is there for emotional well-being, career guidance, physical health and wellness, financial support, or all of the above, a mentor is someone the student can trust to help with life. Athletic training students have identified mentorship as being responsible for providing necessary role modeling which helps them gain an appreciation of the roles and responsibilities of an athletic trainer (Mazerolle & Benes, 2014). These mentors embody professional identity and their role within a community of practice which acts as a representation of what students should expect when they enter the workforce.

Mentoring relationships are often based off of a certain level of respect from both sides (Nottingham & Kasamatsu, 2018). These mentors are individuals who serve as role models for the students. They exhibit the skills and the type of professional characteristics the student strives to work towards mastering. When a student feels their presence is respected, a sense of approachability is gained. Approachability has been discussed as a primary characteristic of mentoring relationships (Pitney & Ehlers, 2004; Nottingham & Kasamatsu, 2018). However, initiative of the protégé is one of the prerequisites for the initiation of mentoring (Pitney & Ehlers, 2004), but this step is made difficult if the student has felt disrespected in the past. Within athletic training, preceptors say they want the students to take initiative; however, when preceptors are viewed as unapproachable, students are going to be less likely to make the first move. This study explored these relationships and how they influence professional identity development throughout their education.

One last factor identified by Pitney & Ehlers (2004) was accessibility, with effective mentors being able to balance their responsibilities to allow time with the students. When preceptors are viewed as less accessible, they were more likely be viewed as unapproachable which inhibits the growth of the relationship. Positive learning experiences from mentors were often characterized by effective communication (Nottingham & Kasamatsu, 2018). Early in the mentoring relationship clear expectations are identified and regular check-ins regarding goals and progress are necessary. In a new relationship, these types of early communication can help break down some of the initial barriers regarding trust and respect. Clear expectations and accountability help build respect between both individuals.

Athletic training students often recognized preceptors as mentors due to the amount of one-on-one exposure they have with the students (Pitney & Ehlers, 2004; Mazerolle, Eason,

Nottingham, & Barrett, 2016). Students valued when preceptors took the time to actively teach in the clinical setting because it helped them learn in two environments simultaneously (Nottingham & Kasamatsu, 2018). This attention to the students' education demonstrates some of the previously mentioned characteristics such as approachability, accessibility, and respect. Mentors are able to provide practical and tactical knowledge the students can use later in their education or career (Lubin & Hamlin, 2017). Students look up to these individuals to help support and guide them throughout their education. As a part of this study, these relationships with mentors were examined to better understand how students are using these experiences and relationships to help influence their future role as an athletic trainer.

Peer Influences

Another influential player in athletic training students' education are the peers they learn with every day and presents another avenue of social learning exposure for the students. Instructors and preceptors often experience role strain which makes creating learning experiences for the students difficult at times. Preceptors not only work with the students, but they are also expected to balance patient care and often 6other administrative duties (Bowen & Carline, 1997; Henning, Weidner, & Marty, 2008). In times when it is difficult for preceptors to balance these responsibilities, peers can be a beneficial resource to help supplement learning and minimize strain on the preceptor. One suggestion has been to use peer-assisted learning for clinical teaching, feedback, and mentoring (Henning, Weidner, & Jones, 2006).

Peer-assisted learning has been described as "the act or process of gaining knowledge, understanding, or skill in athletic training-related tasks among students who are either different or equivalent academic or experiential levels" (Henning et al., 2006, p. 102). Not only does peer-assisted learning help reduce the preceptor's role strain, but it also helps facilitate deeper

understanding for the assisting peer. There must be some synthesis of the information being taught to the other peer, which demonstrates a higher level of understanding. An added benefit of peer-assisted learning is improved peer relationships which plays a role in persistence in athletic training programs (Young, Klossner, Docherty, Dodge, & Mensch, 2013). Improved relationships help create more positive learning environments. When students take the time to help others learn, they are demonstrating they are a more central participant which suggests they have transitioned towards becoming a full participant within a community of practice.

Henning et al. (2006) found that students perceived learning a moderate to large amount of clinical skills from peers. Although there was no way to determine what was actually learned, the students' perception of learning from peers suggested there was enhancement of the material learned in classroom or from preceptors. For this reason, it has been suggested that students are paired with peers at their clinical sites to help improve the learning. This means the preceptors have more students to supervise, but a conducive learning environment where peers can support each other can help ensure this is a positive experience for all. Without knowing the full extent, it is difficult to differentiate which skills are being taught or learned from peers. However, if students are learning a moderate to large amount from peers, this could help explain why students struggle with the tacit responsibilities and the development of a professional identity. As peers have a limited scope and preceptors deal with role strain, it would make sense as to why students only seem to comprehend the technical skills upon entering the workforce. These ideas represent a gap in the literature regarding the different social learning experiences of athletic training students and this study explored how these relationships with others influenced the students' development throughout their education.

Phenomenology has been utilized to evaluate student experiences with peer learning (Bates, 2014; Walker, Thrasher, & Mazerolle, 2016). Bates (2014) specifically looked at the experiences the students had with peer-assisted learning built into their athletic training program. Improved communication skills was the most commonly given response regarding the students' experiences with peer-assisted learning. The participants also described the development of relationships with peers and their ability to socialize and network with other professionals. These socialization skills were reported to be beneficial in their current jobs, suggesting a positive outcome from the peer-assisted learning. Although peer-assisted learning is designed to help with knowledge acquisition, it turned out the embedded social aspect played a role as well. The clinical setting lends itself to peer-learning interactions, but little is known regarding the focus of these interactions in athletic training and if they focus more on technical skills or provide a platform to practice communication skills. It is essential to learn how students are exposed to a community of practice and what role they play within that community to provide insight into entry-level professionals' skill development.

Professional Socialization in Athletic Training

Effective anticipatory socialization is helpful in preparing students to join the community of athletic trainers. Socialization provides insights into the professions' culture and behavioral norms (Bourdieu, 1990). The quality of clinical education can be improved with strategies to address the socialization process which helps develop legitimation (Klossner, 2008). Legitimation relates to athletic training students' feelings of practicing as an athletic trainer or how students move from peripheral to central participants. Meaningful situated learning is important in this process as it helps students develop their place within the community of practice through actual learning.

The reciprocal nature of these factors explains why social learning is essential in athletic training education. Anticipatory socialization helps build relationships and developing relationships facilitates legitimation. While legitimation facilitates professional socialization, building relationships is essential to foster legitimation. One aspect will struggle to develop without addressing the other and for this reason each of these factors needs to be addressed for students to become a part of the community of practice.

Social Learning in Athletic Training Environments

From a historical prospective, there are multiple professions where it is not considered feasible to judge performance on outcomes (Kolb, 1984). Medicine is one of these professions where the emphasis is on controlling the means of performance as opposed to outcomes. Athletic training would fall under this umbrella of medical professions which explains why socialization is used to introduce new professionals. The unpredictability of sports and physical activity makes it impossible to control for all the outcome variables regardless of the prevention measures or treatment provided. For this reason, outcomes-based performance is not a feasible means of evaluating performance, especially as the social components often influence results. Professional socialization not only addresses the technical side, but also incorporates the social perspective to address the totality of factors influencing outcomes. Anticipatory and organizational socialization provides knowledge, skills, and orientation into an individual's professional identity (Kolb, 1984), which encompasses the tacit, social skills essential to working as a healthcare professional.

Although social learning occurs in multiple environments of athletic training education, it is more prominent in the clinical setting. These clinical experiences provide students with an opportunity to learn in the professional athletic training setting (Schellahase, 2006). The

unpredictability of the clinical environment provides valuable experience to students. Central to these experiences is legitimation. In the clinical setting, legitimation occurs as athletic training students look for acceptance from others to confirm their progress (Klossner, 2008). When others affirm a student's development of a professional identity, the initiation of the process of professional socialization occurs. Students progress from peripheral to central participants during this process of legitimation as they join their community of practice.

Both preceptors and peers can provide support, however the roles of each may be different. Students reported feeling less anxious when practicing in front of peers and experience less pressure when asking peer tutors questions (Weidner & Popp, 2007). By decreasing the stress levels during practice, students can develop greater confidence in their skills therefore improving role performance. Increased success in role performance leads to legitimation (Klossner, 2008). Students slowly move from peripheral to central participants in this process. When they reach the center, these students are able to problem solve and develop plans to address the needs of their patients. Ultimately, the social learning and support in the clinical environment facilitates legitimation which is all a part of the anticipatory socialization process.

Importance of Anticipatory Socialization

Regardless of setting, "when education is based on experience, and educative experience is seen to be a social process, the situation changes radically" (Dewey, 1997, p. 59). As helpful as textbook knowledge can be, there is no substitution to working alongside an athletic trainer or peer who has more experience. A textbook cannot teach you how to handle a disgruntled coach, an overbearing parent, or a grieving patient. Knowing when to return an athlete back to participation after a serious injury is not a skill that is automatically gained upon graduation or certification. Understanding the work ethic required to be successful in the profession is best

learned by watching those who have been doing it without advertising their efforts. Those people are the ones who do the little things every day because they know it is the right thing to do and not the easy thing to do. Each of these examples of central participation relate to the essence or core of what it means to be a part of a community of practice and identity formation as a professional in the field. Listening to how students experienced this exposure will help better prepare the students of the future.

Social learning should view participation in learning as more than just engagement in *some* activities with *certain* people. Although this participation does imply some aspect of social encounters, it will not lead to the same personal transformations as being active participants of a social community (Wenger, 2009). These communities of practice are where identities are constructed and where future athletic trainers are shaped. A student's relationship with their mentor has been identified as an important aspect of their anticipatory professional socialization (Pitney & Ehlers, 2004). Creating an identity in practice is both a social and a learning process. Community membership gives the fundamental formation within social contexts while identity is a process that incorporates past and future experiences which influence the present (Wenger, 1998). The social context of learning in athletic training is essential to the development of proficient athletic trainers who are conscious of themselves as professionals.

Role conflict in athletic training students, or the inability of students to know or understand their roles in different setting, has been suggested to be a negative effect of inadequate anticipatory socialization and can inhibit their learning (Klossner, 2008). When a student experiences role conflict, their ability to transition towards a full participant is hindered. If the expectations are unclear, the students in conflict may end up as periphery participants because they do not know when or how to get involved. When the academic programs and

preceptors do not explicitly describe the role of the different clinical experiences, reaching learning objectives is made difficult. It is up to the athletic training programs to help create an environment that minimizes students' feelings of role conflict during situated learning experiences. When students spend extended time in these ambiguous roles they miss out on opportunities to practice and refine their performance in the clinical setting. Communication and clarity are necessary components of the anticipatory socialization required to help alleviate the insecure feelings of students. In order to understand these aspects of anticipatory socialization, students from different levels in their education were interviewed in this study.

Students' anticipatory socialization sets the tone for their first moves as an athletic trainer. During the organizational socialization process of athletic trainers entering the National Collegiate Athletic Association (NCAA) at the Division I level, much of the resilience was through trial-and-error (Pitney et al., 2002). They were faced with situations they felt unprepared for which suggests their formal education missed things. Athletic trainers entering the high school setting reported similar feelings as their organizational socialization was often individual and informal which resulted in trial-and-error learning (Pitney, 2002). Although there was an acknowledgement of using new colleagues and previous mentors to build a new community of practice in both of these populations, athletic training programs need to create stronger anticipatory socialization strategies to minimize the volume of trial-and-error learning.

Prior to entering the workforce, students should be aware of what is required of them and this should be addressed during exposure to a community of practice during their anticipatory socialization. Even though it will take time and practice to hone all of the skills required to provide high-quality patient care, students should not be left to learn these things on their own. Recently credentialed athletic trainers identified one barrier to their preparation as the lack of

opportunities to practice their advanced athletic training skills (Thrasher et al., 2018). Students described this barrier as being dictated by the preceptors and the effort they put into coordinating these active opportunities for students. Anticipatory socialization should provide a chance to build legitimacy as an athletic trainer and provide students with the confidence to address the totality of care that an athletic trainer is expected to provide.

Another concern of the adequacy of anticipatory socialization relates to the upcoming changes to the profession because of the shift to entry-level master's programs. The lack of current formal preparation processes, or anticipatory socialization, resulted in many students deeming it necessary to complete graduate assistantships to gain the appropriate level of experience to fully prepare them for practice (Pitney et al., 2002). The access to these graduate assistantships in the future will likely decrease. There is a possibility the name of these positions will just be changed to internships or something that resembles the previous structure (Cavallario & Van Lunen, 2015). A shift to internships opens up the door to numerous other arguments such as the value of an athletic trainer and how athletic training will gain legitimacy as a healthcare profession with such positions available. There is another route being proposed instead of graduate assistantships which is residency programs, but only nine accredited programs currently exist in the United States (CAATE, 2019) which will provide opportunities for a minimal number of students. Although these concerns are important, they are outside the scope of this study and therefore will not be discussed in length.

No matter which way it is viewed, students graduating with their entry-level master's degrees will have access to different entry-level athletic training positions than they do currently. These different positions will change the access to organizational socialization processes and occupational avenues to fill the gaps from their anticipatory socialization. Since the future

landscape of the profession is still unknown, athletic training programs should take the necessary steps to graduate students who had active opportunities to prepare for their entrance into the workforce; to feel like they are a member of a community of practice and have been given ample experiences to develop their professional identity.

Athletic training educators are often not in the clinical setting while the students are working and learning on a daily basis. Although they may have an idea of what is occurring in a particular learning environment, without directly asking the students about those experiences in a more holistic manner there will likely be aspects overlooked. There have been calls to re-evaluate how students are prepared for their initial entry into a professional role (Pitney et al., 2002), to spend less time on technical skills and more time on soft skills (Aldret, 2018), and how to manage the interpersonal skills required to communicate with a variety of stakeholders (Carr, & Volberding, 2011). Each of these items could be addressed with further understanding of the situated learning of anticipatory socialization for athletic training students. Some of the most personally transformative experiences have been from the learning in social communities (Wenger, 2009). It would be helpful for educators and practicing athletic trainers to gain more knowledge in how these social communities help mold the future of the profession. This understanding can help answer the question as to how early access to a community of athletic trainers helps prepare students who are confident in their ability to enter the workforce and provide the totality of care expected of the profession.

Conclusion

Based on the literature reviewed, there are a variety of gaps within the athletic training education literature related to social learning. As it stands, anticipatory socialization has been inadequate at preparing students with all of the desired traits of members within a community of

practice (Pitney, 2002; Pitney et al., 2002). This inadequacy suggests students may not be provided with opportunities to act as central participants during their education. Levels of participation within the clinical environment are not well known and represent a gap being addressed with the current study. There needs to be a better understanding of the social interactions within the clinical environment to determine which positive and negative factors are influencing student participation.

Another component related to participation is the ability to develop a professional identity. Previous research has identified mentors as being influential in learning (Cruess et al., 2015; Marañón & Pera, 2015), but how these mentor/mentee relationships are developed to help athletic training students in the process of creating a professional identity has not been explored in depth. Mentors are not the only individuals who students are exposed to and the research referencing social interactions among peers is also lacking. Overall, there is a lack of understanding of the role that social learning plays within the clinical setting due to the limited research available in this area. The next chapter describes how descriptive phenomenology was used to help address these existing literature and methodological gaps. Through a pair of interviews with athletic training students and focus group interviews with preceptors, this study provides more insight into social learning and the role it plays in professional identity development.

Chapter III: Methodology

Phenomenology has been used in a variety of healthcare professions including athletic training to evaluate different components of education (Meadus & Twomey, 2011; Tavakol, Dennick, & Tavakol, 2012; Bates, 2014; Walker, Thrasher, & Mazerolle, 2016). This chapter will present the research design for this study by first explaining phenomenology with specific emphasis on descriptive phenomenology. The purpose of the study was to explore how students experienced social learning within a community of practice of athletic trainers.

To ensure situated learning is worthwhile, it is essential for all aspects to be considered, which includes not just the technical aspects but also the social interactions. The learning environment contains both physical and social elements educators need to be aware of to ensure growth of the students (Dewey, 2007). Clinical experiences have the potential to teach the students not only how to apply the content from their courses, but also how to function in the social realms of an athletic trainer. These experiences help shape the professional they will develop into and this requires attention to acquiring specific skills throughout their anticipatory socialization. Through phenomenological inquiry, this anticipatory socialization was explored from the viewpoint of the students who were learning in the clinical setting. Preceptors experiences were also included as a secondary component to provide more insight into the student responses.

Theoretical Framework

Social learning involves the interactions between the self, others, and the environment which results in the development of skills and knowledge (Given, 2002). Each of these experiences are individualistic as students are going to perceive learning encounters differently. Observation of other people in everyday situations is a key characteristic of social learning

(Bandura, 1986) and what students take away from these observations will vary. Exploring the essence of these social learning experiences provided beneficial information into understanding the phenomena of communities of practice in athletic training. There is a fundamental social component within community membership which leads to the formation of identity (Wenger, 1998). A better understanding of how students subjectively perceived their learning, from and in relation to others, was used to help create learning environments conducive to helping students develop their professional identity. Identity is "produced as a lived experience of participation in specific communities" (Wenger, 1998, p. 151), while phenomenology is used to explore the lived experiences of others. For this reason, phenomenology lends itself as an appropriate method to answer the research questions as a way to learn what role social learning played within the students' clinical education through the lived experiences. These student perceptions can be a useful basis to justify modifications and improvements in the environments quality (Dunne, McAleer, & Roff, 2006).

What is Phenomenology?

Stemming from philosophical assumptions, phenomenology involves understanding the meaning, structure, and essence of lived experiences. Edmund Husserl has been credited as being one of the first individuals interested in the study of how people describe and experience things (Vagle, 2016). One of the most basic assumptions used to explain phenomenology is there is no separate reality for people between the subject and the object, only what they experience and what it means to them (Patton, 2002). This assumption of interdependence requires attention to perceptions and the meaning of conscious awareness. Although everyone has their own individual experiences, the goal of phenomenological research is to find the core of the shared experiences to describe a phenomenon. The goal of this study was to explore the social learning

experiences of athletic training students to learn how communities of practice influence professional identity development.

Phenomenology differs from other types of quantitative social science research in the appreciation of the subjective accounts of participants. Instead of viewing responses as a set of static, objective results, the individual's affective, emotional, and imaginative life are explained from their perspective (Moran, 2002). Other types of research are often concerned with whether something has happened, how often it happens, or how an experience is related to other factors. Phenomenology is less interested in these types of questions (van Manen, 1984). One main contribution of phenomenology is the protection of "the subjective view of experience as a necessary part of any full understanding of the nature of knowledge" (Moran, 2002, p. 21). To understand any phenomenon, the human experiences must be evaluated to discover the essence of a phenomena. Listening to the students who were learning in the clinical setting presented a chance to get to the core of the social interactions in the clinical setting.

Essence, or the indispensable quality of something that determines its character, is used to describe abstract concepts, feelings, or experiences. When trying to capture the essence of a particular phenomenon, the descriptions of the experiences help others grasp the nature and significance in a way that has not been seen before (van Manen, 1984). The abstract nature of the essence of a phenomenon can make it difficult to understand, which is where the language used by participants can help demonstrate the lived experiences in a deeper way. There is no specific amount of time within a community which will equate to an identity being developed. It is not a box that can simply be checked after a certain number of days working in an athletic training room. Identity is not something that can be acquired at one point, but rather it can appear more salient at certain times or during certain experiences (Wenger, 1998). The idea of identity

constantly being renegotiated can make it difficult grasp, but through language, objects of consciousness are able to be communicated to others just as they are presented (Giorgi, 1997). Students' interactions within their communities of practice can be combined with one another to help describe the essence or the indispensable quality of its character. Consciousness is the means for which to access these experiences which could be physical, may no longer exist, or could even be a dream or an idea (Giorgi, Giorgi, & Morley, 2017). Bringing these unspoken experiences together can help others understand what is actually being absorbed by the students and helped identify the gaps in anticipatory socialization.

To fully appreciate the essence of the individual's experiences, it is essential to avoid premature interpretation of the phenomenon. Epoché, which is a Greek term used to describe a suspension of judgment, is the term used to describe this removal of preconceived ideas (Husserl, 1931). Prior understanding, assumptions, or beliefs might lead researchers to interpret the experiences before truly evaluating the significance of the phenomenological questions (van Manen, 1984). However, this does not suggest prior beliefs, assumptions, or biases should be avoided or forgotten. Husserl (1931) thought these everyday biases which make up the basis for truth and reality should be suspended. This suspension or bracketing allows for experiences from participants to enter the consciousness as if for the first time (Moustakas, 1994). During phenomenological reduction, bracketing is utilized to keep the focus of the research separate from the outside world. Only after the phenomena has been understood from within can misunderstandings be evaluated to further evaluate knowledge and expose gaps (Moran, 2002). Epoché is a way to clear the mind and allows the researcher to see things as they are experienced by participants. An introduction to descriptive phenomenology will be presented next to provide insight into the methodological principles specific to this study.

Descriptive Phenomenology

Amedeo Giorgi (1985) proposed a phenomenological methodology which focuses on the description of experiences. By utilizing phenomenological reduction, intentional objects of consciousness can be described, which he explains as "pure" phenomenology (Giorgi, 1997). Phenomenological reduction is a defining characteristic of this style of inquiry and consists of two parts: (a) bracketing past knowledge, bias, or understanding about the phenomenon which allows for a fresh perspective and descriptions that are precisely how they are experienced, and (b) the withholding of the existential index or to consider what is given precisely as it is, a presence or phenomenon (Giorgi, 1997). Through withholding the existential index, items are evaluated as a presence which does not automatically determine existence. Nothing is lost during this process, but responses are stated as *presenting themselves as* opposed to the responses being as they are presented. If both of these items are accounted for, then the current phenomenon can be described in its fullness. Without reduction, past interpretations or influences can creep into the current situation which will not result in the most rigorous research standards being met. These influences can then bring in the subjective realities of the researcher as opposed to the realities of the participants experiences.

The individual steps of phenomenological inquiry are not much different than is standard for most qualitative research. Giorgi (1997) outlines the following steps to help create a consistent phenomenological approach. The steps include: collection of data, reading the data, breaking the data into some kind of parts, organization and expression of data, and synthesis for communication to the community. Ultimately the claim that Giorgi (1997) makes is the descriptions of the concrete experiences are an indication to what the subjects were present to, not necessarily the objective nature of the phenomenon.

One common problem is people are often unable to observe their own behavior (Bandura, 1986). This can occur in both learning and social situations, and people are often surprised by their interactions if given a chance to replay a situation. In the clinical environment, preceptors may not understand how their interactions with students are being received. This could inhibit the amount of access students are given to become more central participants. The objective nature is also important, but social and situated learning revolve around personal interactions which can be construed differently for everyone. Whatever the phenomena or situation, every experience is individualized. It is essential to pay attention to the nature of an individual's consciousness as it has experienced a phenomena, as their subjective experience is their reality. Although the preceptor had one view of how they were providing access to the community of practice, it could be possible that a student perceives it differently and feels their access is being hindered.

Through phenomenological analysis of social learning, the subjective reality of how the students experience what it means to be a part of a community of practice was brought to life. Description of the phenomena gives meaning to the experiences. Even as every student had an individualized experience, the collective accounts gave importance to each student's encounter. Just saying the current anticipatory socialization methods provide adequate access to these communities of practice does not ensure this was how the students' viewed it, as gaps in entry-level professionals have continued to be identified (Massie, Strang, & Ward, 2009). The details, biases, errors, and prejudices need to be understood as precise and descriptive as possible, which is where phenomenology comes in, to learn about students' experiences in the clinical environment with as much description as possible. Together the students' shared experiences provide a way to evaluate what and how anticipatory socialization was occurring.

Study Design

This study combined multiple resources to explore social learning in the athletic training clinical environment. A series of student interviews were used to evaluate components that influenced their development of a professional identity. Following these interviews, focus group interviews with preceptors were completed. Together the information demonstrated students' exposure and experience with a community of practice. To triangulate the students' experiences, preceptor focus groups were used to give a voice to the other side of the clinical learning environment.

Participants

Students were recruited from one athletic training program at a Division I institution in the Midwest. Ten athletic training students who were currently working towards their bachelor's degree in athletic training were recruited for this study (Table 1). In phenomenological research, the number of participants is often dependent on the phenomenon being studied (Vagle, 2014). The number of participants needed to provide a sufficient sample and saturation of information depends on the content, time, money, and resources (Seidman, 2006). As each participant completed two interviews, the principle investigator was able to explore the responses more in depth, which provided sufficient data for analysis.

The gender dynamics of this study lean heavily towards the female perspective. Although the national average for baccalaureate athletic training programs is sixty-three percent female (CAATE, 2019), the National Athletic Trainers' Association (NATA) reported that fifty-six percent of its members were female (NATA, 2018). The athletic training program being studied was predominately female (74%) which is higher than both the NATA membership and national averages for female students which helps explain the higher percentage of female participants.

Efforts were made to ensure perspectives from both males and females were included, however majority of the participants who volunteered were female. The limitations of this gender balance will be discussed more in Chapter Five.

Table 1

Student Participant Demographics

Name (Pseudonym)	Gender	Age	Year in Program
Rae	Female	19	1st
Kaelyn	Female	23	2nd
Matilynn	Female	21	1st
Chloe	Female	21	1st
Grace	Female	22	3rd
Arizona	Female	20	1st
Meredith	Female	20	1st
Jack	Male	20	2nd
Sig	Female	22	3rd
Norah	Female	22	2nd

Along with the student participants, two preceptor focus groups were conducted. Each group consisted of three or four athletic trainers currently working as preceptors at the same institution as the students being interviewed (Table 2). The groups were divided based on years working as a clinical preceptors. Preceptors with more than five years of experience as a preceptor were considered the experienced group, whereas the other group consisted of preceptors with less than five years of experience in that role. The purpose of dividing the groups was to keep preceptors with similar length of experience together so their responses would not be influenced by preceptors with more experience in the role. The amount of time they have spent as a preceptor could influence how they approach different learning situations and the clinical setting, so this division was seen as a beneficial component. As the preceptor insight was a secondary component, not as much depth was required to provide data for analysis and the two focus groups were sufficient.

Table 2

Preceptor Participant Demographics

Name (Pseudonym)	Gender	Years as AT	Years as Preceptor
Dave	Male	15	2
James	Male	3	2
Ann	Female	4	1
Mas	Male	15	3.5
Lynn	Female	15	15
Bob	Male	27	25
Grace	Female	24	9

Recruitment

Participants were purposely sampled from the athletic training program where the principle investigator taught at the time. A separate recruitment email was sent to the possible student and preceptor participants. The pool of potential participants in the region was limited and due to limitations of time and resources, students from the principle investigator's institution were recruited if they had completed at least one semester of clinical rotations. This participant pool helped ensure that students had clinical experience in a variety of settings to base their responses, while also providing a range of experiences between students' current year in the athletic training program.

As part of the selection process, students with different years of experience were recruited. The selection variety helped demonstrate how the students' participation experience evolved throughout their education. Students enrolled in the athletic training program during the 2019 spring semester were divided into two groups, first year students and upperclassmen students who were in either their second or third year in the program. The second and third year students were combined as those cohorts were smaller and combined were similar in size to the cohort of first year students. From there the students were anecdotally identified as either

outgoing or reserved in temperament by the principle investigator and one other faculty member who completes all the student advisement in the program.

The purpose of dividing the student personality types was to get student responses from a variety of students, some who were more outspoken and active in the clinical setting compared to students who were quieter and reserved. As one of the research questions was exploring how students' roles evolved through their education, this variety in temperament helped evaluate if students with different observable traits experienced the communities of practice and their involvement differently. The number of participants per group was reflective of the overall number of students in the program. Identity development is always ongoing so the inclusion of students at different times in their education provided an element to explore these transitions and how they were occurring in the clinical setting.

Data Collection

Each participant participated in two semi-structured interviews as the primary method of data collection. The principle investigator conducted the initial interviews in person. The initial interview questions were open-ended and designed based on the literature on clinical education and socialization into athletic training [Appendix A] (Moustakas, 1994; Seidman, 2006). As phenomenology is based on the individual's experiences, themes were not addressed prior to the interviews. This helped ensure the essence of the responses was not influenced and reliably represented their perceptions of the experiences.

Prior to the interviews being conducted, the interview questions were reviewed by another athletic training educator with over twenty years of experience. This individual has served in a variety of roles as an athletic trainer, most recently as a Clinical Education Coordinator and Assistant Professor at a Division I institution. After the questions had been

reviewed, they were pilot tested with two previous students who the principle investigator had worked with in the clinical and classroom setting. No responses from the pilot testing were recorded or used in the final data analysis. The pilot testing did not suggest adjustments were needed. Together the collaboration and pilot testing helped ensure the interview questions and script were creditable and appropriate to answer the research questions.

Through a series of two interviews (Figure 1), with each generally lasting about forty-five minutes, a more in-depth understanding of the experiences was obtained. The first round of interviews established a context of the participant's experiences (Seidman, 2006). In the second round of interviews, a template of questions was used [Appendix B] along with additional questions based on their first interview. These additional questions most often asked the students to reflect at a deeper level on situations they discussed in the initial interview. Seidman (2006) suggests the interviews occur between three to seven days apart. Each subsequent interview was completed within seven days of their initial interview. This helped provide time for the participants to ponder the experiences discussed while not allowing too much time to need to refresh what had been previously discussed.

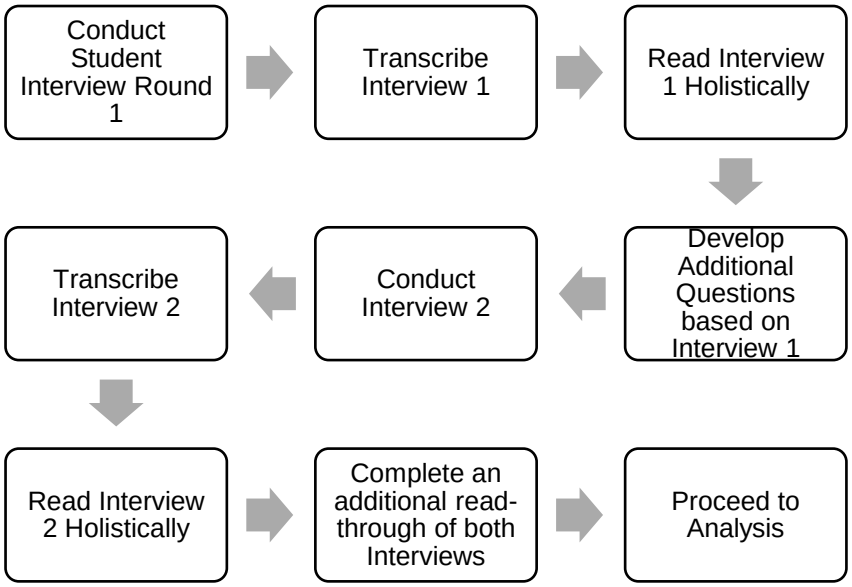

Figure 1: Student interview data collection model.

After each of the interviews was recorded and transcribed, the next step was to read the data. Although this seems like an obvious step in the process, Giorgi (1997) places explicit attention on the topic. He reiterates the holistic nature of phenomenology and he advises completely reading through the data before starting any sort of analysis. After reading through the interview transcript fully, there was a global understanding of the data. In order to provide insight into which social experiences needed to be explored more in depth, this global understanding of the data was an appropriate step before conducting the subsequent interview with each participant. As the researcher was reading through the data, areas which sparked additional interest or needed further explanation were marked. Once the reading was complete, the marked sections were returned to and questions were created to help address areas which needed clarification or to expand on experiences. Each participant's second interview started out with their individualized questions based on their first interview and then finished with a uniform set of questions. The second round of interviews provided the interviewer an opportunity to explore what the participant thinks these specific social experiences meant to their individual experience.

Once the student interviews were complete, the focus groups were initiated with the preceptors. Each focus group consisted of one sixty to ninety-minute session with the emphasis on professional identity, communities of practice, and student participation within those communities. A semi-structured interview guide was used to complete the focus groups [Appendix C]. After each of the focus groups was completed, the same procedures that followed the student interviews was completed. The goal of these focus groups was to learn how preceptors view their role when working with athletic training students. Since the focus of the research was social learning within a community of practice, focus groups provided an

opportunity to examine mini-communities of practice and how they viewed their own participation within these communities. The preceptors' explicit explanation of professional identity, their community of practice, and the role they play in helping introduce students into this community provided evidence to add to the students' experiences. It also provided insight for the implications of the research based on some of the conflicting student and preceptor responses. Overall, there were more similarities in responses than anticipated which suggests the preceptor responses were able to help validate the student experiences.

Data Analysis

Institutional review board approval was obtained prior to the initiation of any participant recruitment. Consent to participate was obtained from each of the students prior to the initiation of any of the interviews. All of the interviews were audio recorded and then transcribed by the principle investigator. All transcriptions were encrypted to ensure security of responses. Any notes the principle investigator took during the interviews were also evaluated by the principle investigator.

After the interviews were completed, the data was analyzed and meaning units or themes were identified (Figure 2). Analysis was completed by the principle investigator and started with an initial read-through of the transcripts to get a general idea of the participant's responses. During the initial reading, the data was horizontalized, meaning every statement was given equal value (Moustakas, 1994). From here, the transcripts were re-read and meaning units were identified. The basis for this step was meaning discrimination and was best understood from a disciplinary perspective as well as sensitive to the phenomenon being investigated (Giorgi, 1997). Meaning discrimination is the process of more carefully reading the data to create parts known as "meaning units." These meaning units were created by marking points where the

researcher experiences transition points in the data, thus discriminating the meaning units. The descriptions themselves were not the emphasis for the meaning units, but rather the attitude and activity of the researcher (Giorgi, 1997). This "discovery-oriented" approach allowed for unexpected meanings to be found in the data, as there was not a specific criterion being followed. While reading the data, there was not a focus on certain experiences; whenever there were moments when there was a shift in the attitude by the researcher, a meaning unit was created. These meaning units were a variety of phrases, sentences, and stories which were relevant to the research and required further evaluation. Meaning units were coded in vivo when possible to help keep the data close to those who were experiencing the phenomena.

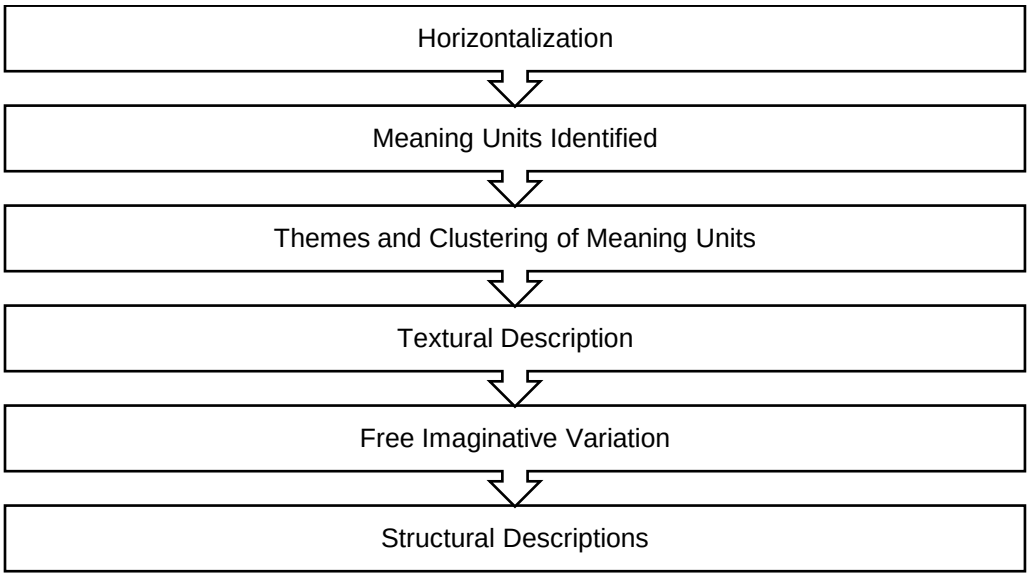

Figure 2: Model of phenomenological data analysis of student interviews.

Phenomenological reduction began as the data was being reorganized which is where the meaning units were established. The researcher examined, probed, and re-described the meaning units to find the value in each unit. Statements that did not pertain to the research questions or were overlapping were then deleted (Moustakas, 1994). From here the meaning units were grouped together into themes and overall themes which were then used to create a textural

description of the phenomenon. Following this step, free imaginative variation began; the goal was to identify which aspects were essential to the essence of the phenomenon.

Free imaginative variation is the method to better identify which items are essential for the phenomenon (Giorgi, 1997). If changes are made to aspects or part of the phenomenon but the phenomenon remains identifiable, this would suggest these parts are essential for the object. For example, as long as peers are kept in the equation, this type of social learning remains the same. However, if peers are replaced with a professor or parent, there is a completely different dynamic, hence a different phenomenon. It was up to the phenomenologist to find these experiences and describe them with objectivity (Kissell, 2018). The structures that were created from this process could come from the perspectives of one participant or many. The aim in free imaginative variation was to "arrive at structural descriptions of an experience, the underlying and precipitating factors that account for what is being experienced" (Moustakas, 1994, p. 97). Free imaginative variation helped clearly illustrate which themes were influential to the development of a structural description of identity development in athletic training students.

In the end, there were textural and structural components identified as being essential to social learning. The textural components provide insight into what was occurring in relationship to their development of a professional identity. What was taking place in the clinical setting and within the communities of practice that influenced their identity development? The structural components were how the students were experiencing social learning. How were the students involved within the social learning and how did this influence their clinical experiences? Together, the textural and structural components provide an overview of the lived experiences of these individuals within their clinical education. As the preceptor data was used as a secondary

component, to provide justification or clarification to the student responses, holistic themes were developed.

Trustworthiness

A variety of procedures were utilized throughout the research process to help build trustworthiness of the data. Through researcher journaling, member checks, and triangulation between the student interviews and the preceptor interviews, the data was representative of the group being studied. Together there was support from different sources to not only ensure that proper research protocols were followed, but also that the data provided the transparent experiences of the participants.

Researcher Reflexivity. In order to ensure the integrity of the participants' responses, the principle investigator had to minimize previous understanding of anticipatory socialization and read the transcripts with a clear mind. Throughout the interviews and data analysis it was essential to bracket personal thoughts and ideas. This was necessary to ensure the analysis was focused on the participants' experiences and not the principle investigator's view of the phenomenon (Moustakas, 1994).

To assist with this bracketing process, writing-to-learn was used to make thinking visible (Kleinsasser, 2000). This technique allowed thoughts to be inspected, reviewed, considered, and viewed as a separate set of data. Prior to each session with the participants or the data, a journal was kept to write any thoughts the principle investigator might have regarding the topic. This can be in the shape of developing theories, dilemmas in the research, biases, or vulnerabilities (Kleinsasser, 2000). Whatever the journal entry of the day contained, the bracketing of these thoughts provided an opportunity to evaluate the preconceptions that might have been held by

the researcher at the time. By making these thoughts visible, the researcher was able to go into the phenomenological research with a clear mind.

Reflexivity should also be addressed prior to beginning the research project. While the principle investigator worked as a preceptor, the students often informally expressed their concerns and feelings regarding other clinical sites and preceptors. The principle investigator served in multiple roles throughout the research process, as an educator, preceptor, and researcher, which provided added challenges. While serving in a variety of roles it was essential to keep those roles and interactions separate from the research being conducted. Being aware of these roles helped keep the principle investigator tuned into the separate expectations of each role. Throughout the duration of the study, a separate journal was used to record any interactions or thoughts that presented a crossover between the two roles.

As for previous knowledge that was formally or informally shared, students had strong opinions on working with different preceptors and in different settings. This shaped their mindset regarding their clinical experience before even working in a particular environment. However, the goal of the interviews was to learn about the student experiences within their community of practice and how these social experiences have shaped their identity as a professional. Getting to the core of each of the student experiences, whether positive or negative, was made easier by the series of interviews. Despite hearing more negative feedback regarding the preceptors in the day-to-day interactions, the students seemed to report more negative peer interactions during their interviews which may hint at the larger role that peers play in the clinical setting.

Member checks. Upon completion of transcription and data analysis, member checks were completed to ensure accuracy of the responses and interpretations (Creswell, 2016). The participants were asked at the end of their interview if they were willing to volunteer to help with

the member checks. If they agreed, they provided an email address to complete the member checks. Each student or preceptor was emailed a written description of the themes created from the data, along with their individual supporting quotes that were used in the analysis to provide insight into the themes and subthemes. Member checks allowed the participants an opportunity to critique the created themes as well as make grammatical edits to their quotes. To provide feedback or to confirm the analysis, there was a link to a Qualtrics survey for the participants to complete.

Triangulation. Converging the themes found in the preceptors' responses with the student interviews helped provide trustworthiness of the findings (Bowen, 2009). This convergence gave insight into how the preceptors perceived their participation within the community of practice and the types of relationships created during situated learning experiences. Looking at the data from a variety of angles between the preceptors and the students helped create a fuller picture of the phenomenon being studied. No single method was going to adequately solve a problem with multiple perspectives (Patton, 1999). This is why it was essential to evaluate data from a variety of sources to corroborate findings or provide a chance to explain any contradictions. These contradictory findings were further investigated by the researcher to evaluate what could be occurring (Bowen, 2009). The differences in some of the student and preceptor responses regarding their experiences within the clinical environment helped provide depth to fill some of the current gaps in the transition to practice for entry-level athletic trainers.

Patton (1999) describes the triangulation of sources as a way for the researcher to examine the consistency of different data sources within one method of research. The one-on-one student interviews and preceptor focus group interviews provided data in two different ways to

provide deeper analysis of the phenomenon of the community of practice. Different types of data captured different pictures of the phenomenon. The researcher tried to understand and explain the differences or show the consistency in the patterns to contribute to the overall credibility (Patton, 1999). Phenomenology presents the manifestation of a phenomenon from multiple perspectives and the triangulation of the students and preceptors helped provide depth to the textural and structural themes.

Reflexivity Statement

Throughout the entirety of this research study, I have held a variety of roles simultaneously. It is hard to identify a primary role, as they were all occurring simultaneously. As an Instructor, Athletic Trainer, Preceptor, Clinical Education Coordinator, Advisor to the student lead organization, and Researcher there were multiple overlapping roles. Each of these roles have helped create an open and trusting relationship with many of the students. Although there was overlap between the roles throughout the study duration, the conflicts that could arise were addressed through reflexive journaling process described earlier. This relationship as an educator was beneficial, as the students have demonstrated trust and willingness to share their opinions and views in the past, both formally and informally. The willingness to help in the past suggested the students were open to participating and providing valuable data. These relationships were bracketed prior to any of the interviews as was discussed during the reflexivity section.

There were a few assumptions I had due to the multiple roles I served during my time at this institution and during this research study. The primary assumption related to the independence given to the athletic training students from the preceptor. Some preceptors have a difficult time letting the students think and learn on their own. One way this presents itself is

when the preceptor interrupts the students in the middle of performing a skill or insists that students can only perform nominal tasks. Although there may be some instances where it is essential to correct a skill while it is occurring, it is my belief that students lose the ability to think critically when they are continually interrupted when practicing a skill. Constant interruptions or corrections frustrate the students and they find it difficult to learn how to practice independently and think critically. Students have brought these concerns to me before and state how preceptors who do these things create a difficult learning environment.

However, on the flip side, I have also received feedback of the opposite nature. There are some preceptors who are hands off in the athletic training room. During discussions with these preceptors, this is done on purpose to help the students gain some independence and learn how to function in a chaotic setting. Although students do appreciate this independence compared to other sites, they also report wishing they were able to observe and learn with the preceptor more. The assumption with this feedback is there is an important social component to students' clinical rotations. Older students thrive on the independence, but at the same time wish they had someone to observe and learn from at the same time. Based on these different perspectives I have gained while in my role as a preceptor and clinical education coordinator, I believe there should be a balance in the learning environment between independence and socialization.

The level of communication between all involved parties, students, peers, and preceptors, also influences participation within a community of practice. When preceptors do not clearly state their expectations, students get lost about their roles. This student uncertainty can sometimes result in preceptor frustration as they assume the students should know how to participate within the community. Often peers can help with these miscommunications, as they have learned from previous experience how to maneuver the new settings. However, this relies

heavily on peer communication and willingness to welcome new students to participation within the community. These assumptions illustrate how influential communication is to becoming a member of a community of practice.

One of the positive things about students working in a variety of clinical settings, is the ability to work alongside numerous preceptors. Each preceptor has strengths and weaknesses, and students are able to observe these differences. My assumption is that these encounters help shape the student into the professional they will become in the future. Different traits will resonate with students as they identify with positive and negative characteristics of the professional they want to become. Ideally the students get some opportunities to practice these skills prior to graduating, but ultimately the hope is they have started to put together their professional identity with the characteristics they observed as students. Identity will continue to change with new experiences and as roles change, but the traits students observe early in their career will be the foundation for their future. In my time as a clinical preceptor, I try to acknowledge my strengths and weaknesses with the students so they can learn to evaluate their own; however, at the same time I work to teach the students to trust themselves as they are learning and practicing in their new roles.

Delimitations

Upon evaluation of potential participants in the region, the numbers did not suggest the possibility of adding depth or variability to the data for analysis. These concerns of potential participants lead the researcher to use students only from her own program, resulting in a singular institution being evaluated. It is typically advised against using students who are currently under the supervision of any of the researchers associated with the study due to conflicts of interest (Seidman, 2006). To help alleviate any concerns of conflict of interest,

additional steps were taken to ensure trustworthiness of the data. One step that was taken to decrease conflicts of interest included recruiting students outside of formal class time to not confuse participation with course grades.

Although the future of athletic training education is entry-level masters, an undergraduate athletic training program was the emphasis of this study. There were two reasons for this choice: access and standards. As undergraduate programs still greatly outweigh the number of graduate programs in the country, there are few programs in the region to study. This hindered the access to participants. The second reason was that evaluation of either of the types of programs will not represent an accurate view of what the future looks regardless of the students interviewed. Programs are not required to meet the new educational standards until July 2020 (CAATE, 2018), which means programs are still teaching to the 2012 standards. Although there were some similarities, there are some substantial changes to the format and expectations of programs. The current study provides a better understanding of what aspects work and should be carried through the transition, while also providing insight on which changes could be made to benefit the future students. Up next, the data analysis will be presented and the findings and discussion will explore the lived experiences within the clinical environment.

Chapter IV: Findings and Discussion

Ten athletic training students participated in a series of two semi-structured interviews to discover the essence of creating an identity as a professional. These lived experiences were explored through their clinical education within the athletic training program. To compliment these responses, seven athletic trainers/preceptors participated in two focus groups to provide more insight into these experiences. The student participants were at varying levels within their education at the end of the 2018-2019 school year, with a range including students wrapping up their first year in the program to those preparing to graduate. The preceptors were split into two groups, one group with less than five years of experience working as a preceptor, the other group with more than five years of experience in that role. Although there were a range of student levels of education, their clinical experiences had many shared qualities.

The student data was organized into five sections that identify the primary themes from the findings of the study. Two themes were textural and three were structural. Textural themes explain *the what* of an experience. In this study, the textural themes describe what the students were experiencing in their identity development in the clinical setting. From here, the structural themes describe *the how* of the experiences. The structural themes help explore how the clinical experiences influenced their identity development. Both textural and structural components are necessary to understand the complexities of their clinical experiences. Learning what the students experienced and how they experienced social interactions provides the insight into how a professional identity is developed. Within each of the themes, student quotes were used as evidence. The two textural themes that emerged from the analysis were collaboration and competency. The three structural themes were communication, social pressures, and building relationships.

As a secondary component to the student responses, the preceptor data was organized into three holistic themes. The identity development of the students was the primary goal of the study and the analysis of the preceptor data was used to evaluate if there were major differences in the learning interactions in the clinical setting. Two of the themes, building relationships and learning interactions, helped support the student data. A third theme brought up some potential insight into some of the struggles in the communities of practice in athletic training. This last theme was the comparison of a town versus a neighborhood and how athletic trainers function differently in each of these scenarios.

Not only did the last theme provide a structural component to preceptor data, but it provided an interpretive backdrop to better understand how communities of practice function. The principle foundation for the theme was how each athletic training room is its own little neighborhood, where people feel comfortable reaching out to their neighbors. Together these neighborhoods create a town, or the department of sports medicine. Although there are similarities throughout neighborhoods, each has its own customs and functions slightly different which can make communication difficult. Throughout their education, students move between the neighborhoods with the goal of their collective experiences being to have them feel comfortable working within the town as a whole. This analogy from the preceptors will be used throughout the analysis to help frame the students' experiences within the community of practice.

Composite Textural Descriptions

The first part of the analysis involved the textural descriptions of the phenomenon. There were two primary themes identified from the student responses which were collaboration and competency. These two themes presented what the students experienced during their clinical

education. Collaboration represented a transition throughout the students' time in the athletic training program as their roles evolved. Competency was the result of experiences the students were exposed to which developed their criteria for professional identity. They were exposed to what it means to be an athletic trainer and explained what these experiences meant to them.

Collaboration

When the students were asked about their clinical education experiences, one of the most prominent themes throughout was collaboration. This collaboration occurred in a variety of ways as the students transitioned from observing to being introduced to patients to being guided through clinical practice. These primary components hinged on learning the expectations of the clinical setting. The students described what type of collaborative experiences they had with peers, preceptors, and patients. Each of these textural components, observation, introduction to patient care, guidance through independent practice, and learning the expectations, will be broken down below to evaluate what was experienced by the students.

Observation. Almost every student described their experiences of observation as a student in the clinical setting. As students began their time in the athletic training program (ATP), there was the initial difficulty of moving from an observation student to a first-year student in the program. Arizona described her transition to the program and said, "At the beginning of the year, I was just a little observation student. So, I was like 'I don't know what I'm doing.'" Prior to entering the ATP, the students must obtain a certain number of observation hours where, as the name entails, they can only observe the interactions taking place. Upon officially entering the ATP there were feelings of still being an observation student who hopes to join the program someday.

Meredith explained she typically has to "watch it or at least hear it before I can do it. I'm not a big 'jump right in' right away. I kind of have to take my time and then I can pretty much just go with it and just run with it then." This demonstrated the students' desire to observe prior to trying things themselves. Multiple students described what they learned through their observation of more experienced students or preceptors. Rae had found that she gets the most out of watching how other people do things. She explained,

> I like watching the upperclassmen and even some of my classmates. They have more figured out than I do in different aspects, so just seeing how other people do stuff helps me figure out how I want to do it and what's easier for me.

Jack mirrored those thoughts as he described what he has gained or learned about what he wants to be when he is working independently. Through observation and being in clinical rotations, Jack said,

> You learn a certain way, what works well and what doesn't work well. So, just picking up those things along the way and how to handle situations and how to deal with athletes and how to provide feedback and how to talk to an athlete if they're injured.

Just being at the clinical rotations and observing other students and preceptors provided the students opportunities to learn how to function as an athletic trainer. They watched how others work and use that information when it is their turn to practice their skills.

As an observation student, the students have not yet entered the community of practice. These observation hours provide exposure to a profession and the expectations of individuals within the ATP. The transition from an observation student to a new student within the program was something that some of the students described consciously recalled struggling with. As a new student, they felt like they were on the fringe of the community and were unsure of how to

become a more active member. Another aspect of observation came when many students described their preference to observe others perform skills prior to trying something themselves. Students used these observation experiences to learn what works and how to make it easier for themselves and the transition to providing patient care will be explored next.

Introduction to patient care. The students described how either upperclassmen or preceptors helped initiate working with patients. Two students, Grace and Matilynn, described different examples of interactions they had with peers or preceptors in their early experiences in the clinical setting. Grace recalled how she had a third-year student who took her hand to introduce her to new patients and threw her into the initial contact with patients. Now that Grace is in that position, she said, "I definitely don't want to push that on people especially if it isn't their thing." Although she does encourage the newer students to join her conversations with patients, she tries to prep the students prior to the interaction. Grace has found the newer students "kind of react to that a little bit better where I'm not directly putting them on the spot, but they're also with me kind of hearing things that I'm taking with." She took the previous interactions with upperclassmen and modified how she introduces new students to patients so the students do not feel put on the spot.

Matilynn recalled a conversation with her first preceptor regarding integrating herself into the clinical setting. The advice: "Introduce yourself to the athlete first and then just talk to them." She took this advice to heart and brought it to every new clinical rotation throughout the year. Now she goes into each new experience with the mentality of not depending on other people telling her what to do, but rather taking the initiative to introduce herself to people. On top of that initial advice, Matilynn thought,

> The preceptors did a really good job of making sure that although we were really confused and had deer in the headlights [look] most of the time we were in the [athletic] trainer's room, they did a really good job of trying to help us and introduce us to athletes and different tools and techniques and that kind of stuff as early as possible so that we were interacting with everybody.

Each of these examples demonstrate how helpful it is for new students to have someone to help initiate working with patients. Even something as simple as introducing themselves to the patients is enough to get the conversation rolling. With the help of an upperclassmen or a preceptor, the new students can join conversations. Meredith experienced upperclassmen who pushed her to ask questions as she recalled them telling her, "If you can just start somewhere, you know more than you think and so just start somewhere, it doesn't have to be right." Eventually it clicked for Meredith as she got more practice from these types of interactions.

Just starting with something helped the new students get to know the patients, even if it was the superficial components of the patient such as their name. When it came to early interactions with patients, most often they were initiated with the assistance of a more experienced member of the community. With the advice from preceptors and upperclassmen, the new members learned to initiate conversations with patients.

Guided to independent practice. Another piece that goes along with the initial introduction to patients is the transition of skill development and practice. Often the students described how their encounters transitioned from being guided by an upperclassman or preceptor to gradually becoming more independent over the years. When discussing managing concussions, Sig explained,

> I was definitely very guided the first couple of times. I worked with an upperclassman or I watched somebody else do it. Or I walked through it like "Hey, I did the symptoms, what do you think I should do today? This is what I was thinking, what do you think? Is this the right way?" And then kind of walking through that.

Meredith had similar experiences with peers where she described how she will "tag team it with someone, just to bounce ideas off of them and make sure that we're doing it right." This is often paired with having someone watch them or grabbing someone to help when they get stuck. Both of these experiences are ways that students use others to help as they are building their knowledge base.

Grace acknowledged that early in her education she would hand patients off to preceptors when she was unsure what to do next. However, now Grace explained,

> I think that's changed, where I don't necessarily go and ask them a whole lot about it. I mean I still do but no. If I can come to a confident answer that I've learned and feel confident about that interaction with, the preceptor has kind of decreased.

Her independence in making decisions has grown which decreases the amount of guidance she sought out. Similar to Sig's experience with concussions, Grace stated that now "I'm more confident in that process. Like I know when the right step is and like know what my mental guide would be for those steps." Being guided through initial interactions helped demonstrate to the students what steps come next in the process and how to implement those plans.

As the students are gradually introduced to the clinical setting, they are given opportunities to begin doing more with the patients. Central to these interactions was the chance to practice independently, with more experienced members of the community close by to assist when needed. With more practice, the students began to feel more confident in their abilities to

work independently and their interactions with the more experienced members decreased. Lastly, as a piece to each of the previously discussed topics the last subtheme to collaboration was how the students learn the expectations of the clinical setting.

Learning the expectations. Although there were described differences between each preceptor, many of the students described how the preceptor sets the expectations for a specific clinical site. As Sig described, "They know what the flow is in their athletic training [room]…so they kind of help with the transition to getting the flow." Rae agrees it is normally the preceptor laying down how they do things in their athletic training room, but she noted that "the upperclassmen help a lot with what's expected of us individually, the day-to-day what we should be doing." In Rae's experience with the upperclassmen, in the first weeks she was getting "shown the ropes. They kind of take you under their wing and get us to what we do or whatever." So even though it is initially the preceptors who set the expectations, it is often the upperclassmen students who are introducing new students into the more intricate aspects of the daily operations of the clinical setting.

In Chloe's experience, she felt like the other students did a good job of interacting with the new students. In her words,

> Most of them are very good at integrating you into their routine and telling you like "This what we do every day. This is what we start out with. This is how we do things. This is how the preceptor likes things," and then they'll give you a tentative schedule so that you know what times to be there and then you also kind of get to know your role. The more you work with them, you see the different interactions that the upperclassmen have together, and then you just kind of fill the gaps where needed.

As the upperclassmen students learn the expectations of each preceptor, they are often the ones in contact with the new students to communicate those nuances. Sig has realized the amount of responsibility she has been given over the years and has stepped into the role of trying to prepare the students who will be stepping into her position. Sig described, “They have to be ready to step up in that position. So, it would be good for them to have at least more information than what they do, like what we would have had, we didn’t know anything.” When Sig became one of the upperclassmen, she did not feel like she had any guidance from previous students on how to manage those new expectations. As Sig had helped guide the upcoming upperclassmen, she had been able to step back and phase herself out of that role to aid in the transition after her graduation. There was a desire by multiple upperclassmen to better prepare the less experienced students so they are able to be leaders when their time comes.

Working within a community of practice comes with a set of expectations that are central to that community. The students felt like each athletic training room had slightly different nuances to the daily operations, which was communicated by the preceptors. The newer members to the community were shown the expectations by the upperclassmen students. Some of the more experienced students felt like it was their duty to help prepare the other students to step into the position as a leader. Based on the upperclassmen remarks, it does not sound like this was something that happens all the time, as they felt like had no idea how to transition into the role as someone the newer members looked to for advice.

Discussion of Collaboration

As a new student, the place everyone started out is through observation, however this does not stop at any one point, as the students described continued learning through observation at multiple points. To make the transition from observation to patient care there was often

someone to help initiate the conversation. Without being pushed to initiate conversations by members within the community, the students felt like they remained an observation student or someone who was not yet a member of the community. After the initial introduction to patients and the clinical setting came guided practice. Whether it came from peers or preceptors, the students described how they were guided as they began their skill development. As they became more confident in their skills and decision-making ability, they decreased the amount of support they sought out from others.

When it came to learning the expectations of the clinical setting, these were primarily laid out by the preceptors. It was up to the preceptor to lay out the expectations at each clinical site. Some sites, such as football required more structure to ensure each of the many moving parts was working as a team. It was often the upperclassmen students who end up ingraining these principles into the new students when they get to a new clinical site. The expectation is the upperclassmen students have been exposed to the daily interactions in the clinical setting and they can introduce these concepts to the new students. Some upperclassmen even felt it was up to them to prepare the upcoming upperclassmen to be more educated about their responsibilities in that role.

As a whole, the students experienced collaboration in a variety of ways in the clinical setting. Whether it was to observe how others work together or through their transition to a new community of practice, the students worked with peers and preceptors to learn the expectations of an athletic training room. Key to these textural experiences were the other individuals in the clinical setting. Each of these external forces helped the students through their transition towards what it meant it be a member within the community. Collaboration was one of the primary ways

the students learned about their role as an athletic training student. The second textural theme, competency will be explored next to discover what this development looked like for the students.

Competency

One of the keys of clinical education experiences was the opportunity to build competency in the skills required of an athletic trainer. When the students described what this process looked like, one thing they identified was what role their mentors played in this type of learning. They were questioned on their feelings as a student compared to being an athletic trainer and what it means to be a "respectable" professional in the collegiate setting. Lastly, the students shared their experiences with the learning process and what helped them adjust to a new learning environment. Mentors, the respectable professional, and adapting to the learning process represent the three primary elements of competency which will be further examined.

Mentor roles. As the students learned what it took to be a competent athletic trainer, the examples they were most often exposed to were mentors within their clinical rotations. These mentors were typically the preceptors the students work with daily, however peers were also described to be influential in the learning process depending on their own level of experience. Norah described mentors as generally "someone with a skill set that you're trying to gain and is willing to teach you." The students also want someone they can talk to and ask questions. Chloe agrees with the idea of mentors as someone she can talk to but includes that they are a leader as well. Someone willing to teach and being open to communication were other keys to mentorship that were mirrored in many of the students.

Chloe went into depth on her experiences with mentors during the early months within the athletic training program. One of the things she had to learn in her first year was that everybody was not going to tell her exactly what to do, but to her "…that comes along with

growing either as a professional or a student or whatever it is." Although this concept was difficult for her to grasp at first, she went on to say, "…Now I can kind of see why they try to just guide you in a direction rather than just telling you exactly what to do because that's how you learn, is by figuring out yourself sometimes." From Chloe's perspective, learning does not occur when everything is explicitly stated, which was difficult for some of the students to grasp if they had not previously faced this mentorship style.

Jack offered a different but similar perspective to how learning occurs. The way Jack put it, "I want to say it's more individual driven. You have to initiate your goal or you have to ask the preceptor for help or ask him questions about what the goal or to advance." In his experience, the preceptors had a lot on their plate and it required him to realize the two-way relationship required in learning. Jack stated, "If you don't put the work in or if you don't expect to learn from them or if you have a problem with their authority as a preceptor, things won't go well." This demonstrated how the preceptors are pieces of the mentor relationship, but furthers the idea that students need to be willing to put in the effort.

Preceptors serve many roles and being a mentor to help guide the students is one of them. The students' valued someone who took the time to teach them and the majority of the students identified the willingness to teach as being one of the primary traits that drew them towards potential mentors. Rae added she looked to other students as mentors too and appreciates "the ones that are willing to help or go the extra mile to help me with something." Chloe stated, "Being a good mentor, you recognize when a person needs to be told what to do and when a person needs to be just guided on what to do." Together the students described a desire to learn and be guided by people with more experience. Regardless of if it was a preceptor or another

student, the participants sought someone who took the time to help them, although over time they began to understand they had to become active participants in their learning.

Athletic training student vs. athletic trainer. One of the transitions students experienced throughout their education was the difference in feeling like an athletic training *student* or feeling like an athletic trainer. When asked where students felt they were in this transition, it became apparent that students make this transition at a variety of points within their education. Half of the students identified themselves as being somewhere in the middle of feeling like an athletic trainer. The other students were split between strongly stating they did not feel like an athletic trainer or identifying how they felt like an athletic trainer at their current point in their education.

The following statements are included to help describe why students felt like they had not made the full transition to athletic trainer. These are some of the responses of the students when asked if they feel like an athletic trainer.

> Arizona (First Year Student): "Yeah. Actually. A lot of the time when I was at football, I would have my own people and I would just set up their own rehabs and I would walk them through it and stuff like that. And even at the Hyslop they sometimes even let me pick what modality I want to do on them or what I think I should do and stuff like that. So yeah totally and every time someone comes in and I'm like 'What do you need?' I don't feel like a student anymore. I feel like I'm a [athletic] trainer…"

> Matilynn (First Year Student): "For athletes to come in… and then go 'Hey Matilynn, what am I doing today?' I think that was a big spot of where I actually start to feel like more of an athletic trainer than a student because I was the one they came to...And being

able to be the one to make the decisions of how everything would flow for that day, based on how much time we had and what they wanted done and kinda stuff like that too."

Jack (Second Year Student): "Smaller or in different rotations or there's less people or if there's a certified next to you all the time, you may feel more like a student because you're always next to them and I don't know. You just always have the feeling of you're below kinda. Just because you, you aren't certified yet."

Grace (Third Year Student): "Yeah I think it's more or less because I mean obviously everybody's not going to know everything but I haven't graduated yet. I think that's the big thing that I haven't passed everything yet and I'm still working under people you know as teachers and preceptors. And I think that not necessarily hierarchy, but that ladder. I don't feel one hundred percent like 'Yep! I'm your athletic trainer.' Like I still have people that I have to talk to. Granted yes, we're gonna have to talk to physicians and all that stuff afterwards, but yeah I don't know."

Both Matilynn and Arizona described how they are able to initiate conversations with patients and started working with them independently. They both also described the ability to make decisions as being an influential component in their development. There was a feeling of autonomy described that played a role in their feelings as more than just a student.

On the other end, both Jack and Grace discussed how they felt there were still people they were working underneath. Each of these experiences included some component of the role of the preceptor. Whether its proximity or the feeling of having someone above them to report to,

one of the main themes of students feeling like an athletic trainer relied on the preceptor's role in their clinical encounters.

Together, each of these quotes highlights the importance of being given opportunities to work autonomously. Tasks such as choosing the modality to use are low stakes and provided the students with a chance to test their hand at making their own decisions. Ultimately, these students were aware of the presence of their preceptor which brought them back down to acknowledging their role as a student.

In contrast to those thoughts on their progression, the following statements were made by other students when asked whether they feel like an athletic trainer.

> Sig (Third Year Student): "Sure. I think sometimes I've dealt with sophomores without telling the preceptors. We had one last week, she left 30 minutes early. When she was only supposed to leave like 15 minutes early. We really didn't talk to the preceptors, just kind of talked to her because she'd been doing it before, but this time we actually could have used her.

Notice the encounter Sig recalled was the result of independently making decisions and not relying on the interaction with the preceptors. It demonstrated her ability to apply interpersonal skills and act on concerns she had observed from her peers. The following accounts represent students on the other end of the development spectrum.

> Chloe (First Year Student): "Umm, no. Not at all. Because where I'm at in the program right now, being a sophomore I don't have all the skills that obviously upperclassmen do. I definitely see that in some of the seniors, where I'm like 'Okay. You actually look like a certified athletic trainer right now. You can run the whole athletic training room by yourself.' But where I'm at, personally, I definitely do not feel that at this point."

> Rae: "Not really…I think personally confidence and just my skills in general. Where an athlete walks in and I can start to finish their whole trip to the athletic training room. Sometimes I can if my patient's coming in for rehab or treatment, but if someone walked in, I did like an eval, decided on what we're going to do that day for them, and then came up with the plan myself – if I could do that, I think that'd be the first step."

For the students who did not strongly identify as having experiences where they felt anything more than a student, the overlapping idea was skill development. Although there was some reference to preceptors or upperclassmen, it was primarily a personal construct where they did not feel they had the skills required of an athletic trainer. There was a lack of confidence in skills which held these students back, compared with other students who were more greatly influenced by the role of the upperclassmen and preceptors who they were reporting to.

During the students' transition throughout their education the combination of skill development and autonomy were the primary identified experiences which influenced a student's identity as an athletic trainer. One small piece was the skills and knowledge acquired, but throughout the majority of the student's responses the primary factor was the preceptor's role. The preceptors were the ones that afforded different levels of autonomy to the students, which altered the amount of decisions the students were able to make when working with patients and peers.

The next component discovered through the evaluation of the experiences students had with mentors and their transition in roles as an athletic training student was what a "respectable" professional looked like. The students were asked to reflect on these experiences with their preceptors and to describe what an athletic trainer does which brings up the third component to

competency which related to the students' view of the understood expectations of a "respectable" professional.

"Respectable" professional. The students broke down what professional identity was and what it looked like to them. Many of the students struggled to put a specific definition to "professional identity," however through their experiences they were able to describe the interactions they have had with preceptors which embodied this idea. Majority of the aspects described were external, where the students were comparing themselves to others throughout their learning. One clear aspect of being respectable was the desire to be competent. Another piece the students brought up was wanting to have a good reputation as an athletic trainer and were conscious of how they want to portray themselves in their career.

Part of how they portray themselves as an athletic trainers related to how they presented themselves, which was another example of the external factors that influenced their identity development. Being on time and appearance were examples of ways athletic trainers portray themselves to others. Matilynn described simple things such as "wearing clothes that are nice looking clothes. Even though it's just khakis and a sweatshirt, it's still not ripped khakis, not this really grungy sweatshirt that you've been using since you were in middle school." Presenting themselves as professionals is one part, the second aspect is being respected in their role. As put by Matilynn,

> But I think for me those are my two main things in a profession. Having that professional identity is being able to not only present myself as a professional but also once I'm in the position that they respect me as a professional to maintain that relationship.

Not only did Matilynn want to possess the skills to maintain respect, but she also acknowledged the normative components of what was expected of her as a professional. Appearance and dress

code elements of these socially defined expectations of an athletic trainer. Rae described professional identity as,

> I think it's the way your patients or the people you're working with view you, see you, and the job that you do….When they hear your name the way they think of you and the way you do your job.

Chloe agreed that "…it's being [a] respectful adult or whatever you are." Even as students, there was this understanding being developed to portray themselves as someone who is respected by others. They learned what it meant to be this type of professional from the preceptors they work with on a daily basis. A few students discussed their observations of a dislocated wrist during a football game and they saw how the preceptors acted in an emergency situation and the respect and authority these individuals possessed. On top of being competent, Meredith adds,

> I also want to be a respected person along with very respectable of others. And I think you can see people who just stand out like that. Where it's like "Oh yeah, they know what they're doing. People know they know what they're doing and you can go to them for anything."

Through experiences such as the dislocated wrist, the students saw preceptors who were respected by the patients, the coaches, the team physicians, as well as other students. This level of respect and competence was something many of the students associated with professional identity.

There was a conscious awareness of how others viewed them as influencing the students' professional identities. The students expressed how the external aspects influenced their perceptions of their own identity. There were references to experiences which address the way other people viewed them as influencing their identity. For example, both the views of the

preceptors, their peers, and the patients were highly discussed as interactions where they were extremely conscious of their performance and will be explored more in depth in upcoming sections. Even the way they portrayed themselves was based on the social expectations of what an athletic trainer should be or what it means to be "professional." There is no advantage or real reason athletic trainers need to wear khaki pants, but it was one of the socially defined norms the students have also adopted. Feeling competent is probably the only identified factor not directly related to social expectations, however it could be argued even competency is a socially defined component. As newcomers, the external views of what it means to be a "respectable" professional were influential in their development process. Lastly, the learning process the students encountered throughout their clinical rotations will be evaluated.

Learning process. The students expressed the different components that made up learning in the clinical setting. One thing that helped during their clinical education was understanding the expectations. Chloe described what the transition to her fourth rotation in Year One was like for her. In her words,

> I definitely was not as nervous or even I wasn't nervous at all going to the fourth one because I knew what to expect. I knew what was expected of me. I felt like more so than I did the beginning of the year and I was just able to do more things.

Prior to even getting to a new clinical rotation, just understanding the expectations helped with the transition. Rae expressed similar feelings when she said, "When I'm actually doing it in the clinical setting, that's when I feel I make like the biggest strides… And then also seeing upperclassmen and certifieds to do it, you kind of catch on to the normal, sort of." For Rae, being able to see others working in the clinical setting and then having opportunities to practice those skills provided some positive learning experiences.

Another component the students identified in the learning process was feedback and communication. When preceptors or upperclassmen explained what they were doing, while they were doing it was helpful for new students. As Matilynn put it, during the first few months in the program, "You know absolutely nothing…I think that was the biggest part for me was to have the explanations." A majority of the students identified a desire for constructive criticism throughout the learning process. Sig stated,

> Feedback in general would be good. If you're going to do it and nobody is going to tell you that you did it right or you did it wrong, then you're never going to know if you need to improve on it.

Meredith had similar feeling when she stated, "I want to be as competent and know as much as I can. And so that's another reason why I take feedback, I love it. Just because I'd rather know more than less and hear more than hear less." The students wanted the preceptors or peers to help provide insight in their skill development. Without feedback, they described feeling unsure of their abilities and whether they were performing skills correctly or incorrectly. Although they preferred feedback more often when learning new skills, after they had their competence validated it was not as necessary as often; however, there was agreement among the students that feedback was still nice to hear even if it was something they felt comfortable performing.

Students at different levels in their education discovered learning is a long process that is not going to happen overnight. Even if not understood immediately upon entering the program, the following statements provided insight into what the students understood learning in the clinical setting to look like. Meredith, at the end of her first year stated,

> I think the biggest thing, and we are told to ask questions, but I think more than that is just be confident in yourself. You might not know it all, but be confident that you can get

> there. Not necessarily confident that you know everything right away, but just go in knowing what you know and grow from that. Just find some takeaway every day. And it doesn't have to be massive, but it adds up to be massive in the end.

Sig, who was just wrapping up her third and last year in the program described a similar sentiment. She said,

> Don't freak out. You'll learn it eventually. You don't need to know it all right now. There's no point in trying to learn how to do a full eval your first year, when you don't understand what you're doing. So, it takes a long time to figure it out, why you're doing what you're doing. Not just doing the steps.

Together these two thoughts help clarify what the learning process looked like from students at different levels of their education. Although there was a desire or feeling like they need to know everything right away, this was not what clinical education was about. From their experiences, it started with the expectations, then required listening to feedback and constructive criticism, and eventually through three years of education, the learning process came full circle.

Discussion of Competence

Mentors were both preceptors or other students who were willing to take the time to teach the newer members of the community. The students looked to someone who has a skill set they desired and wanted to learn from someone who takes the time to teach. Learning that everything is not always given to them was a difficult concept in the beginning, but the students learned to appreciate their active role in the learning process and understood it required effort on their part if they wanted to acquire competency. As the students progressed through their identity development as an athletic trainer, there were two primary factors that influenced their experiences. First, there was a level of autonomy the students described. The role and influence

of the preceptor was an idea that crossed over each of the different levels of identification and related to the opportunities for autonomous practice the students experienced. Autonomy provided chances to make decisions and test how much they knew. The second factor, skill development, was found in students who did not experience feelings as an athletic trainer. These students did not feel like an athletic trainer yet, with their lack of skills being the primary reason they identified.

Being a "respectable" professional is often dependent on the social expectations created in a particular field. For the athletic training students, these expectations were primarily external which included appearance, being timely, and obtaining a certain level of competence. The students described their professional identity as being how other people view them or how they portray themselves, which helped explain why the influence of the preceptors and the ability to make decisions were impactful moments. If they were working with someone who views them as a student, they conform to those ideas and were not likely to identify as anything more. As Jack stated, if they were constantly in the presence of their preceptor, it was hard to feel like anything more than a student because there was always someone right there overseeing their actions. The opportunities to make decisions are minimized; their autonomy stunted. More chances to work independently provided challenges to test their knowledge and practice their decision making skills.

Ultimately the learning process is designed to build competence over time. As the students were exposed to different representations of "respectable" professionals, they slowly learned what was expected of them as athletic trainers. Through constructive criticism, students' competence was validated. Feedback in the clinical setting was crucial to helping the students understand when they are on the right track. The students expressed how valuable this feedback

was to their progress. Even though they may want all the answers in their first year, over the course of the three years they understood that learning is a long process they needed to accept. Validation from others helped the students begin to build their professional identity as they were able to practice autonomously, which ultimately helped build their competence to becoming a "respectable" professional.

Textural Essence

The clinical setting provided opportunities where students were exposed to a community of practice of athletic trainers. Throughout these experiences, students were exposed to a variety of different neighborhoods within a town. The students collaborated with other neighbors as they were introduced to providing patient care. Through this collaboration, students observed and were guided through their learning as they discovered what was expected of members in each neighborhood. There was exposure to the different nuances for what was occurring in each setting.

Although preceptors allowed for varying levels of autonomy, the students recognized what the process entailed to learn the intricate aspects of the profession. These experiences provided a platform for the students to not only learn what a "respectable" professional was, but a chance to put their learning to use. Students experienced varying levels of identity development throughout their clinical education as they learned what competency looked like within each neighborhood. The preceptors, as the most experienced members within the town, provided the greatest examples as to what was expected as a professional. Together, through collaboration and competency, the students were exposed to what it means to be an athletic trainer. To what it means to be a member of a neighborhood and the learning required to eventually belong to the town as a whole.

Composite Structural Descriptions

After the textural themes were created, the structural descriptions were evaluated to provide depth to how the social learning experiences influenced the students' identity development. The three structural themes were communication, building relationships, and social pressures. There were both positive and negative communication factors which influenced the students' clinical experiences, with aspects of each resulting in changes to how they communicated in future interactions. The reciprocal nature of confidence and patient care was one piece of building relationships, as well as a genuine interest in the well-being of the students. Each of these parts played a role in how the students approached their clinical rotations. Lastly, the social pressures associated with the clinical setting played a large role in the validation of the students' identity development. The pressures the students put on themselves and from their peers, preceptors, or patients each influenced how involved they were in the learning process. Together these structural themes provide examples of how the students were learning and working within their community of practice.

Communication

One of the primary structural themes all the students experienced was the role of communication. A majority of the students referenced how negative peer encounters affected their learning and actions. Another struggle identified was unclear expectations or miscommunication from the preceptors. On the positive end, the students explained how asking questions helped their learning encounters and the role this type of communication played in their development.

Negative peer encounters. A majority of the students experienced some sort of negative peer interaction during their clinical education. Often these negative experiences influenced how

they communicated with others in the future. As a first year student, Kaelyn recalled being told by an upperclassman that she "won't make it," which came out of nowhere as they were cleaning up one day in the athletic training room. Although Kaelyn found this comment surprising and "harsh," she did not let it ruin her day. She went on to say, "I think I kind of just realized I needed to not let them walk all over me. Like I needed to speak up for myself and I think that helped me grow too." One of the simple responses to how negative experiences changed Kaelyn communicates with newer students was, "I guess I don't really bash them if they have a question or tear them down if they don't know something. I kind of just explain it to them." There was similar sentiment from other students who had negative encounters that influenced how they provided feedback to newer students. They recalled how they had felt when they were either talked down to or had negative feelings after a comment from a peer. This influenced how they communicated with peers moving forward to minimize the chance they would make others feel the negative way they had felt before. Chloe described how as a newer student, some of the upperclassmen had a "demeaning" or "know it all" attitude when discussing the concerns of her and her classmates. She felt, "Our concerns weren't valid because they went through it, they got through it, and so they think we're fine." For this reason, Chloe seeks out to be more approachable when she is put in that position.

Negative encounters or communication from upperclassman did run through the students' minds as they were working with patients. For example, when asked if Arizona would avoid seeking out help from a student who she's had a negative encounter with she said,

> No. Well if the other option was get another senior to help me then yes, I would avoid going to them. But if she's the only person, then I'd say no because I'm not going to mess up something just because she's a jerk to me.

Ultimately the students did not express completely avoiding peers they have had negative experiences with, but they do keep them in mind and act accordingly during future interactions.

Another example of how a negative learning encounter influenced future actions was described by Meredith. After practicing a learning scenario with her peers at her clinical rotation, she "definitely felt down for a few days after that scenario just because I felt like it was our fault for not understanding what they [upperclassmen] meant." Moving forward at the clinical rotation it was "hard" for her to get over those feelings, but she tried to be more upfront with the upperclassmen. For example, she stated things like, "Is this what you are asking?" to clarify what the other students were asking to make sure everyone was on the same page. Meredith was not the only student who expressed having to think about what she was saying to upperclassmen prior to saying it in order to avoid a negative reaction.

Each negative learning encounter the students had with peers influenced how they interacted with others in the future. Most often, if they were someone who was talked down to or the recipient of negative comments, they did not want to come across that way with others in the future. The result of the negative encounters was the realization of the type of communicator they each tried to be. Another component of communication was unclear expectations which will be explored next.

Unclear expectations. The importance in understanding the expectations of the clinical setting have already been explored. This section addresses what happens when communication breakdowns lead to unclear expectations and how these breakdown influenced student experiences. The miscommunication of expectations was most often in relation to preceptors and their ability to help students navigate their roles. Meredith explained how she liked everywhere

she's been, but there were a "few things about one that I would change, with communication." She stated,

> Not everyone was on the same page with everyone's roles. Whereas at every other spot, it was clear…and I think it was intended that way, but then the delivery throughout my whole experience there, it slowly went down and down and so then, like in the middle of it, we were kind of like "Okay, I don't know my role." It was just a weird, don't know how we got here, type of deal.

Chloe made a similar statement regarding preceptors ability to communicate with their students. In Chloe's experience,

> I think as a student that's very hard to navigate. I mean obviously you just go with the flow and you still do what you know what to do, but I think as a student especially, that's very difficult because you don't know if you should be doing more or if you should be more involved. If you should be trying to get all the new cases or if you should be stepping back and letting the other person who is not as involved take a chance on it or something like that.

Arizona expressed frustration when it came to the expectations of different preceptors. In her experience as a first year student she was "not supposed to do a whole lot," but at times had been asked to do things she had not been taught yet. This resulted in frustration and confusion as Arizona felt it was up to her to learn how to do these new skills, but then she felt like she would get questioned by preceptors as to why she was trying to learn new things. From her perspective, this resulted in frustration on both sides, as the preceptors and her tried to work out each person's roles and expectations.

Each of these experiences described how unclear communication from the preceptors made it difficult to know what was expected of the students. Although there was addressed reliance on using other methods to learn what to do, through peers and observation, the students' clinical experience would have been more positive if their roles were clearly understood from the beginning of each rotation.

Asking questions. When expectations were unclear, one of the structural components to clarification was the ability to ask questions. Creating a learning environment was centered around approachability and communication. Without approachability, the structure to ask questions was insufficient. Kaelyn stated, "I feel like all-in-all you have to be approachable because if you're not then you're not going to have good relationships with anybody really." This statement could be interpreted in both the relationships with patients or with preceptors, as both could be impacted by approachability. Not only do patients have to learn about their injuries, but students need to be able to learn from their preceptors and peers. In this way, one of the foundations of learning was approachability which made it easier for others to ask questions.

When it comes to how students experienced their ability to ask questions in the clinical setting, Chloe said,

> I feel like I've always been pretty comfortable with that and across different preceptors no matter where I'm at I still, I don't know, asking questions to me is a very important part of my learning process because if I don't know something and I watch somebody else do it. I want to be able to do it the next time knowing what I'm actually doing not just going through the motions. And so, I try to ask a lot of questions.

Meredith had a similar early encounter in her clinical experience. She stated,

> The first semester I felt like I could really ask anything which, I think, is kind of where you do start as a first year. You do want to just be able to ask anything and then you learn stuff along the way about where to necessarily start…And the whole time it's just been encouraging and they want you to feel like you can ask questions. Whether it be upperclassmen or preceptors. So, I think that the environments that I've been in haven't necessarily been pushy but that have had the "What you put in, you get out" feeling.

The students were aware of the role of asking questions to broaden their knowledge and understanding. Although this was not something that was always implemented right away, it was a concept the students learned to accept. As Norah reflected on her past experiences, she wished she had been more willing to ask questions. She described, "It will save you a lot of stress in the future. Of wondering 'Should I know this? Am I supposed to know this? Am I doing this right?'" There was a fear that limited her from asking questions because she "wasn't sure if I could basically." This fear could have been alleviated by a willingness to open up more and communicate with her peers and preceptors to determine what was expected of her. This experience demonstrated another example of the two-way relationship in learning, but the students also needed to feel comfortable enough to ask questions to aid their learning. Over time the students appreciated how important asking questions was to improving their experiences.

Discussion of Communication

Negative encounters with peers, most often described as specifically with upperclassmen, influenced their future interactions. Not only did they alter how they communicated with upperclassmen with whom they had a negative experience with, but it also influenced how they communicated with peers in the future. Through the negative experiences they were subjected to, the students discovered what type of communication was helpful to them and they tried to

implement those principles in future communication. Although the students did not express as many negative communication encounters with preceptors, the students still identified different weaknesses in preceptor communication with students. Often due to miscommunication, this led to students not knowing what their role was in the clinical setting which made navigating learning experiences difficult.

Another component that structured how students were developing their identity was their willingness and ability to ask questions. This relied on the approachability of other members in the learning environment, but with approachability came the ability to build relationships. When students felt more comfortable in their clinical environments, they were more open to asking the questions about what was expected of them and how to progress their education. As with some of the other points, this was not always a principle the students were able to grasp right away, but they learned to appreciate how it benefitted their learning.

As was hinted, communication and approachability impacted the ability to build relationships. These relationships hinged on a genuine interest in others well-being and impacts both the patient and the students encounters. Additionally, the relationships students have with others played a role in their confidence when working with patients. Each of these ideas will be further explored.

Building Relationships

Continuing with the idea of communication and its role to students' learning experiences, building relationships was another primary theme. Not only did building relationships help structure students' patient care experiences, but it also helped with their confidence in those experiences, or vice versa. Regardless of the direction in this relationship, there was a clear connection between the student's confidence and their patient care experiences. Lastly,

throughout their clinical education the students discovered how a genuine interest in the patient's well-being improves relationships. On top of that, the students described how their relationships with their preceptors influenced their learning environments. Together, the students learned to appreciate the interpersonal aspect of the profession.

Confidence and patient care. There was an identified dynamic between working with patients and students' confidence. The students felt confidence was important for patients to build trust; however, they also stated their confidence in themselves grew when patients trusted them. On top of this dynamic, there were the preceptors' interaction which influenced the trust of all involved parties. This section explores each of these dynamics and their role in building confidence.

One example of the interplay between patient trust and student confidence was when Norah described her clinical experiences. She stated,

> I think the fact that they, the athletes, trusted me enough to come with me helped my confidence a lot. It made it easier to make those decisions, just work with them because once you get to that point, you're not having to convince them that you know things.
>
> They kind of are to a point where they trust that you know things which is really helpful.

Not only did patient trust help her confidence, but she felt her confidence helped patients feel more comfortable. Sig expanded on the role of confidence in patient care when she said, "It was very nerve racking I would say. Anything that you do that you've never done before is very hard to fake confidence. Because that's a big thing with athletes is being confident so they trust you." Together these ideas demonstrated how building relationships revolved around confidence. Both students felt they needed to be confident in order to build trust and create a foundation for those relationships.

The role of the preceptor also influenced the patient relationships. In discussing how preceptors kept their distance during patient care experiences, Kaelyn described, “It shows the athlete that they trust you, that the preceptor trusts you, and it also helps us kind of learn more.” As a student, it helped Kaelyn’s patient care when the preceptors were not always directly watching because it showed both her and the patients there was trust in her skills. She continued, “If we don’t know/understand something or what we’re doing then we could ask them, but I don’t want them over my shoulder staring at what I’m doing either.” In this way, the preceptor giving the students more independence not only helped build the student’s confidence in themselves, but the students also perceived it as helping the patients trust them more.

As a student, Norah felt, “I think it’s helpful to be around preceptors who don’t need to have their full faith in you the minute you get to that rotation, but just having some confidence that you do know how to do some stuff and just, it’s hard.” Norah fidgeted as she was reflecting on experiences where she felt as if she needed to do everything right to avoid losing learning opportunities. She identified as an independent person and asking for help meant she was genuinely struggling with the task at hand. However, she had experiences where those tasks would be taken over by the preceptor she was working with whenever she asked for assistance. She valued learning opportunities and she felt like she was robbed of these moments which made her not want to work with certain preceptors in the future.

Confidence is not a skill that can be given to the students. Based on the students’ experiences there are numerous encounters that helped build confidence over time. Students felt their skills were trusted by preceptors when they were given more autonomy and patients who came to the students for treatment or rehabilitation demonstrated some level of trust. These trust interactions are both examples of little encounters that showed the students they should be more

confident in themselves. At the same time, the students felt there was a need for them to be confident in order to build patient trust. Overall the students demonstrated a conscious awareness of wanting to portray themselves as confident in front of patients in order to build trust, as trust was a structural element to relationships. Another influential aspect of relationships was the genuine interest in the well-being of others.

Genuine interest in well-being. One of the identified components of being an athletic trainer was being caring and compassionate. The students expressed how this did not just relate to the patients. From their experiences, the students described how preceptors who demonstrated a genuine interest in their well-being helped with their day-to-day interactions. Preceptors who showed a genuine interest in the students was another structural component of how relationships influenced their clinical education experiences.

When discussing the relationships Sig had made with her mentors, she identified some of the traits already addressed such as being "open" and "very verbal." Sig further described the different traits of mentors who she has appreciated. Sig stated,

> Probably somebody that can also give attitude. So, they're not just gonna be mad at you or anything. Like they can give you crap and then you can take it versus somebody just yelling at you and not saying anything to you.

This point demonstrated how the relationship played a role in the daily interactions between students and preceptors. Back and forth banter, as Sig suggested, occurred when Sig felt like she had a relationship with her mentor and there was an understanding of mutual respect. Relationships like this helped make for better learning experiences for Sig.

In her experiences so far, Meredith has learned the importance of athletic trainers showing interest in athlete's physical and emotional health. Meredith stated,

> There are a lot of other factors that can play into a mood that they're having or why they weren't performing as well during practice or a game. And the same goes for everyone. No one is different in that aspect. There are always multiple things that play into why a person acts the way they act. And so, when preceptors genuinely ask me "How are you doing?" or even "How are classes?" Because a lot of times it's strictly athletic training clinical setting only type stuff and so then when you get the people who ask about other life things, I think it speaks volumes compared to just what you have to say almost.

For her, she has noticed the similarities in patient care and how her interactions were influenced by preceptors' care for her well-being. These interactions helped shape how she approached patient care in the future. Norah had similar feelings with her experiences when she said, "I don't think that athletes want to come talk to you if they don't know that you actually care for their well-being." In Norah's experience, she has noticed the importance of caring about others and how it can help build relationships which improved future interactions.

Arizona's discovery of the deeper nuances of what an athletic trainer does changed how she viewed the profession and her future aspirations. When explaining her views, Arizona stated,

> Athletic trainers, you get to see your patients all the time. You get to see them go through practice, how they move, what they're doing. You don't just see them for the bad part, you see them for all the good parts. And it's such a bigger connection and relationship, so that definitely changed my view last year I would say because I didn't really, I knew what an athletic trainer was but now I really know and I understand it and I'm like "Yeah that's definitely where I want to go."

At the core of Arizona's experience with athletic trainers in the collegiate setting was the relationships with patients. These relationships were what set this profession apart from many

others, which she had not realized until she was working in this setting. The relationships were something that many students identified as to why they eventually chose athletic training. When they worked alongside preceptors who demonstrated how to build these relationships, they gained a greater appreciation for this skill and observed the role it played in providing patient's with a positive experience. At the same time, the students began to identify preceptors and mentors who made their well-being a priority, thereby building stronger connections and relationships. A genuine interest on the preceptors' behalf made the students learning environment more welcoming.

Discussion of Building Relationships

Although the role of each interaction was not fully clarified, the students identified how confidence and trust were essential structural aspects to building relationships with patients. Not only did their confidence in themselves help build trust with their patients, but the patient's trust in the students helped improve their confidence levels. The students experienced a reciprocal relationship between confidence and trust. On top of that, when the preceptor demonstrated trust in the students, by not always standing over their shoulder for example, it showed the patients they had confidence in the students' skills. There were multiple layers to confidence and trust between the students, patients, and preceptors, but how it influenced their clinical education was an idea which calls for further exploration. What was certain were the identified social factors which play into confidence as the students transitioned through different roles within their community of practice.

Building relationships was also centered around a genuine interest in the well-being of others. Not only was this one of the priorities of athletic trainers, but the students also identified this as a factor that helped influence their clinical experiences. Preceptors who took an interest in

getting to know the students were well received and the students appreciated those efforts. For both patients and students, building a genuine interest in their lives helped create relationships which influenced their learning experiences in the clinical setting. The last structural component identified was the social pressures the students experienced in their clinical experiences. Although building relationships were some of the positive aspects of their development, there were some social pressures which had mixed reviews. These social pressures will be further examined.

Social Pressures

There was an overwhelming response throughout the students about their interest in being right or their fear of being wrong. The different social pressures from preceptors, patients, and peers were identified by the students as influencing their desire to be right. Being pushed in by peers and preceptors helped students discover what they were capable of and often resulted in the students seeking opportunities to be more independent. As the skills developed and the knowledge continued to build, the students embraced opportunities to do more on their own. These social pressures were the last structural theme and it gave insight into how the students' interactions with others influenced their development throughout their time within the athletic training program.

Being right. One thing was certain. The students had an intense desire to be right or rather there was a clear fear of being wrong. Whether their fears reflected the thoughts of the preceptors, their peers, or the patients, the social pressure to succeed was a consistent presence. Some students described a fear of disappointing people, while other students were afraid of how they would look in front of their peers if they were wrong. The one component which appeared in a variety of forms was the anxiety and nerves that occurred when working with patients. This

anxiety hinged around the concerns with what the patient was thinking about the students' skills. Together these experiences shaped how the students developed throughout their education as they tried to meet the expectations of others.

Disappointing others. "I don't like to be wrong. I don't think anybody likes to be wrong," stated Chloe. When probed, many of the students shared similar feelings to Chloe. "But on the flip side of that, I like to learn and with learning is being wrong," Chloe continued as she elaborated her dislike of being wrong. She had learned to accept it more and understands the need to continue to grow within the profession which she thought, "I'm getting better at that. Slowly." Arizona exclaimed similar feelings about being wrong as she described how hard work always paid off in high school for her. "That's how my life was and then coming to college, you work hard and you're still probably going to get it wrong. Am I'm like 'Gosh this is a struggle for me,'" reflected Arizona.

Norah recalled her desire to meet the high expectations of the preceptors, which she said was her "biggest thing." She continued,

> Because I feel like if I do something wrong it then kind of turns into "Well what else don't you know how to do?" or "Why didn't you ask this question in class when we did this?" Or that kind of stuff. So basically, I just don't want to disappoint people.

When questioned further, Arizona came to a similar conclusion when she said, "I guess the answer would be I don't like disappointing people. That would definitely be, that *would* be the answer." Both students felt like their failure to perform to the standards of those around them would leave them a disappointment. To avoid this disappointment, the students described not adding as much to group discussions or minimizing the questions they would ask if they were

overwhelmed or unsure of something. On top of wanting to meet the preceptors' expectations were the peers the students worked alongside. Peers added different levels of pressure.

Peer pressures. "It's like a social thing, almost then," said Meredith when discussing how interacting with peers changed motivation to join conversations in the clinical setting. She described some of the peers in her class as being "beyond smart," but the social aspect influenced their participation. Meredith went on to say,

> Where it's not necessarily scared to join that conversation, but they might not feel like, I don't want to say at that level, cause I don't think it's a level. Almost more shy about it or scared that they'll be wrong. I think is probably the biggest thing. More scared that they'll be wrong, but for the most part I think everyone or the majority in my class feels like they can give their ideas whether or not it's right.

To her, it's not because her peers did not know the answer, it was whether they felt comfortable to put themselves out there. At times Meredith felt there was a stigma from the upperclassmen that the first year students knew nothing. In order to avoid playing into that stigma, she felt her peers would not say anything to minimize chances of being wrong and fueling the stigma. Arizona shed some light as to why they were afraid to try to answer questions. She described how she felt when her peers acted like they knew what they were talking about and why she avoided this type of behavior. She explained,

> There's people in my class where they're like "I know this," and then they fall flat on their face and I'm like "You looked so dumb right now." I know it's a learning experience but I'm sorry I'm not going to be like "I know everything."

Observing peers who were overly confident and failed to do things correctly has scared other students from putting themselves in that type of position, conditioning their experience.

Situations similar to what Arizona described provided insight into the structural components as to how students develop into a professional. Through experiences where they watched their peers fail, the students were conditioned to protect their own identity. They did not want to be seen as the first year student who did not know anything, so the result was being more cautious around peers in the clinical setting. Lastly and one of the most mentioned pressures, was the pressure to perform well in front of the patients.

Patient care anxieties. "I feel anxious and worried what other people are thinking or especially what my patient's thinking…," stated Grace. A majority of the students described how important the patient's view of their skills meant to them. One of the fears Grace had was if the patient was questioning her and thinking "She doesn't know what she's doing." Jack went a step further in his description when he said, "I just didn't want to make the wrong decision right away. Cause you're dealing with someone else's life. You don't want to mess up their life." The students wanted to be viewed by their patients as someone who knows what they are doing and will do the right things to make them better. This desire influenced their patient interactions, as it was continually in the student's mind.

With time, Grace recalled, "Going through this program [I] have realized the patients in the clinical setting know this is my classroom and most of the patients are awesome about it…They understand why we're there." She learned how to communicate with patients so everyone knew when a learning encounter was taking place. Through this communication, she did not need to feel as much pressure to test a new skill perfectly the first time. However, for newer and less experienced students, there was still a fear of what the patient was thinking about their skills.

There were comments relating to how students felt differently when learning in front of patients compared to learning in front of peers. Rae stated,

> A lot of times if someone else does something wrong and they're getting feedback, it's probably something I would have done wrong. So, I'm guessing other people would maybe do what I did wrong too…I feel like it's more of a learning thing when it's other kids in the program versus the athletes.

Even though there may be no difference in what was being learned, the presence of the patient changed how the students perceived the learning encounter. Grace had similar feelings as she stated, "Whereas the patient, they have that trust in us and confidence that we're going to help them…. But peers we know that we're in the same boat and learning the same things. So, we brush it off…" The students felt like the patient's expected them to know what they were doing, whereas their peers understood they were all constantly learning.

One thing that helped Matilynn was when the preceptors told her, "It's okay not to know. It's okay to have no idea what's going on." This helped with her future interactions as she reflected, "So I think that really helped, for me to once again with that self-awareness and self check-in, after they told me it's okay to not know things. Then I can tell myself that it's okay to not know things." The students had this initial idea where they had to know everything when working with patients, but being told this was not the reality of working in the clinical setting helped alleviate some of those worries in the students.

Being right conclusion. More often, students in the beginning of their athletic training education felt a need to be right. Initially, they described a fear of disappointing others as they most often wanted to perform up to their preceptors' expectations. They worked alongside their peers and did not want to be viewed as the student who was behind everyone else's skill or

knowledge level which provided additional pressures. However, when it came to getting feedback, the students described preferring this to occur in front of their peers as they understood the role of these types of interactions. Without a doubt, the students did not want feedback in front of the patients. There was an identified fear or anxiety accompanied with working with patients, as the students were consciously aware of what the patient was thinking about the care being provided. Although over time, some of the more experienced students described how communication with the patients can help ease the pressure when practicing or learning new skills. Overall, whether the pressure came from preceptors, peers, or patients, the students felt they needed to be right when they were in the clinical setting which influenced how they interacted with each of the respective parties. Although the fear of disappointing others was most often described as an internally defined construct, there was external pressure from peers and preceptors to do more at their clinical rotations.

Getting "pushed in." Taking advice was not as easy as it seemed, and sometimes it took a little push. Many of the students felt as if they were often pushed into learning in the clinical environment. Kaelyn described her struggle to take the advice because as she put it, "I felt like I didn't know as much, so then it was like I can't really do anything if I don't know anything." In situations such as this, getting pushed in helped students discover how much they actually knew. Arizona stated, "It's more you just gotta push yourself in… I've noticed if you don't jump in, they just grab you and pull you in anyway. Which is good. I think you need to be." Although Arizona was one to push herself in, she had observed how some of her peers need to be pulled in by preceptors or upperclassmen.

One example of how students have been pushed to do more was when Rae explained doing an evaluation on a body part that she had not done before or did not feel comfortable with. Rae explained,

> They kind of let me do as much as I'm comfortable with and then just being around if I have questions or if I miss something they'll be like "Okay, well you're skipping something. Think about what you missed." And if I can't get it they kind of help me. They push me to do it myself but then help me if I really need it, kind of thing.

When someone with more experience pushed her to do more but stayed nearby for help when she got stuck, she felt comfortable to do more. This idea was similar with numerous students as they described trying something new. Matilynn gave more insight into what these initial learning experiences looked like when she described,

> Another part would be just the fact that you're kind of thrown into the situation of having nothing but knowing how to tape an ankle basically… And so, I think it was that Sink-or-Swim kind of method that I think really helped to reassure the fact that you will never know what's going on. And it's okay. Cause it's like you're either going to sink in this constant worriness pool or you're just going to float on top of it and you're going to be okay with the fact that there's so many things going on that you have no idea. But you're just getting kind of, almost ignore it. And just go with the things that you know about.

From her perspective, getting thrown into the clinical setting was exactly what working as an athletic trainer will be like in the real world. There are many things athletic trainers cannot be prepared for, but they still need to be able to do their job. Sometimes this involves going with the flow and figuring things out as they come, and so in Matilynn's eyes it made sense why this was how she was introduced to the clinical setting. For her it helped validate her decision to pursue

athletic training as a career. Students did not have all the information they needed prior to working with patients; athletic trainers will not have experience with every scenario they could see. This is one reason the students felt their preceptors push them to do more, to start building those practical critical thinking skills early. Once the students were pushed into patient care, there was a shift in how they wanted their development to continue. They had a taste of what it felt like to work with patients, which fueled the desire for more chances to work independently.

Independent decisions. Throughout the student responses, there were multiple references to how being able to make independent decisions influenced their confidence in themselves. Multiple students identified the differences in preceptors, most specifically relating to the level of independence some preceptors allowed their students compared to the more restrictive styles of others. The students identified pressures placed on themselves to perform independently as they progressed through the program, as well as how the lack of autonomy limited their engagement and desire to do more. These types of experiences suggest how important independence was to the students in their progression.

As Jack prepared to enter his final year in the program he described, “I would like to get used to that and get used to making decisions on my own and not having somebody there to, kind of like a pacifier, to go to every time I need help with something.” Sig shared similar thoughts, as she said, “I mean that’s the goal anyways. When you leave you should be able to make those decisions. You shouldn’t be scared to make decisions.” The students understood how once they finished their education, they will not have that preceptor to fall back on. This realization fueled their desire for opportunities to practice those decision-making skills now, in order to feel more prepared for the real-world.

Chloe described herself as an independent person which was why she struggled with having someone tell her what to do. She was “not a big fan” of being told what to do. Chloe continued,

> I don't like getting my hand held all the time. I get sometimes when I'm scared or I don't know what I'm doing at first it helps, just to get your feet wet. Get your foot in the door type thing. After you kind of know what to do or where to go or who to ask then it's like OK, you don't need someone telling you what to do anymore.

Sig further explained why she did not appreciate always being told what to do. In her words,

> It's kind of like, I don't know how to describe it, I don't want to say it's crushing but it's limiting. Probably would be the right word because you're never making decisions and you're never doing anything different. You're just doing what you're told and then you're getting done with it, so you never want to do anything extra because you're already doing what's told, so why would you go out and try to do stuff extra if they're pretty much controlling everything else.

Although Sig felt limited in her actions when she had no independent choice, she did understand some clinical settings benefit from having structure. For example, Sig felt, “Football needs to be structured and there's really not room to figure it out. You kind of have to know what you're doing. Otherwise there's not going to be time to try to let people do other stuff.” Different environments lend themselves better to providing learning moments in the students’ experience. When there were a variety of moving parts, structure helped ensure everyone was on the same page, whereas smaller environments made it easier to adapt on the fly.

In Jack’s experience some preceptors were “more laid back and they’ll let you do more. Let you go out on your own more and then they’ll just check in with you.” There were

differences in preceptor characteristics, which Jack felt resulted in differences "on how independent or how you feel about making decisions. How free you feel about making decisions." Regardless of the setting or the preceptor interaction, the students desired opportunities to make their own decisions and learn from those actions. To the students, these independent actions will be what prepares them when they are athletic trainers. Depending on the learning environment, students put pressure on themselves to work independently to prepare themselves for the future. The pressure the students described was often internalized to be more active participants within their environment.

Discussion of Social Pressures

There were numerous social pressures which structured and influenced how students entered a learning environment. Students explained how the fear of disappointing others, the fear of looking dumb in front of peers, and the anxiety of what the patient thought about their skills were constant aspects when they were working in the clinical setting. Each of these components played into their desire to be right or their fear of being wrong. One thing new students often needed in the clinical setting was a little push. The students described getting pushed in as being helpful for them to better understand the world of athletic training and to get them performing skills they may not think they have yet.

The last component of social pressures stemmed from the students' internal pressure on themselves. The students placed pressure on themselves to make independent decisions to prepare for life after being a student. This internal pressure occurred more often in students who already had some experience and were transitioning towards being a central participant. They sought out chances to make their own decisions as they thought this was essential to prepare them for the future. Although there were benefits to the more structured learning environments

and times when students needed to be walked through things, at a certain point the students wanted the chance to test themselves and what they know. If they were constantly told what to do, the students did not think they would ever know the true extent of their knowledge and skills. Each of these pressures influenced how students entered and learned in the clinical setting.

Structural Essence

Students expressed communication concerns, the importance of relationships, and social pressures as structural components to their development in the clinical setting. The social influences embedded in each of these components highlight the role peers, patients, and preceptors played in the students' development. Not only did these influences positively influence students' confidence, things such as communication styles and a fear of disappointing others negatively impacted students' learning potential. As students were pushed into unfamiliar environments, they often felt the need to be right, however the openness of others to answer questions helped alleviate nervous or anxious feelings of being wrong. The students also expressed the importance of caring about patients' overall well-being and pointed out this genuine care for others did not stop with patients. A genuine interest in the students' well-being was helpful, as the students were more willing to reach out to individuals who were more approachable.

When the students described how they were experiencing their identity development, there was continual reference to the social interactions within the clinical setting. Learning how to communicate, building relationships, and the overall social pressures were all structural components to their development within a community of practice. Within a town, each neighborhood has its own social norms. These norms influenced how members approached and grew as individuals. The students discussed how different communication concerns and social

pressures influenced their learning environment. Without being explicitly told how a neighborhood functions, members felt like outsiders; similarly, when neighbors extended an open invite to ask questions, it was easier to feel like an active participant in the neighborhood or town as a whole. Social pressures pushed members to try to fit in to a new environment, but this sometimes required a push from members on the inside. However it occurred, the social influences of others impacted how new members developed their identity within the neighborhood. Without the internal pressure to become an active member in the neighborhood and the external assistance to get acquainted, feeling at home in the town was difficult.

Focus Groups Composite Descriptions

There were three composite themes identified from the focus group sessions. From the beginning, the preceptors stressed the importance of building relationships and learning how to communicate with other members within a community. Preceptors realized they needed to consider the students' mental health status as an additional factor to the construction of relationships. Mental health was necessary to be mindful of as the preceptors identified its role in the students' ability to learn. As the students were transitioning to different roles within the community, the preceptors shared how some of these roles and expectations changed. The preceptors expressed some concern as to how students take advantage of the experiences within the clinical setting and whether or not they grasped the full extent of the expectations. The connection of both the students and the preceptors responses was presented in the final theme which was the community of practice viewed from the perspective of a town. Each member shared experiences from their neighborhood with the clinical setting to get a better understanding of how the town as a whole functions. Ultimately, the triangulated essence of the identity development within a community of practice will be presented.

Building Relationships

Each of the focus groups discussed the role relationships played in the students' clinical education. Bob discussed how he tried to keep the students involved and pushed them to talk to the patients. He stated,

> I work with a smaller group than most, where it's a benefit for them to get to know the athlete. And I think that's a huge benefit for the students. To where they get to know the athletes to where they're comfortable. And I think that might be the downside of some of the sophomores when they come in just to observe. They don't get to know the athletes.

Over the years, Bob has seen how building relationships with the patients helped both the students and the patients feel more comfortable. Bob described how students who primarily observed and did not get to know the patients had a more difficult time learning because they do not get the chance to be involved as much. James described similar struggles with students who were not at the clinical rotation daily. In his experience,

> I feel like sometimes them not coming in every day will/might lead to them being a little offish and not wanting to get so hands- like they don't push themselves to get hands on cause maybe they don't feel comfortable enough coming in at different times, not seeing the same people. They don't build that rapport.

From James' point of view, there was a benefit for the students being around the patients consistently and building rapport. He felt they were more willing to push themselves to do more when they were working with a consistent group where they got to know the patients on a deeper level.

Another component of building relationships was the ability to communicate with others. Dave explained,

> I've always pushed the communication quality for everything….To work with your co-workers, to work with your athlete, to work with your coaches, to work with your administrators, to work with everybody…So I think that is one of the biggest things that students need to know.

Right from the beginning, Dave pushed students to at least get to know the athletes and just have easy conversations. In Dave's work as an athletic trainer, these basic conversations about school, classes, or things unrelated to their injury were what made it easier to have more difficult conversations in the future. The experienced preceptor group furthered the communication point as they described relationships with coaches and the importance it played in a student's development. Their views on communication with coaches is stated below:

> Bob: "It's important for them to have to deal with that unexpected question. 'What are ya doing for him?'"
>
> Lynn: "But you also have to have a coach that understands. You need to explain to the coach that I have students, they're educating, they're going to be making decisions, they're going to be part of the process, they're going to be communicating with the student athletes first before I do. If I say I don't know what's going on right now, I'll let you know. And I happened to have coaches that were fine communicating with with students and grill them and you know like literally grilled them probably."
>
> …
>
> Bob: "I think it's the person, it's also the buy in that they value or at least they're asking the question of you, instead of with me, and knowing that you're part of the

progression of this athlete coming back. I think it's a good buy-in from the athletic training student."

Grace: "And it's a transferable skill. There's always gonna be somebody above them….So when they get into the real world wherever that is there's going to be somebody that's more of an authoritative figure."

Bob felt the final step in a student's clinical education was the ability to communicate with the coaches, which was mirrored by others. As Lynn pointed out, there needs to be a relationship between the preceptor and the coach to ensure that everyone was on the same page regarding expectations. The ability to communicate with coaches reflects the ability to make decisions, think quickly, and demonstrated to the preceptor if the student was prepared to practice independently. When the coaches asked for the student's input or perspective, it helped the students build confidence. As the students were being questioned by a member from outside the community, it suggested they were a full member of the athletic training staff.

Although the preceptors addressed the importance of communicating with coaches, few students referred to these types of interactions. The explanation for this could be due to the fact that the students were more concerned with other aspects of their development but it could also point out a gap in the students' clinical education. Bob said its one of the final pieces of the puzzle, but even admitted he did not always remember to communicate with coaches to open up this path to ensure students were getting this type of experience. What was uniform throughout the preceptor and student responses was the role that building relationships was to providing patient care. Newer members needed to learn how to start a conversations, as they transitioned they began to build rapport and earn trust. This transition in communication prepares students to become a full member of the community; someone who understands the role relationships play

in being an athletic trainer in the collegiate setting. One piece effected an athletic trainers' effectiveness at building relationships, with both patients and students, which was mental health. Its role has more recently been brought up in discussions and was something that each of the preceptor groups touched on.

Student mental health. Another aspect related to building relationships was the role mental health played in the interactions with the students. Both groups discussed the role student mental health played in their clinical education. James stated, he tried to evaluate "their attitude, what they're-, how if they're stressed lately, [inaudible], and kind of forming your day around how they are. How much you can more information you can push on them before they just like they can't handle it…" Everyone agreed they think about mental health when working with students, however there was some discussion about how this dictated their learning. The preceptors had internal and external issues with whether or not the students attitude should be able to dictate their learning. There were concerns with the students' mental health hindering their ability to work in the clinical setting.

Grace explained why and how she handled students who may be dealing with mental health struggles. In her experience, "They're not prepared to be there. You've got 20 outside influences. They're not ready to learn; unable to learn that day because of whatever is going on in their head. You have a pointless day." When approaching situations such as this, Grace had found having the students do busy work away from others, such as filing or paperwork, was one way to keep them involved when they were having a tough day. However, if the students were struggling for an extended amount of time "it's having a discussion with them of what else can be done to help them."

One indirect component of student mental health was getting to know the students. In general, Ann explained,

> I think it takes a week or two to get to know the student and to see how they learn or what they work best at and facilitate it from there or push them to do the stuff that they're not exactly great at every day.

Without getting to know the students, she had found it was difficult to know how to best interact with them. Acknowledging a student's mental health was just one piece of working as a preceptor in the clinical environment. These comments correlated with how the students felt about preceptors who took a genuine interest in their well-being. The students acknowledged their clinical rotations were more positive if they had a preceptor who cared about their life outside of athletic training. They wanted a preceptor who tried to get to know them and they can joke around with which aligned with the preceptors who tried to make things fun.

Preceptors who were mindful of the students emotional well-being helped the students during clinical rotations. The goal of clinical education was for students to get real life scenarios to practice the skills they learned in the classroom. The next theme from the preceptor data related to the interactions within the clinical environment. Learning interactions revolved around student engagement, the expectations of students, and the preceptor involvement and each of these ideas will be examined next.

Learning Interactions

Throughout the preceptors' discussions there were a variety of learning interactions which influenced their clinical setting. One of the most prominent concerns brought up was the level of student engagement and their struggle to get some students engaged. Similarly, the expectations of students were discussed which helped provide some insight into the students'

experiences with communication. Lastly, the preceptors acknowledged their involvement in the learning process and how they approached learning in the clinical environment. These interactions were helpful in providing another perspective of situated learning.

Student engagement. The preceptors experienced learning being an unlikely result if the students were not engaged. Recently, the less experienced preceptors observed a student who changed her mind from wanting to be a physical therapist to now wanting to continue her career as an athletic trainer. When asked what reasoning they could give for the change, Dave stated, "I think it was the hands-on stuff that she got to do," which Ann confirmed. Ann continued, "She correlated it to she's had to go through physical therapy and stuff and she's like 'I did the same stuff, but I'm doing it now and I got to be a part of it.'" As James said, these experiences of being "in it" were helpful to help validate what the students were learning. This student's change of heart only occurred after she was given opportunities to join the community and became a larger participant in the learning.

Preceptors wanted students to be engaged and have these light-bulb type moments, but both groups of preceptors discussed concerns with students' ability to take initiative in their learning. There were issues brought up regarding how students approached their clinical education,

> Ann: "Yeah. We're going to give you the opportunities, it's up to you if you take them."
>
> Dave: "Right. And for me personally going back to our hands-on part, do I need to grab you and say, 'I'm going to do this now, pay attention.' Or are you going to be focused enough and say, 'oh he's doing something that maybe I can learn from.'"

There was a struggle between feeling like they needed to grab students to ensure they know when to pay attention and students just being more cognizant of learning opportunities. Dave continued,

> I think it's the reinventing of the focus though. They might be doing something else. You might be filling water bottles and an ankle sprain comes in. What's more important? Filling the water bottles or taking care of the injury?

Dave's comment pointed out the social role the preceptor played in teaching expectations in the clinical setting. Although the preceptors may demonstrate this type of mentality in how they interact with patients, from the experiences described it seemed as if the students did not pick up on these types of situations. Preceptors struggled with knowing whether they needed to or should verbally engage students in learning moments and teaching the students how to take initiative of their learning. Bob also described struggles with some students not being involved in the learning. He said,

> I don't think they enjoy the learning, the profession, anything about it, until they start getting involved. And I don't know if that's just only sophomores. I guess I've seen a couple of juniors that way too, to where again having to hold their hand to get them to buy-in or to do something. But once they get involved in it and then you see that they know what they're doing. But I think it's just that initial getting involved is, I guess I've seen that being an issue. Not very often but that would be one I think.

Both groups identified thoughts as to why some students lacked engagement. Grace stated, "We've got students that don't want to be an athletic trainer…have a different direction they want to go. So, they don't really put in the effort." Having students who do not want to be athletic trainers in the future was something that both groups identified as a barrier to clinical

education interactions. The preceptors struggled with putting in extra effort with students who did not demonstrate a desire to be engaged, especially if they did not have future plans of being an athletic trainer after they graduate. One aspect which is similar to student engagement was the expectations of students and how those were communicated from the preceptors.

Expectations of students. As the students progressed through the program, the preceptors had different expectations. Early on, the primary focus identified by the preceptors was just to get the students involved as much as possible. From things like filling water bottles to asking the simple question of "What can I do for you?" As Mas described, "Just forcing them to get involved." Lynn explained the role asking questions played in her interactions with new students. Lynn stated,

> First years, I communicate and explain a lot. I would have to say. They have a lot of questions. I don't know all the answers to their questions, but they have a lot of questions, so I try to communicate and explain.

There was clear acknowledgement of the communication required when working with new members of the community. Even when Lynn did not know the answers, she still tried to explain to the best of her ability how to navigate the new environment. Compare these expectations to how the preceptors expected the students to act in their third and last year in the program, Dave wanted the third-year students to "treat that [athletic] training room like it is theirs." One example of how Dave approached students in their third year is stated below:

> Cause you're at that point, especially when January comes around, where we're going to help you but we're kind of on the back side right now. Especially with her [Ann] with not having in-season. And then once our season ends it's like, this is yours. Take charge. Ask us to do stuff but take charge.

He expected the students to take charge and start making those independent decisions about how an athletic trainer functions. Bob explained his experience, which echoes what has been said by Dave. At his clinical rotation, Bob treats the third-year students as a full-time member of the staff. Bob stated,

> I think I'm in a unique situation for my senior students stays there the whole year. I think that's very unique and very helpful for the senior. To where I do treat my senior a little bit different as far as giving them the responsibility to run the [athletic] training room. To communicate with the consistent junior that's there for half a year…I think the students learn better from the other students. I think to a certain degree. Not about everything but to a certain degree. I guess I've found that the students don't like, I don't think they learn as much if it's somebody teaching them as an older person, an experienced person that is compared to a student who is there at that time understanding what their insecurities are their issues are. I expect a lot of the senior student to teach as well. So, I think there is a lot of stress for the student. For my senior student.

The students in their third-year in Bob's instance were given a lot of responsibility. The expectations were high, as these students were expected to help bring other students into this new environment. Grace brought up some concerns with this point. In the clinical setting she worked in, she also expected a lot of the second- or third-year students. She explained,

> I think sometimes with the upperclassmen that we think they know, but we forget we gotta explain more. So. Sometimes that does get left out but yes then you kind of assume they know some things. They've been around, they've been in that rotation, they've been with you before. Assume too many things sometimes.

One of the unexpected side effects of giving more responsibility to the students was that sometimes the preceptors were under the assumption the upperclassmen students knew what to do. Although Grace or the others in her group could not think of a specific example, the biggest thing they think the students did not grasp was the "why" behind things. The students have been in a certain environment before so they know how things were run day-to-day, but the application of their progress through the program was not addressed to acknowledge new expectations at a familiar rotation.

Lastly, there was the responsibility of the students to communicate with the preceptors. In Lynn's experience, students struggled to communicate what they have done due to nerves. She stated,

> They have to make a decision. And then we don't want to communicate with or the way we communicate with them is not…They perceive it as you're doing something wrong. They don't take it as a "this is a better way to do it" or something along those lines.

When these interactions occurred, she felt as if the students were trying to match every preceptor they worked with as opposed to building on what they have learned from other preceptors. Ann stated, "They just need to keep learning and there's different ways to do things….They need to form their own little tool belt." Ann believed this only happened if the students were open and receptive to learning from all their preceptors. The preceptors all expressed an interest in working with students who were not afraid to be open about their learning.

The preceptors addressed many of the similar experiences as the students. There was a similar progression in expectations from a beginner to a student who is in their final semester before graduation. Another similarity was the miscommunication of expectations. The students described there were times where they did not know what was expected of them, while the

preceptors acknowledged times where they assumed the students understood the expectations of different clinical sites. This represents a clear misstep in expectations and helped explain the students feelings. Communication with the preceptors also appeared to be an issue which would align with some of the social pressures the students described. There was a fear of disappointing others or making the wrong decision which the students explained held them back during certain situations. These social pressures helped provide insight into some of the preceptors experiences. Lastly, the preceptor involvement in the learning interactions will be discussed.

Preceptor involvement. As much as the preceptors believed the students needed to take the initiative to be engaged in their learning, they also understood the roles they played in the student's learning. Dave stated, "I always want them to ask questions. Right? But I want them to understand when it's time to ask good questions." Multiple preceptors agreed there was a right time for those conversations to happen. One of Dave's reasons for wanting the students to be conscious of when they are asking questions was to make the conversations higher quality learning moments for everyone. Dave continued,

> Instead of looking at that time, let's go back. Cause I think we *both* can learn how to, as a preceptor we can learn how to convey what we did, instead of just showing what we did….They saw it. Let's talk about it. And now you do it.

The preceptors wanted to make sure the timing is suited for learning. When a patient recently tore her anterior cruciate ligament (ACL) and was crying hysterically, James understood the value in the learning opportunity, however the patient's care took the priority. In this situation, he did not want to miss this opportunity for the students to practice their skills, but acknowledged there would be a better time to involve the students. Little moments such as these

present a social learning moment, when the students were able to observe how the preceptor managed the situation and how to care for the patient.

Bob described how his interactions were shaped to help the "patient to get some confidence" in the students. Through conversations outside the athletic training room with the patients and one-on-one talks with the students, together he helped the students create a plan. Bob recalled,

> [I] just remember way back when I was a student, the idea of having your preceptor over your shoulder. The comfort in doing that. And then the athlete wanting the more experienced person doing it all the time. So, I step back. I sit in my office and I watch and I listen and see. Listen to the interaction and then unless there's something that I'm concerned about as the athletic training student and the athlete are working together, I usually don't butt in unless there's something that needs correction.

Grace had similar sentiments in how she felt like she made the students nervous when she stood directly over their shoulder. Over the years, the preceptors have become aware of the role their presence played in student-patient interactions. They remembered what it was like for them as students when someone was directly overseeing them and the uncomfortable feelings they had. These previous experiences have shaped how they interacted with the students as they tried to build confidence in the students.

Learning interactions were a combination of factors. First the students needed to demonstrate a desire to be engaged in the learning. Engagement was often related to the expectations that are communicated to students. At times, these expectations were not always verbalized or were at times assumed which provides insight into why the students explained a misunderstanding of what was expected of them. Ultimately, the preceptor involvement set the

tone for the learning interactions. It was the preceptor's role to teach the students when these quality learning moments occurred and how to take advantage of them.

Town vs. Neighborhood

When both focus groups discussed what a community of practice looks like, there was a similar theme throughout. To put it broadly, Lynn said, "We all have the same vision, the same common goal. Same common goal for patient care and education, and we all somehow get there on a different path. With our own independence and decision making." The key similarity both groups discussed in reference to "independence" presented what this community looked like.

Dave initiated the analogy of a town compared to a neighborhood. From his point of view, "So the town, you know everybody in town right?... But you know your neighbors, you can stop over and say hi and be comfortable." Translated, Dave was comparing the individual athletic training rooms where all the preceptors work in as the neighborhoods and the Department of Sports Medicine as the town. Mas pointed out that "getting out to other people's neighborhoods would be a great asset," but he went on to further explain, "I tend to get tunnel vision when I'm working with my group. And so, it's not that I don't pay attention to what other people are doing, but I tend to just focus on my area." The other focus group had similar feelings, as Bob, Lynn, and Grace discussed,

> Bob: "…I think the athletic training room is a little bit different than our department. I think communication in the athletic training room is much better than our department as a whole. Really the only time that we collaborate or go over things is when they have official meetings. Me anyway because I'm on..."
>
> Lynn: "An island."

Bob: "....on an island, yes to a certain degree. But I think if you look at the athletic training room with myself and two to three to four students at a time I think that's treated a little bit different. There's more communication. Probably not as much as some. But I would think the staff collaboration is something that I think everybody's always said that we should/need to do more of. It's just the idea of getting everybody together. And maybe that's not the setting. Maybe it is more so the idea of a small little one on one discussions or whatever impromptu type gatherings. Maybe that might be a better way of doing it."

Both groups explicitly described the desire or benefit of increased interaction between neighborhoods, but the biggest struggle was getting everyone together. As full members of the community, the preceptors struggled to interact with other preceptors. Although the students are rotated throughout different clinical sites and work with a variety of preceptors, they were often exposed to only one or two preceptors at a time. This did not present an opportunity for students to fully observe how to collaborate with other members, as their experiences with the preceptors were often isolated to a particular clinical site.

When discussing student interaction, Bob stated, "I would say again the ones that don't get involved or they're hard to get them involved… they don't feel part of the team that way. They don't feel part of the sports medicine team….until they start getting involved." The preceptors explicitly identified the importance of getting their students to get involved in the community, but then did not manage to do the same for themselves as the preceptors stated they struggle with getting outside of their neighborhood. Although both Bob and Grace felt they work poorly within their town, Lynn explained,

Lynn: “I think we do OK. I do. I think we all do OK but we've all just got into a ‘we communicate well when we need to,’ I would have to say, and then we all just do what works for yourself. Like for ourselves. And that's how we survive.”

Grace: “Surviving is the answer….It’s not thriving, it’s surviving.”

Lynn: “I mean you just do what works for you. You do what works for the people you're in charge of, whether it is administratively, or whether it is your team, or whether it is whatever you have. I don't think anybody's role has been defined only as in within their teams I would have to say, but they just do what you need.”

When further questioned about what influenced their need to survive, time was the identified object by all the members of the group. The experienced preceptors stated how patient care was usually what takes priority because it was “time sensitive.” As Lynn discussed patient care, she stated, “The urgency and the urgency is what gets you. That takes priority.” In the experience Mas had prior to working at this institution, this focus on patient care and service had been beneficial; however, not only was this setting more spread out, but he feels like it had hurt him here due to service *and* education expectations. Compared to other jobs Mas had worked, this environment was more spread out, which means the preceptors were not in contact with each other as much. On top of this, there were multiple responsibilities outside of the service component of this job which made it more difficult. The preceptors struggled with the responsibilities to provide both service and education in the traditional classroom setting. With patient care, precepting, and teaching expected, the preceptors were torn as to how to manage each effectively. These multitude of roles help explain why the preceptors struggled to manage each of their responsibilities and more specifically why they had issues with their role as a preceptor in the clinical setting due to the urgency of other duties.

Preceptors Essence of Clinical Education

Athletic trainers working within the community of practice shared a common goal to provide high-quality patient care while simultaneously providing educational experiences to athletic training students. The department of sports medicine was a town, while each athletic training room was its own little neighborhood. They each had their own ways of communicating, but they all desired to accomplish the goal of the community. It was easier to talk to neighbors compared to someone from across town where there was little day-to-day interaction. The athletic trainers within each of these neighborhoods described getting tunnel vision, where their focus narrowed down to the time sensitive and critical components of their job, which was most often described as the patient care responsibilities, leaving student education as a secondary priority.

When it came to introducing new members to this community, there were a variety of communication styles used. With the new and less experienced members, there was more communication and pushing them to get to know other members within that community. Whether it be patients, peers, coaches, other preceptors, the goal for the newer members was to get comfortable communicating within this community. For more experienced members, sometimes this communication and clear set of expectations was forgotten because it was assumed to be understood already.

There were multiple barriers the preceptors identified from their experiences which influenced students' interactions in the clinical setting. Not only did the students have to be in the right mental state to learn, but they also needed to be willing to take the initiative to join the conversation. The preceptors have observed the students were nervous to communicate the decisions they have made, which made it difficult for the preceptors to provide feedback. The

level of preceptor engagement influenced the student interactions. Similar to their patients, the preceptors identified the value in building relationships with other members of the community.

Essence of Phenomenon

When moving into a new town, there were numerous factors which needed to be accounted. Through the help of neighbors, the introduction and socialization process begins as the new individual learns how to navigate the town. The comfort was felt within the neighborhood more quickly, where the social expectations were easily understood through consistent exposure. Observing how others interacted with one another helped identify the norms of the neighborhood, which should help prepare for the active involvement in the town, but does not account for different nuances of other neighborhoods. It took explicit communication of expectations to help further address the intricate aspects of the town, which were the responsibility of the more experienced town members. New members needed to take the initiative to become involved, but this required some direction as to how this could best occur. These guided experiences helped the new members transition to an old-timer within the town, ultimately with hopes of identifying as a member of the town enough to be able to call it home.

Conclusion

When bringing the student and preceptor responses together, communities of practice played a role in the students development. Students experienced a slow transition throughout their time in the clinical setting, with their roles evolving as they became more engaged within the community as they moved from the periphery to central, active participants. Ultimately, when the students progressed to feeling independent, they identified more as an athletic trainer versus a student. Miscommunication of expectations made it difficult for newer members to navigate each neighborhood and seemed to hold their progress back. More experienced members

were given the responsibility of bringing in the new members and taking a larger role in the community. Within these communities, social interactions played a prevalent role in the students' levels of participation. The next chapter will discuss the implications of these findings and make recommendations for students, preceptors, and athletic training programs to ensure students are experiencing high-quality clinical rotations.

Chapter V: Conclusion and Implications

In order to understand which areas athletic training education needs to adapt, the student perspectives needed to be further evaluated. Clinical education is a primary component of healthcare education and is where the students begin to develop their identity as a professional. This study explored the social influences in the clinical setting and how these influenced the identity development of the athletic training students. As peers and preceptors helped with the transition from student to professional, independence was one of the factors in the students identifying as an athletic trainer. This chapter will discuss the research questions and provide recommendations for athletic training programs, students, and preceptors. Lastly, the lessons from the research, implications for practice, and future research recommendations will be reviewed.

Conclusions

Identity development was fostered in the clinical setting when students were given opportunities to build independence in their decision making. Peers and preceptors helped introduce new members to what athletic trainers do on a daily basis. As students slowly began to learn the expectations, they transitioned from guided learning experiences to independent practice. The more independence the students were afforded helped their identity development, as these experiences within their clinical education were identified as the most impactful.

A constant in athletic training was social influences. The students noted their peers, preceptors, and patients all presented different types of social pressures. Through the relationships with each of these groups, students described how their learning was influenced by previous encounters. The preceptors pushed the students to build relationships early to improve the confidence both in themselves and in the patients. Although the preceptors pushed the social

aspects to help the students build confidence in their technical skills, one additional outcome was the socialization into the community. These relationships were beneficial in providing quality learning opportunities as they made it easier to ask questions and learn from others around them. However, there were negative social interactions which influenced how they communicated and worked with peers, while also creating a barrier to learning in certain instances.

This study's purpose was to explore anticipatory socialization in the clinical environment and how it influences identity development. Ten athletic training students completed a series of two interviews to get an in-depth understanding of their clinical education experiences. As a secondary component, two preceptor focus groups were conducted to triangulate the students' responses. Together the responses helped understand what experiences students were being exposed to in the clinical environment and the influence those settings had on their identity as an athletic trainer. Each of the research questions will be further examined next.

Developing a Professional Identity

The overarching research question explored how athletic training students develop their professional identity through social learning. Developing a professional identity was not something that happened overnight or with the flick of a switch, yet some students were able to describe specific moments where they felt like an athletic trainer. They had the feeling of being the most central participant within a community; that their opinion mattered and they were respected by those they work alongside. This development happened slowly, over time, and through learning with others in the clinical setting. As much as identity is internal, it was a heavily social experience for the newcomers to the community.

Students at all levels of their athletic training education figured out learning is a long process and as much as they would have liked to rush it, they needed to let it run its course.

Through watching, listening, and questioning, they were slowly absorbed into the community. As the students worked in the clinical setting, they learned what it meant to be a respectable professional and were given experiences to practice those observed traits. Bowman, Mazerolle, and Barrett (2017) found clinical education experiences built students' confidence, preparedness, and awareness of their skills and roles. In another study, graduate-assistant athletic trainers reflected they were more prepared if they had active, hands-on opportunities during their clinical education as students (Thrasher, Walker, & Hankemeier, 2018). Clinical education is where the students started to have these impactful opportunities to help prepare them for their future as a professional. Within these learning opportunities and clinical experiences came a variety of social pressures which impacted their experiences. Understanding these pressures can provide insight into how these experiences impact a students' learning.

The students most often expressed a desire to be right. Exploring these thoughts helped to better understand what pressures influenced their progression as they were developing their own identity as an athletic trainer. As newcomers to the communities, there was more emphasis on the external factors in development. Although the students described how they felt the need to perform in front of their peers and the preceptors, ultimately they wanted to perform their best in front of their patients. One explanation is athletic training students have been found to view the student-athletes as a support network. Satisfaction of social support from student-athletes was found to be a significant predictor of depression symptoms in athletic training students (Crutcher, Moran, and Covassin, 2018). This suggests athletic training students see the student-athletes as potential support systems which leads to more positive mental health outcomes. However, negative encounters or a lack of social support from the student-athletes could explain why the students were conscious of what the student-athletes thought during their interactions.

When it came to wanting to perform well in front of patients, the students described their confidence played a role in the patient experience. Either the patient's trust helped build the students' confidence or they felt the need to be confident before the patient would trust them. To further complicate the dynamic, it has been found that without the feelings of support from the student-athletes, the athletic training students' mental health outcomes decline (Crutcher et al., 2018) which could then alter their confidence in those situations. Relationships or rapport with the patients is beneficial for athletic trainers and can help during times of patients' emotional or physical pain by making it easier to discuss their problems or concerns. The preceptors explained how they pushed the students to build relationships with the patients to help make everyone feel comfortable in the working encounters, however the preceptors had found the newer students struggled to initiate patient encounters. The students' feelings on wanting to be right suggests the struggle to get students engaged could be influenced by the social dynamics of the clinical environment.

One way the preceptors eased the new students in to these social interactions was by having the students try to just talk to the patients. Clinical teachers of medical students identified a need to actively involve students, especially the less confident ones (Horsburgh & Ippolito, 2018). Before athletic training students need to know how to do anything, they need to be able to communicate and start building relationships. The implication here is the tacit skills, such as communication, are the first type of competency students are being exposed to within clinical education. These communication skills will come in handy when they build the knowledge base to work more in depth with the patients. If they have built rapport and trust gradually over time, suggesting competency in the social aspects of the profession, the students will be more equipped to excel at the technical skills.

Preceptor interaction can play a large impact on student learning (Thrasher, Walker, & Hankemeier, 2018), but time pressures can make this difficult (Horsburgh & Ippolito, 2018). Some students struggled to make these initial social encounters early in their clinical experiences and if the preceptor was busy with other tasks, the students were likely to continue to sit on the outside looking in. It was helpful for the new students to be introduced to communicating with the patients from the preceptors. Tacit skills such as how to communicate during an emergency or providing support to a distressed patient are social interactions that at times need to be explicitly described regardless of time constraints. Learning how to initiate a conversation with a patient may seem simple for the preceptors, but as a social competency it needs to be attended to like any other skill. As the students were conscious of a variety of social interactions, any effort by the preceptors to help facilitate early social encounters can help ease the transition to the community.

One way to help overcome communication or confidence barriers is through supervised autonomous experiences, with support provided only when needed (Carr, Timson, & Volberding, 2018). These experiences allow students to address and lead low-pressure cases, but helps provide valuable experience. Many of the students from the current study described how supervised experiences gave them the confidence to do more than they would on their own, which in turn provided them with a feeling of independence when practicing new skills. There was something helpful about having someone who observed their skills which gave the less experienced students the confidence to try new things. To create these supervised autonomous experiences, the preceptors need to have some level of trust, or the belief in the reliability, truth, ability, or strength, in the students. Supervised autonomous experiences demonstrated trust from the preceptor which helps explain why the students felt more confident to push past their

believed limits. Trust is essential to students feeling comfortable and with trust comes independent learning opportunities due to a decrease in the social pressures inherent in the desire to be right.

Throughout their education, students were transitioning through their identity development journey. Students at all levels were able to describe moments where they felt more than a student. Identity development is a constant work of negotiation of the self; it is constantly changing and evolving (Wenger, 1991). The negotiation of self evolves with more experience, but for the newcomers to the profession, students were influenced by the external factors. Each experience was a little different as the students grow to understand the profession at a deeper level. Newcomers used those early moments to compare their progress with those around them and it was often the social pressures that either hindered their initiative or fueled their performance. An early interaction may have given the students a feeling of belonging and these experiences built on each other as the students become more involved in their transition, thereby helping develop their identity. Members within a community or the oldtimers do not rely on these external factors to validate their roles. Their role within the community is accepted and with this comes the more internal reflection on the type of professional they want to be. This internal reflection came from the more experienced students who desired more opportunities to work independently and test their knowledge. Legitimacy comes from being given a specific role (Horsburgh & Ippolito, 2018), and the independence associated with these experiences will be discussed further in the next section.

Athletic Training Student Role Evolution

One of the secondary research questions was evaluating how the athletic training students' role within their community of practice evolved throughout their undergraduate

education. They start as outsiders, but upon entering the program begin to observe what it means to be a part of the community. With the help and guidance of peers and preceptors, these other members of the community helped the students slowly become a more central participant. Through these social interactions, the students were able to learn what is expected and how to be an active member.

Based on different preceptor characteristics, some students felt as if they were afforded more independence as they transitioned to their central roles, however some students explained feeling like they maintained their role on the periphery at some clinical sites. Medical interns had similar preferences, with a desire for more detail-oriented supervisors early and more autonomy as they gained confidence (Karp, Hauer, & Sheu, 2019). Similarly, these interns welcomed being observed or observing a supervisor during a task when it represented progress towards the student doing the activity independently. For this reason, different preceptor characteristics are appreciated at different stages of their education, with students preferring more guidance early and more independence as they progress. As students enter a new environment, they thrive when they have the support to get started and then desire the chances to demonstrate their independence and skill development.

Students described being pushed in right from the beginning and preceptors confirmed this was typically how they introduced students. One of the previously cited strategies for involving students was to challenge them, which can help the student overcome barriers of self-confidence and any lack of proactive attitude (Carr et al., 2018). The first thing many of the preceptors discussed promoting was getting the students comfortable communicating with patients, which the students also described as one of their first roles in the clinical setting. Appropriate trust from the supervisors promoted students' perceptions of being able to contribute

meaningfully to patient care (Karp et al., 2019). This would suggest if students are given appropriate trust from preceptors early in their experiences, such as basic skills or interacting with patients, they can start the transition towards becoming a member of the community from their first experience. Appropriate trust can be easily given to new students with early skills and it assists the students with their transition into the community.

As the students continued to have these guided patient-care interactions, with either peers or preceptors, they built their confidence and started to trust what they had learned. Clinical education experiences have been identified as a main component in the facilitation of role transitions for students, with supervision playing an important role in the preparation of future professionals (Bowman et al., 2017). Similar factors including academic rigor, active clinical opportunities, and their preceptors were found to facilitate preparation of athletic training students (Thrasher, Walker, & Hankemeier, 2018). A lack of effort to address these areas could result in their being a barrier compared to a facilitator for learning.

There were a few disjointed thoughts between some of the students and the preceptors. Specifically, at one of the rotations multiple students described not feeling like they had much responsibility whereas the preceptor described wanting the students to do as much as possible. These misaligned experiences could help explain why some students do not have the skills necessary to practice independently. Their clinical education experiences did not fully prepare them to be an involved member of the team, contrary to the statements of the preceptor. Although the preceptor exclaimed they wanted the students to be active participants, students did not feel like they are given opportunities to be active members in this setting. It is possible the preceptor had the right intentions, but when it comes down to actions, the patients were the main priority leaving the students behind. Doing as much as they can could also be interpreted

differently if there are low levels of trust in the students. A main contributing factor to learning in previous research has been the ability to perform skills as opposed to just gaining hours without hands-on, authentic experience (Thrasher, Walker, & Hankemeier, 2018). If the preceptor's view of engagement is doing what is told and accumulating hours, this would also explain the differences in opinions. Care should be taken to help re-align both parties in situations such as these to help ensure students are not just being exposed to, but are given practice in become an active participant within a community.

In the beginning, the students thrived with the help of those with more experience. It was helpful to learn from peers who had recently been through the same stresses or preceptors who have been in their role for years. As their comfort within the clinical setting increases, the students sought out opportunities to transition into more independent roles. These independent learning experiences were where the students begin to identify as an athletic trainer. Throughout each of these transitions, mentors play an influential role as the students navigate the new expectations.

The Mentor/Mentee Relationship

The other secondary research question of this study was to examine how athletic training students are experiencing the mentor/mentee relationship during their situated learning in the clinical setting. The students were exposed to a population of individuals who had skills they wanted to obtain. However, the students learned they were not going to be given all of those skills; instead of being explicitly told everything, their mentors were there to help guide them through their learning and they were going to have to put in effort too. Mentors are vital to learning not only knowledge, but also ideas, values, and attitudes to help shape students' identities (Marañón & Pera, 2015). Mentors are the ones who can help fill the gaps of the social

expectations to push the students to build their own philosophy as a professional. Both preceptors and peers were influential mentors and communication played a large role in these interactions. Another structural component of these mentor relationships was the genuine interest in their well-being and an awareness of students' mental health.

Throughout their descriptions of their mentors, the students most often referenced preceptors as being the people they looked up to. The students expressed an overwhelming desire for mentors who demonstrated a willingness to teach. Marañón & Pera (2015) studied nursing students and discovered a mentor's willingness to undertake their role and their rapport with students was essential, even more highly desired than the nurse's knowledge or teaching skills. These findings align with the current study, where the students were looking for mentors who took the time to teach in the clinical setting. One explanation for the students' desire to work with someone who is willing to teach them is the previously discussed need to be right and journey to find confidence. The students were socializing with athletic trainers who exhibit the skills they want to possess, which would make sense why they seek individuals who are willing to pass on the knowledge they have acquired over the years.

The preceptors discussed the initiative they were looking for in students; rather than feeling like they had to pull people into learning situations, they wanted the students to recognize when a learning opportunity presented itself. Horsburgh and Ippolito (2018) found most students "recognized the need to be proactive about identifying and creating their own opportunities for practice" (p. 6). Based on the perspectives of the preceptors and students, the question remains if the students know how to act on these opportunities. From the interactions reported on both sides, the students still waited to be pushed into learning experiences from preceptors or more experienced peers. It is unknown if the students from this study could identify these

opportunities, but one justification for the preceptors' feelings would be the social pressures the students reported such as their fear of disappointing others or making a mistake in front of a patient. When the students feel confident doing things such as the nominal daily chores, it is easier and less scary to continue to focus on these tasks than to open up an opportunity where they could be wrong in front of the preceptor, peers, or the patient.

Communication was another theme that influenced mentor and mentee relationships. Although only one student explicitly mentioned peers having potential to be a mentor, many of the students discussed the learning encounters they had with other peers. These encounters would all suggest the students look to their peers as individuals to help guide or share their learning, which is exactly how they described traits in potential mentors. Karp et. al (2019) reported that the relationships between students and near-peer supervisors seemed to promote a two-way dialogue, where the supervisors provided open and honest feedback and the students could voice uncertainties and ask questions. The more experienced preceptors from this study, as well as some of the students, brought up a similar point where it was often easier for students to learn from other students. As they are at more similar points in their education and typically similar in age, it was easier to take feedback and suggestions from their peers.

One of the notable sub-themes from the student responses was how negative peer encounters influenced how they communicated with peers in the future. The students were surrounded by peers in the situated learning environment, so it is not surprising that these negative peer encounters resonated with them and made them reflect on what type of peer they wanted to be in the future. Whether the students explicitly acknowledged their peers as being mentors, their comments suggest the impact their peers play into their development. Henning, Weider, and Jones (2008) reported athletic training students perceived learning a moderate to

large amount of their clinical skills from peers. In the current study, the negative experiences often lead the students to wanting to improve their communication, suggesting they see themselves transitioning into the mentor role throughout their education. They desired being the peer they would want to learn from and altered their communication to meet those expectations.

Another aspect of communication which influenced the relationships with students was the lack of clarity in expectations from some of the preceptors. The students, especially the newer ones, expressed concern with how some of the preceptors communicated expectations. Appropriate trust grows from initial discussions about expectations for specific tasks, where students never feel like they are thrown in without preceding discussions on their prior experience and the steps of tasks (Karp et al., 2019). The preceptors in the current study did acknowledge they sometimes struggled to communicate expectations, while others explained that they leave a lot of that up to the older students. This represents a gap in what the students are seeking and what the preceptors are providing in the clinical setting. Unclear expectations and role clarification could explain why students have difficulty adjusting to new positions after graduation.

The students desired preceptors who did not need to have full trust in them right away. Clinical education is designed to provide opportunities to learn and grow through direct patient care guided by a preceptor (CAATE, 2018), but some of the students' perceptions of what was expected of them by preceptors is concerning. Some students felt they were supposed to know more than their education allowed, while others were not trusted to advance their participation level. Both of these issues are alarming and represents a gap in student-preceptor interactions. Medical interns thought trust empowered them to be open and honest with their supervisors about their comfort level in performing different tasks (Karp, Nathan, Hauer, Karen, & Sheu,

2019). Athletic training students in this study had similar experiences, where the ability to ask questions helped ease stress of performing tasks they were not prepared for. The perception of over-trust occurred when supervisors were too busy or overwhelmed, which resulted in inappropriate level of readiness or lack of clear guidance to the interns (Karp et al., 2019), which some of the athletic training students also experienced. It is understandable how trust cannot be automatically given to all students, but without open dialogue or low-risk opportunities to build trust, students will continue to learn where it is comfortable which is often from the periphery.

One last theme was how the relationships between the preceptors and students influenced their experience. The students described appreciating preceptors and mentors who took a genuine interest in their well-being. All the preceptors mentioned their efforts to be aware of the students mental health to ensure they are prepared for learning, although some explained differences in accommodations. The less experienced students appreciated the preceptors who sought to learn more about them besides just athletic training related topic; the more experienced students valued the relationships they had built with the preceptors. One study found that undergraduate athletic training students' perceived stress levels were moderate and one-third of the sample's scores were above the cutoff score which would indicate risk for clinical depression symptomology (Crutcher, Moran, & Covassin, 2018). These results demonstrate the applicability and necessity of the preceptors' attention to athletic training student mental health. Findings such as these suggest there is a need to be conscious of the mental health of the athletic training students.

The effectiveness and efficacy of social support has been shown to help perceptions of stress and depressive symptomology, with family and fellow athletic trainers contributing the most to predicting levels of perceived stress (Crutcher, Moran, & Covassin, 2018). When

preceptors are supportive, levels of stress decline which is why building those relationships with students is beneficial to their learning. Not only can the relationships help with mental health, but faculty and students have alluded to mentoring relationships in the clinical setting assisting the transition to practice through open dialogue (Bowman et al., 2017). Together these ideas highlight the role of mentors as a support system for athletic training students. Whether or not it is intentional, social interactions within a community of practice influence how a member is able to transition to a central participant. When members genuinely cared about the well-being of others within the community, newcomers personally experienced and were socialized to understand this as an expectation.

Communities of Practice and Social Learning in the Clinical Setting

One of the problems being explored with this research was what anticipatory socialization looks like and how students are being prepared for independent practice. The preceptors in this study came up with a metaphor to describe their experience within a community of practice which provided the framework for analysis. If the community of practice is a town, what was found from the present research was the students were being exposed to individual neighborhoods. The members within the communities described difficulties communicating with everyone in their town. There was great communication within their neighborhoods, but this did not extend to the entirety of the town. The struggle to get out of their own neighborhood could help explain why previous research has found that recent graduates struggle when they are introduced to a new setting or town (Aldret, 2018; Pitney, 2002; Pitney, Ilsley, & Rintala, 2002). The students here were learning from individuals who identified struggling getting off their island, which might have bigger implications for the profession as a

whole and not just recent graduates. If experienced members of a community have issues, it is no wonder the new members fail to meet the totality of expectations.

Within these neighborhoods, the preceptors unanimously felt like patient care was their main priority. The urgency of the patients' needs puts the athletic training students in a secondary position, which the preceptors discussed as a struggle they did not know how to address. The resulting struggle stems from preceptors wanting students to know when to take advantage of a learning opportunity and feeling like they needed to push or pull the students in. From the preceptors' perspective, if the students want to join the community they should be able to recognize the urgency of patient care situations and jump in themselves; however, based on the student experiences, the social pressures and fear of being wrong seemed to be holding them back.

The level of independence afforded to students was dependent on their clinical rotation and suggests there are concerns for the placement of students into appropriate clinical sites. Although there were strengths to certain preceptor styles, such as the structure at football helping introduce new members or the expectation of third year students to run the athletic training room at other sites, student placement and experiences need to be intentional. Varying levels of preceptor trust makes it difficult to ensure that anticipatory socialization prepares students for their role as an athletic trainer. Professional socialization was the most important factor perceived to impact diagnostic reasoning (Kicklighter, Geisler, Barnum, Heinerichs, & Martin, 2018). A lack of or ineffective professional socialization, along with real time constraints, were the largest barriers to diagnostic skills. This further explains some of the benefits of the role of socialization and how it can be used to help prepare students. Independent practice through socialization helps students improve their skills and thought processing, but requires the trust of

the preceptor in order to implement with patients. Regardless of the clinical site, the role of socialization, independence, and trust needs to be understood by all parties to ensure students are afforded appropriate experience.

Athletic training students identified feeling like an athletic trainer when they were given independence and an opportunity to think for themselves. Even students just wrapping up their first year in the athletic training program stated having experiences of identifying as an athletic trainer, which bodes well for the future of athletic training education as program length will likely decrease with the transition to entry-level master's. Students felt better prepared to assume their roles when preceptors allowed them to conduct evaluations, make decisions, and determine treatment plans under supervision and with feedback (Thrasher et al., 2018). It is not the number of years in the program that students need to feel like an athletic trainer, it is the *experiences* within those years. Identifying as an athletic trainer was the result of perceived independence in decision making situations, while those who have not felt like an athletic trainer described a lack in competence or skill development. Each of those factors can be altered by different types of preceptor interaction.

Ultimately, membership within a community translates into identity as a form of competence (Wenger, 1991) and it is up to the members of the community to demonstrate and provide opportunities to build this competence. The students from this study expressed external social factors as influencing how their role within the community progressed. Newer members were constantly comparing and adapting to how to fit within the clinical setting. Whether it was the experiences they were having with peers, patients, or preceptors, the newer students were trying to figure out how they fit in and how to find safety in their future experiences. Once the students became central participants and had their roles validated by members within the

community, the external social factors were less influential on their identity. There was a sense of belonging within the community where they no longer felt the need to compare with others, instead they were able to look inward as to the type of professional they desire to be.

Communities of practice provide the foundation to what it means to be a professional, but students need to be given opportunities to join that community. Lave and Wenger (1991) described the difference in talking *about* and talking *within* a community. Talking about athletic training from the periphery would likely lead to the oversimplification of athletic trainers as water boys/girls and the people who tape ankles. Talking within a community requires a full understanding of the depth of the profession and how to act within this group. The purpose of clinical education for newcomers is not to learn from talk primarily as legitimate peripheral participants; it is not enough to just be told what to do and watch from the outside. The more students are held on the outside, filling water bottles and completing other nominal day-to-day tasks, anticipatory socialization will be less likely to prepare them for their future roles. Students need to be in the thick of it, making decisions and learning from their mistakes in a safe environment with the guidance of others.

Although the students expressed how observation helped them learn what the normal is, the encounters which left a lasting impression were the ones where they were central to the learning. It was developing a rehab plan, managing conflict among their peers, or progressing an athlete back to participation which made an impact. “It is to learn to talk as a key to legitimate peripheral participation” (Lave & Wenger, 1991, 109). As the students become an active part of the conversation, they build their ability to talk about *and* within a community. Not only do they learn how to talk with the community members, but they are more motivated to join the community when they are given opportunities to practice as a legitimate member.

Whether or not they explicitly realized it, the students described numerous peer interactions in relation to their learning in the clinical setting. This suggests peers play a larger role in absorbing newer students into the community of practice than may be understood. Peer socialization was an unexpected aspect which was a central dynamic within the communities. Although the more experienced students described how the preceptors helped introduce them into the new neighborhoods, after the initial expectations were passed down, it was up to these students to do more of the introduction of the newer students. If students are doing more of the introduction to the community, this could help explain why students are not prepared to meet the totality of expectations from employers (Aldret, 2018). Students are often concerned with obtaining technical skills thereby those are the skill they are most likely to pass down which helps explain the limitations of new graduates.

Lave and Wenger (1991) explain situated learning activities are transformed into legitimate peripheral participation and is motivated by newcomers' desire to become full participants. The current research supports this idea. As the students gained exposure to learning experiences in the clinical setting through their interactions with peers and preceptors, they desired independence to practice their hand at being an athletic trainer with help nearby when needed. Building an identity is worked out through practice, as social discourse introduces newcomers to narratives, categories, roles, and positions through experiences of participation (Wenger, 1991). Clinical education presents newcomers to these types of social experiences to create their identity, with the most defining experiences occurring when the preceptors offer some autonomy to the students. With each of these experiences, the students were able to slowly adapt to the learning process as they navigated the external social influences to develop their idea of what it means to be an athletic trainer.

Lessons for Future Study

Throughout the research process there were multiple lessons learned which deserve being studied further in the future. The primary limitation of this study was the singular athletic training program which was included. This singular program only gave insight into a narrow view of how communities of practice function and how peers interact with each other. A secondary limitation to this single program was the higher percentage of female student participants in the study (90%). This was partially due to the higher percentage of females within the studied program (74%) which is higher than the national average for baccalaureate athletic training programs (63%) (CAATE, 2019). Future studies should seek out more of the male perspective to see if it aligns with the predominately female voice of this study.

This study also only included clinical experiences in the collegiate setting. Considering athletic trainers work in a variety of healthcare settings, it would be beneficial to include clinical experiences in other environments. Likewise, the preceptors were all in employed in the collegiate setting so there was only one perspective of these roles. It is possible that students are exposed to different types of learning, for better or worse, in other settings which should be explored. Broadening the scope to different practice settings would help athletic training programs determine where the highest quality learning moments are occurring and whether it is the preceptor or the clinical site that influences the students' learning more.

Implications for Practice

As athletic training education embarks on the transition to entry-level masters, there are takeaway points for all included stakeholders. In general, athletic training programs need to evaluate the clinical sites and opportunities within those locations. Qualitative research provides a more in-depth exploration into the student experiences and with this insight preceptors can

evaluate how they are interacting in their roles. Preceptors represent the professionals the students look to as they begin learning what it means to be an athletic trainer. This puts preceptors in a unique situation to help build relationships with the students and guide them into the professional world. For athletic training students, there needs to be a willingness to put themselves out there and to take full advantage of all the presented learning opportunities. Each stakeholder needs to recognize the role they play in helping prepare the future of athletic training.

Recommendations for Athletic Training Programs

If the profession wants to prepare students to be able to make decisions and communicate effectively, they need to put a greater focus on what this preparation looks like from the student perspective. The role the athletic training program has when it comes to clinical education is primarily how it prepares the clinical preceptors. Every education program's curriculum has its own structure which will present pros and cons, but considering the identity development is most often occurring in the clinical setting, more focus should be placed on these social encounters. Students and preceptors need to understand their role in the learning process and should be prepared accordingly. By explicitly explaining the expectations of both the students and the preceptors, athletic training programs can set the stage for the clinical setting.

Preceptors need to be consistently reminded of the influence their interactions have on the students' clinical experiences. If preceptor training is only occurring annually, there should be some sort of checks and balances to ensure the preceptors' focus does not drift away from the students when it gets busy. These checks and balances should be initiated by the programs to have the preceptors reflect on their experiences with the students and create professional goals for themselves. Time is already a major concern so finding ways to streamline the load and

maximize the student experiences are essential. Whether it is for professional development or for student feedback reports, the preceptors should be asked to reflect on their interactions and create goals for themselves in relation to their students.

Students have multiple roles during their clinical education and it would be beneficial if these roles were explicitly explained throughout the process. Early on, the students need to understand what is expected as they transition through their new clinical experiences. Participation will vary depending on the student's level of education or the specific clinical site. For this reason, it is essential for both the program faculty and the preceptors to clearly communicate the expectations. If all involved stakeholders assume someone else is providing these explanations, the students will be left with incongruencies in their roles. One of the preceptors in this study admitted she assumed the students who have been at her clinical site in the past needed little introduction upon their return. The flaw in this assumption is a student in their first-year in the program is going to recall and be exposed to different components compared to a third-year student. On top of this, based on the student responses each clinical site provided different levels of responsibilities which would influence how prepared a student would be to step into a leadership role. As students progress through their program, it is often expected they will be the ones who introduce new students to the day-to-day functioning of the clinical setting, but depending on the students' current understanding or level of comfort, this transition could present multiple barriers if their previous experiences kept them on the periphery. In order to avoid these types of assumptions, each student should explicitly have the expectations communicated to them within a clinical site.

As program structures shift, curriculum changes take place, and clinical education opportunities evolve, it is essential for programs to think about the experiences influential in

helping the students grow into professionals. There needs to be an emphasis on supervised autonomous practice to provide chances for the students to make decisions in a controlled manner. If the students are not getting an opportunity to practice independently, under the supervision of their preceptor, they will struggle to feel prepared for their new roles after graduation. Students need to feel like they have choice regarding their actions and this is where the autonomy comes into play. As students in this study explained, when they were constantly told exactly what to do, their initiative decreases. Independent thought helped the students feel like an athletic trainer, so it is up to programs to find ways to create these experiences. Athletic training programs need to instruct preceptors how to implement these clinical teaching techniques to provide more autonomous practice, such as working with low-stakes cases and providing continual feedback, both positive and constructive, on students' skills and attitudes.

At the same time, the role peers play in the clinical setting should also be considered. The current study discovered the students spend a lot of time learning from and with their peers, with the more experienced students often recognizing their role in helping prepare the newer students. Athletic training programs need to embrace this peer-directed learning as it provides valuable experience for both peers in the learning scenario. If more explicit emphasis was placed on peer learning, newer students may not have as many issues with learning their roles. Peer-directed learning in the clinical setting or problem-based learning in structured peer groups would help prepare the more experienced students with an opportunity to practice their communication and other skills which would be expected in their roles after graduation. Coordinating group learning activities from the classroom to align with clinical sites is another way initiate peer-directed learning. Better communication and guidance through expectations of all stakeholders could help alleviate role incongruencies.

Recommendations for Athletic Training Students

Most importantly, students need to get out there and get in a position to start making decisions early and often. Unfortunately, as the students expressed, this is often easier said than done. After observing something in the clinical setting or learning it in the classroom, students should step up and ask for the opportunity to try it themselves. The moments when students started identifying as an athletic trainer were when they were afforded opportunities for independent learning. There will be experiences that are out of the wheelhouse of a student, but in those instances they need to become an active observer. One piece of active observation is learning when and how to ask questions. Peers should be used as references for how to join conversations, yet again demonstrating the influential social component of the clinical setting. Each of these skills will support the transition from the periphery to becoming a central participant. Students need to take every opportunity presented to learn from people who know what they are doing. Observing, assisting, and eventually practicing are what clinical education is created to do, but it takes effort by the students to choose how much they want to take away from those experiences. Without a conscious effort to become active within the community, identity development will be stunted.

One constant in any healthcare profession and the creation of professional identity is social influences. Whether it is the patients, administrators, supervisors, parents, coaches, peers, there will inevitably be some sort of social pressure present throughout this profession. The one thing that can be changed is how each of these pressures are addressed. The students need to learn how to be an advocate for themselves, their patients, and other members within their community. When an athletic trainer can stand up for themselves and what they know, the pressures do not matter. One step in advocacy is confidence and the place to start building

confidence is in the clinical environment as a student. Students are surrounded by people who want them to grow and succeed, so they should not let the social pressures and the fear of failure limit how much they are putting themselves out there.

Creating an environment where this growth can happen is up to everyone within the setting. Peers' and preceptors' attitudes and communication styles give feedback to the students regarding the safety within a learning space. If the students do not feel safe, whether due to condescending tones or negative remarks, the social pressures can overpower their willingness to try. When students learn how failure is involved in the growth process and are placed in an environment where failing is embraced, the true development can begin. The first step in learning how to fail is actually trying new things and then seeking out feedback. If students can learn how to master these skills early, they will be exposed to more opportunities to practice autonomously and create their professional identity.

Recommendations for Preceptors

Whether it is conscious or unconscious, students develop a professional identity through unconscious patterning of behaviors. Although it is more desirable if the role models were explicit in this process, unconscious patterning will consistently be present (Cruess, Cruess, Boudreau, Snell, & Steinert, 2015). This idea is especially true in the clinical setting for athletic trainers when there is not always the preferred time to explicitly discuss all aspects of the profession. Therefore, preceptors should be aware of the demonstration they are making to the students. It is understood there are time and urgency constraints which preceptors struggle with which makes it difficult to ensure they explicitly pass on their knowledge to the athletic training students, but even if there is not the explicit attention to the skills and tacit components, students unconsciously start patterning what they observe. If there are traits the preceptors observe in

students they do not see as professional, it is essential to look inward and reflect on themselves to identify if the students are just mirroring those around them. For example, if the students communication style with patients is unprofessional, this may be due to how the students have observed their preceptors communicating with patients.

There could be other explanations for students' motivation and observed traits. As discussing mental health concerns becomes more socially acceptable, preceptors will need to be prepared to face those situations. Although learning how to identify patients with mental health concerns and emergencies is something athletic trainers learn to do, when it is the athletic training students they are working with, they often do not have the same formal education in management strategies. As stress and depression symptomology have been identified in athletic training students (Crutcher et al., 2018), preceptors should be prepared to help the students manage these concerns to create a high quality learning environment. Being mindful of students' class load, monitoring their disposition, and making a conscious effort to be approachable are ways preceptors can improve their relationships with students. When concerns are observed, it is up to the preceptor to approach the student and develop a plan of action. Although the patients are often seen as the priority of athletic trainers working as preceptor, the actuality is the management of the mental health of students is no different than managing an injury. Identify the problem, communicate concerns, develop a plan, and seek help when the scope is outside of their management capabilities. There is no reason preceptors should ever feel as if their students concerns are any different than the patients they provide service for on a daily basis.

Although it is acknowledged that clinical experiences are designed to prepare students for the real world where adjustments and accommodations may not be easily addressed in the workplace, the fact of the matter is they are still students. As role models and mentors,

preceptors are in a position to help the students learn how to manage their mental health. The point of clinical experiences is to give them opportunities to learn, but if their mental health is not allowing them to engage in an experience, it typically is not worth it for them to remain in that situation. There is obviously some standard that needs to be set to simulate what it means to work as an athletic trainer, which often entails long hours and unexpected schedule changes; however, the difference is the students are just beginning to be exposed to this world and it may take some extra assistance to learn how to manage those expectations. Learning these management strategies to adapt would be better as a student than if they are working by themselves in a different setting with an unknown support system.

Summary of Recommendations

All stakeholders need to be consciously aware of their expectations. It is up to the athletic training programs to lay out those expectations and communicate the standards for each role. Through preceptor training and structured peer learning, programs can develop the structure needed to provide positive learning environments. Students need to be active participants in not only their own learning but in helping their peers develop. Although they can learn through passive participation, the moments which help shape their identity are when they feel they can independently make decisions. The earlier the students learn to put themselves out there by trying new things and learning from their mistakes, the quicker they will start to shape their future as a professional. Lastly, the preceptors need to understand how influential they are in the clinical setting. Whether or not they have time to explicitly include the students in learning experiences, the students are constantly taking in what they are observing. When preceptors acknowledge their mistakes, create an environment built on open dialogue, and try to build relationships, the students pick up on those things and can feel comfortable pushing themselves

in. If students do not feel safe to make mistakes in the clinical environment, their learning opportunities will decrease and it will take longer for them to feel like a member of the community.

Recommendations for Future Research

One unanticipated relationship in this research was the influence the patients played on the athletic training students' clinical experience. Although it was understood they would be working closely with this population, the results of this study suggested the patients are influential in the students' professional identity development. The students had a variety of social influences, but it was the patients who seemed to one of the primary components in validating their identity. Future research should further explore this relationship between the students and patients to try to uncover how this influences professional development and their transition to independent practice.

There was disconnect between some of the student and preceptor responses which should be explored further as well. Many preceptors described feelings of having to pull students into learning experiences opposed to the students recognizing those situations on their own. The students expressed concerns of ability and if they knew the material to participate, however this does not explain why they do not step up and become more active participants. One thing that should be further understood is how preceptors in a variety of settings are introducing students to these learning opportunities. Although the preceptors feel like they have to pull the students into learning scenarios, this could just be the nature of welcoming new members to the community that needs to be acknowledged. The other factor which could be influencing these experiences is student motivation and if this is why preceptors feel like they are pulling more than embracing learning opportunities. Exploring how the student motivation levels are influenced by different

clinical sites or preceptors is another area that could provide helpful insight into their development. Based on the current research, it could just be the variety of social pressures which influence motivation, but it could also be the students' and preceptors' inability to identify learning moments. It was also identified how when students were not given independence in decision making, their motivation to put in extra effort diminishes. A look into preceptors' level of control as perceived by the students and the preceptors would help clarify why there are misunderstandings of clinical expectations.

Lastly, further evaluating the external and internal social factors that influence identity development should continue to be evaluated. The current research found that students still building their identity were influenced more by external factors. It would be beneficial to take a longitudinal look to explore in depth how the shift between each of these factors influences athletic trainers. By further examining how and when the external factors influence identity development as students transition into practice, athletic training programs and preceptors could better identify how to facilitate the transition. There will inevitably be a need to have both external and internal factors, but ideally strategies can be developed to combine the roles they play in teaching students what it means to be an athletic trainer and what kind of athletic trainer they want to be.

Appendix A

Student Interview Protocol 1

1. Define athletic trainer.
2. Picture a well-respected athletic trainer, what qualities does this person exhibit?
3. Tell me about your life as a student that has led to this point. Why did you choose athletic training?
4. Walk me through a typical day in the clinical setting for you as an athletic training student.
5. How have you been introduced to a new clinical rotation?
    a. How did peers interact with you in this new setting?
    b. How did preceptors interact with you when you started?
6. Imagine you are at your clinical rotation and you are performing a skill or technique you learned in class.
    a. What did this look like the first time you performed that skill? How did this change with each subsequent performance?
        i. What do you do?
        ii. How do you act?
        iii. Are other students involved in the process?
        iv. What does your preceptor do?
7. How are decisions made within the athletic training room?
    a. How are you involved in the decision making process?

Appendix B

Student Interview Protocol 2

1. Explore more in depth about relationships from the clinical environment that were brought up in Interview 1:
    a. Peer interactions
    b. Preceptor interactions
    c. Participant role in those interactions
2. If you think about when you are performing a new skill, what type of feedback would help you?
    a. Now think about performing a skill you have completed numerous times and feel very comfortable with. Would feedback still be helpful? If yes, what type of feedback would you prefer? If no, explain why not.
    b. Describe a time when you got feedback from a preceptor or another student. How did the feedback make you feel? Did it help you perform the skill better the next time?
3. Define professional identity.
    a. Imagine an emergency scenario that is well handled. How does the certified athletic trainer handle the situation?
    b. What qualities or skills does this person exhibit?
4. During you clinical education, has there been a time when you felt like an athletic trainer vs. an athletic training student? What made this experience different?
5. What is a mentor?
    a. What characteristics draw you towards a potential mentor?

    b. Can you give me an example of a specific encounter you had with a mentor that stood out to you.

6. Where do you see your professional self in five years?
    a. What qualities or traits will do you value and hope to embody as a professional?
    b. Has this view of your future self changed throughout your education? How so?
7. Knowing what you know now about working in the clinical setting, what advice would you have given to yourself on day one in the athletic training program?

Appendix C

Focus Group Protocol

1. Introduce yourself and how long you have been working as a clinical preceptor?
2. What does your title as athletic trainer mean to you?
3. Describe your daily interactions as a clinical preceptor. What is your philosophy behind interacting with students?
4. A community of practice is a group of people who share a profession. Either formally or informally created, members practice with a shared understanding of values, norms, relationships, and create their identity within that group.
    a. Describe what that community looks like in your eyes.
    b. How do you function within that community?
5. How do you introduce students to this community?
    a. How do you approach 1st year students?
    b. How do you approach 3rd year students?
6. When thinking about social interactions with students, what qualities or characteristics make the ideal student in the clinical setting?
    a. Can you describe an interaction with a student that possesses these characteristics?
    b. Can you describe a time when working with a student was difficult? What factors played into the interaction?
7. Imagine you are observing a student perform a skill for the first time on their own. How do you go about providing feedback or corrections? Now think of an experienced

student performing a skill they have previously demonstrated mastery, what type of feedback does this student receive?

8. If you could pass on any qualities or skills to your students, what would these be?
9. What is your ultimate goal for students when they reach graduation? Share a moment with a student where you feel like you reached your goal.

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