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THE EXPERIENCE AND PROCESS OF THE WORKING ALLIANCE IN COLLEGIATE ATHLETIC TRAINING

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COLLEGIATE ATHLETIC TRAINING

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Abstract

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As healthcare evolves to consider the psychosocial effects of injury and disease on patient well-being, attention has turned to patient-provider relationships. Heightened attention to the significance of this relationship necessitates healthcare providers shift to a patient-centered model. One foundational model, the working alliance, emphasizes emotional bond, collaboration on goals, and agreement on tasks between patient and provider. Despite emphasis on a working alliance in healthcare research, conceptual understanding of the components of athletic trainer-patient relationships in collegiate athletic training remains unexplored. In this grounded theory study, six participants completed two rounds of semi-structured interviews guided by the research question: What is the collegiate athletic trainer's experience and process of developing a working alliance in athletic training? The results from this grounded theory study emphasizes how athletic trainers create and enter patient and coach relationships and move through the care process, and their experiences with patient investment and ever present environmental, place, and person factors that broadly influence athletic trainers efforts to develop patient relationships and provides a guide to integrate a working alliance into athletic training practice. Bolstering care contracts with informed consent and adapting patient education supports patient understanding, involvement, and facilitates collaboration. Rapport, connection, and trust are essential to developing patient relationships and an emotional bond. Navigating care as partners and educators enhances athletic trainers ability to collaboratively establish goals and agreement on tasks, provide patient-centered care, and improve working alliances. Effectively managing patient resistance helps athletic trainers encourage adherence and buy-in. Drawing attention to establishing and navigating skills most beneficial to training clinical preceptors enables them to model and introduce these skills' value and importance to athletic training students sooner during education. These results also offer a framework to guide education and skills training in Athletic Training Programs, connecting athletic training students with skills that enhance clinical learning and patient-centered care experiences before professional practice. Knowing when, how, and where working alliance skills surface in athletic training patient care enables counselor educators to enhance current proficiency and introduce focused skills training in the athletic training discipline, which may also enhance bond formation, gaining agreement on goals, and collaborating on tasks, thus supporting development of a working alliance.

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CHAPTER I

Conceptual Context

As healthcare evolves, the patient-provider relationship has become essential when considering psychosocial impacts of injury and disease on patient care and creating successful outcomes (Bachelor & Horvath, 1999; Leach, 2005). Of recent interest is the patient-provider relationship's connection to efficiency of healthcare delivery (Elvins & Green, 2008; Holman & Lorig, 2000). Increased attention to the significance of this relationship necessitates healthcare providers shift to a patient-centered model grounded in mutual respect, collaboration (Mead & Bower, 2000), and attention to psychosocial aspects of health and well-being (Engle, 1977; Fuertes et al., 2007).

In psychotherapy and counseling, the therapeutic relationship is accepted as an independent contributor to patient outcome and is considered essential to the healing process (Gelso & Carter, 1985; Horvath, Del Re, Flückiger, & Symonds, 2011). The therapeutic relationship is a partnership embodying how patient and provider think and feel about each other and the influence of these thoughts and feelings on collaborative efforts towards a common goal (Gelso & Carter, 1985). Empirical research on the therapeutic relationship over the last three decades continues to show a consistent relationship with patient outcomes, regardless of specific intervention (Horvath et al., 2011; Martin, Garske, & Davis, 2000). It also accounts exclusively for a modest amount of variance in treatment outcome, elucidating its connection to patient care and positive therapeutic outcome (Horvath et al., 2011). Though widely accepted as foundational to psychotherapy and counseling, the therapeutic relationship has application beyond the boundaries of counseling (Meissner, 2007) and is relevant to healthcare delivery.

Healthcare professions have begun to embrace psychotherapy literature and the therapeutic relationship as a practical approach to improving delivery of care and patient outcomes. Presently nursing, medicine, occupational therapy, and physiotherapy/physical therapy are exploring patient care through the lens of the therapeutic relationship. What these professions are finding is that attending to the therapeutic relationship improves patient satisfaction and outcome across physical healthcare and medical settings (Fuertes et al., 2007; Gyllensten, Gard, Salford, & Ekdahl, 1999; Holman and Lorig, 2000; McCabe, 2004; Palmadottir, 2006; Redfern & Norman, 1999a, 1999b; Szybek, Gard, & Lindén, 2000).

One healthcare profession not found in therapeutic relationship research is athletic training. Daily interaction and close proximity throughout sport participation places athletic trainers in a position to develop relationships with and hold significant roles in the lives of patients (Granquist, Podlog, Engel, & Newland, 2014; Wiese-Bjornstal & Smith, 1999). Simply recognizing the importance of an athletic trainer-patient relationship (Fisher, Mullins, & Frye, 1993), and identifying skills such as rapport, trust, interpersonal communication and listening skills as important to patient care (Fisher et al., 1993; Raab, Wolfe, Gold, & Piland, 2011) does not always parallel athletic trainer confidence in using these skills to create and adjust relationships to patient needs (Clement, Granquist, & Arvinen-Barrow, 2013; Stiller-Ostrowski & Hamson-Utley, 2010; Stiller-Ostrowski & Ostrowski, 2009). In addition, psychosocial strategies, tools meant to support treatment and rehabilitation goals and success, and facilitate rapport and personal connections, are often underutilized in athletic training (Hamson-Utley, Martin, & Walters, 2008; Washington-Loufgren, Westerman, Sullivan, & Nashman, 2004) and

inconsistently applied (Clement et al., 2013; Larson, Starkey, & Zaichkowsky, 1996;

Wiese, Weiss, & Yukelson, 1991). Moreover, though previous research in athletic

training identifies skills and qualities that influence patient care (Fisher et al., 1993;

Granquist et al., 2014; Malasarn, Bloom, & Crumpton, 2002; Raab et al., 2011), there is

no direct reference to the therapeutic relationship.

      The benefits of forming a therapeutic relationship in healthcare are evident, yet

there is little to no research on the integration of the therapeutic relationship in athletic

training. It is unclear how athletic trainers build relationships with injured patients and

the quality of these relationships remains unknown. The remainder of this chapter

addresses the lack of research that examines relationship development between athletic

trainers and patients. I will first present literature that breaks down the theoretical

construct and practical implications of the working alliance in psychotherapy. I will also

consider how it has begun to be integrated into healthcare and other healthcare

professions, and bring attention to the gaps in the athletic training literature about the

process and development of a working alliance with patients.

      In the following review of literature, I addressed information regarding the

importance and clinical significance of relationship development between healthcare

providers and patients and the impact on patient outcomes. I reviewed research from the

fields of psychotherapy and various healthcare professions to uncover the development,

relationship, and impact of the therapeutic relationship on patient care and outcome.

Available literature was critiqued within the current framework of relationship

development in athletic training and the existing lack of attention to the process of

developing a working alliance. I then identified and presented implications for athletic

trainers and counselor educators after the review of literature. Next, I introduced the

reader to how this review of literature, in addition to my personal and professional

experience, informed my conceptual context and social embeddedness within this

research. This apprises the reader of the need to facilitate relationship development and

attend to the working alliance in order to generate positive therapeutic outcomes and

guide the establishment of effective training and educational programs. Finally, I provide

a conclusion and a brief introduction to my methodology.

The Working Alliance

Formed between a person seeking change, and an agent who facilitates change,

Bordin (1979) describes a working alliance as a necessary, if not the most important,

aspect of the change process. Defined by Bordin (1979) as a three-dimensional and over-

arching therapeutic factor, the working alliance consists of three foundational constructs.

These constructs include a) forming an emotional bond, b) agreement on goals, and c)

collaborating on tasks. In essence, how a bond is created and what is done to facilitate

goal agreement and collaborating on tasks are inextricably linked (Norcross & Lambert,

2011). Further, placing emphasis on consensus and process of reaching agreement, as

opposed to provider manipulation of expectations to facilitate change, suggests the

concept of the working alliance is applicable to other relationships.

While other less specific concepts, such as the therapeutic relationship, appear in

the literature and are theoretically related to the working alliance, it is not conceptually

the same. Greenson (1967) initially described the therapeutic relationship as attending to

three components: a) the working alliance, b) transference and countertransference, and

c) the real relationship. Believing that all relationships consist of these components,

Gelso and Carter (1985) assert that each of these elements can serve varying levels of importance, dependent on provider approach. However, the interpersonal value of the working alliance consistently positively impacts helping relationships (Horvath et al., 2011), and is considered the cornerstone of relationship development (Bordin, 1979).

Foundational to relationship development, the working alliance underpins the relationship formed between patient and provider. Providing theoretical clarity to the term relationship, Gelso and Carter (1985) defined relationship as emphasizing the feelings and attitudes patient and provider have towards one another and how they are expressed, rather than emphasizing selection and implementation of specific interventions. Attending to the personal relationship between patient and provider allows the provider to uncover patient desires, and collaboratively develop goals and tasks that address the physical and psychological needs identified by the patient (Mead & Bower, 2000). A working alliance must first be developed, but increased attention to quality and strength of the working alliance augments effectiveness of care and further influences therapeutic outcome (Bordin, 1979; Crits-Christoph & Connolly Gibbons, 2003; Connors, Carroll, DiClemente, Longabaugh, & Donovan, 1997; Gelso & Carter, 1985; Horvath & Bedi, 2002). If relational acts and treatment methods occur simultaneously, the relational construct of the working alliance may enhance care delivery and therapeutic outcomes (Sommers-Flanagan, 2015). This compels provider awareness to initial development and supportive maintenance throughout the therapeutic process.

Rapport, empathy, and interpersonal communication (active listening, open ended questions, acknowledgement and understanding of implicit and explicit meaning, reflecting, and summarizing) are counseling skills that form a foundation for relationship

development (Kottler & Brown, 1996). Collectively, these relationship factors set the stage for cultivating a bond (Sommers-Flanagan, 2015). Uncovering patient needs hinges on communication skills and responsiveness that lets patients know they are heard, understood, and valued (Leach, 2005; MacDonald, 2003). Trust and rapport become paramount to forming a bond and encouraging accurate conceptualization of patient needs and realization of effective treatment (Bordin, 1979; Williams, 1998).

Therapist conditions are not the only force that creates change; mutual liking and understanding, and a collaborative relationship where patients contribute to care are also essential (Hougaard, 1994). A core assumption of the working alliance is that it is dynamically reciprocal and interactive as it develops over time. The adaptive aspect of the working alliance manifests by jointly identifying and creating goals, which promotes a sense of partnership in care and supports patients' ability to adapt and persist (Bachelor, 2013). Aligning goals encourages providers to empathically listen to patient needs and problems and identify outcomes that are a priority to the patient (Sommers-Flanagan, 2015). Once patient goals are prioritized, tasks that are specifically relevant and useful to achieving these goals can be selected and implemented. However, tasks must be applied collaboratively and within the context of a relationship with emphasis on how tasks are integrated rather than which ones are selected (Sommers-Flanagan, 2015). Accurate use of relational factors, joint development of patient centered goals for treatment and rehabilitation, and support of collaboration between patient and provider on selection and implementation of tasks strengthens patient-provider relationships and impacts patient outcome and success (Crits-Christoph & Connolly Gibbons, 2003; Horvath et al., 2011; Wampold, 2000 in Fuertes et al., 2007).

The Working Alliance in Psychotherapy. Empirical research on the influence of the working alliance on patient care over the last three decades continues to identify a positive connection to patient care, and accounts for a modest amount of variance in treatment outcome (Horvath et al., 2011). Instilling trust and confidence allows providers to conceptualize and relate to patient experiences, positively enhance relationships, and influence outcome. Provider attributes and therapeutic relationship factors such as empathy, positive regard, non-possessive warmth, and congruence or genuineness when communicating with patients can account for as much as 30% of patient improvement (Ackerman & Hilsenroth, 2003). Simply displaying qualities that enable patients to feel understood and appreciated further emphasizes the influence of the patient-provider relationship as an independent contributor to outcome (Connors et al., 1997; Horvath & Bedi, 2002) and its role in the healing process (Gelso & Carter, 1985; Horvath et al., 2011; Martin et al., 2000). Apart from the working alliance's wide acceptance in psychotherapy and counseling, relationship development and attention to a working alliance between patient and provider apply beyond the boundaries of the counseling profession (Bordin, 1979; Meissner, 2007). The working alliance is at once "an ubiquitous and universal, as well as essential, perspective" for healing efforts (Meissner, 2006, p. 264). The broad application of the working alliance to support patient care highlights its significance and relevance to healthcare research and delivery across many allied health professions.

The Working Alliance in Healthcare. Though initially conceptualized in psychotherapy and counseling literature (Bordin, 1979; Gelso & Carter, 1985), the working alliance has slowly been translated to the healthcare arena. The patient-provider

relationship has become essential when considering psychosocial impacts of injury and disease on patient care and creating successful outcomes (Bachelor & Horvath, 1999; Fuertes et al., 2007; Leach, 2005). While the therapeutic relationship has been variably defined, Cole and McLean (1994) offer the following definition related to healthcare; "a trusting connection and rapport established between therapist and client through collaboration, communication, provider empathy, and mutual understanding and respect" (p. 49). In an effort to draw the attention of medical providers to the relevance of a relationship with patients and its impact on therapeutic outcomes, Leach (2005) completed a review of medical literature examining rapport and its relationship to patient care. Leach (2005) concludes that patient-provider relationships established with trust and effective communication can become a driving force behind patient motivation, compliance, and satisfaction, pointing to a connection between relationship factors (rapport, trust, and communication) and therapeutic outcomes. Moreover, healthcare delivery's efficiency increases through active participation and shared decision-making between patient and provider (Elvins & Green, 2008; Holman & Lorig, 2000). As such, pockets of healthcare professions have begun to explore patient care through a psychosocial lens by integrating the theoretical constructs of the therapeutic relationship and working alliance into treatment and rehabilitation.

Medicine. Current conceptualization of patient centered care now includes attention to both psychological and physical aspects of health (Fuertes et al., 2007). Research in the medical field has focused on communication, characteristics of providers, and the influence of the patient-provider relationship on outcome.

Physicians can begin to alleviate distress by attempting to understand patients'

expectations, fears, and personal conceptions of illness or injury (Mead & Bower, 2000).

In addition, provider characteristics may influence patient care and the perception of the

patient-provider relationship (Crow et al., 1999). Possessing and incorporating these

characteristics into patient care can provide another approach to support outcome.

Humanistic qualities such as compassion, empathy, and caring have the potential to create

a healing environment (Halstead, 2001), which may enable physicians to better

understand the needs and values of the patient (Bensing, 2000). Building strong patient-

provider relationships is contingent upon communication between both parties. Effective

communication allows physicians to gain an understanding of patients' experiences and

needs. With this understanding, physicians can provide relevant information that enables

patients to collaboratively decide on care (Dorflinger, Kerns, & Auerback, 2013).

Tailoring communication and education to what patients' see as important and relevant to

their current situation (Bensing, 2000) helps transfer control to the patient. Valuing

patients as contributors to their healthcare relates to enhancing motivation for change,

self-reliance, compliance and adherence (Dorflinger et al., 2013; Fuertes et al., 2007).

This has the potential to further promote patient satisfaction and positive outcomes

(Arbuthnott & Sharpe, 2009; Fuertes et al., 2007).

Fuertes et al. (2007) found a moderate to strong correlation between the

therapeutic relationship and its perceived utility for patient outcome. This indicates that

to the extent that therapeutic relationship factors are present in physician-patient

interactions, they may influence patient satisfaction, adherence, and perceived

effectiveness of care. Valuing patient input and facilitating collaboration in treatment and

management decisions can play a role in further strengthening physician-patient

relationships (Dorflinger et al., 2013). Furthermore, ensuring patients have adequate

knowledge regarding treatment tasks and processes can enhance patients' belief they can

successfully engage in rehabilitation tasks (self-efficacy) (Fuertes et al., 2007). Two

domains are essential for attending to the strength of the physician-patient relationship.

First, the emotional domain, relates to developing trust and liking, and second, the

process domain, relates to establishing collaboration on tasks and agreement on goals.

Attentiveness to both the emotional and process domains of patient care influences the

strength of patient physician relationships (Fuertes et al., 2007).

    Nursing. A cornerstone of the nursing profession is provision of care that supports

and provides for basic human needs (Burhans & Alligood, 2010). Nursing care is

provided in a range of conditions within a variety of in-patient and out-patient settings.

Effective use of interpersonal skills such as listening support and empathy helps build

relationships rooted in trust and rapport, necessary components which enhance

therapeutic effectiveness and accurate conceptualization of patient needs (Fosbinder,

1994; Williams, 1998). Respect for and protection of the patient is central to provision of

quality nursing care. Recognizing the importance of patients' varied and distinct needs,

and tailoring care toward patients' physical, psychosocial, emotional, informational, and

other wishes is necessary for individualized care (Williams, 1998; Redfern & Norman,

1999b). Patient perception of how nurses meet their needs is an important consideration.

While patients want their emotional needs to be met, they also desire autonomy and

personal control. Actively involving and including patients in goal development and care

plans enhanced patient perception of quality care and self-sufficiency (Lymer & Richt,

2006; Redfern & Norman, 1999b; Williams & Irurita, 2004). Positive outcomes appear to hinge on the nurse patient relationship, and the extent to which patients' physical and psychosocial needs were met (Williams, 1998). Respectfully listening to and uncovering patients' needs and interests allowed nurses to advocate for and facilitate patient choices and desires (Burhans & Alligood, 2010).

Occupational Therapy. Provision of patient centered care and relationship development has become a central theme for the professional practice of occupational therapy (Canadian Association of Occupational Therapists, 2002 in Palmadottir, 2006). Research on the importance of and attendance to the therapeutic relationship reveals similar outcomes to other healthcare professions. Rapport, open communication and collaboration, and appropriate use of empathy allows occupational therapists to build strong patient-provider relationships, which is seen as vital to professional practice (Cole & McLean, 2003; Taylor et al., 2009). Norrby and Bellner (1995) propose that occupational therapists can effect patient outcomes simply by seeking to understand patients' needs and wishes, effectively communicating the theory and meaning behind therapy, and collaboratively working to identify patient strengths to enable autonomous function. Once patients' needs and access to available resources is understood, skill development in effect can become collaborative, effectively shifting control from the professional to the patient (Palmadottir, 2006). Appropriate use of these skills may allow occupational therapists to guide patient outcome and develop effective therapeutic relationships (Norrby & Bellner, 1995).

Physical Therapy. Specific to physical therapy/physiotherapy (henceforth referred to as physical therapy), interaction between physical therapists and patients

during treatment and rehabilitation is likewise central to promoting health benefits and

positive outcomes (Gyllensten, Gard, Salford, & Ekdahl, 1999). Evidence exists that

therapeutic relationships between patient and provider help providers facilitate

collaboration and patient motivation for enhancing health outcomes (Szybek et al., 2000).

Belief in the interpersonal strength and value of the working alliance is similarly reflected

in physical therapy outcome literature. Physical therapists maintain a strong belief that

clinical experience, professional responsibility, and mobilizing patient resources by

developing a quality patient therapist relationship is more likely to contribute to outcome

than use of a specific treatment (Stenmar & Nordhold, 1994). Creating a therapeutic

relationship between patient and provider comprises rapport building, educating, and

communicating. Interpersonal communication skills, empathy, friendliness, active

listening, and valuing and including patient preferences in treatment decisions, relate to

developing a positive bond (O'Keeffe et al., 2015). Honesty helps build trust and

rapport, which physical therapists consider necessary to patient care (Tracey, 2008).

　　　　Øien, Steihaug, Iversen, & Råheim, (2011) found that checking to ensure patients

had an accurate conceptualization of both verbal and non-verbal communication provided

by the physical therapist, and that messages were understood in the manner in which they

were intended, were critical aspects of quality care. In addition, quality of interactions

between physical therapist and patient may be enhanced to the extent that physical

therapists seek to understand the physical, social, and psychological toll of injury on

patients by listening to and understanding patients' needs (Bellner, 1999; Gyllensten et

al., 1999). Facilitating a therapeutic relationship involves physical therapist

responsibility for negotiating and maintaining process tasks and emotional bonds with the

patient, while inspiring shared responsibility for task initiation and change. Encouraging patients to re-negotiate and re-develop the relationship with their physical therapist based on their needs as treatment progresses can stimulate increased collaboration and responsibility for the change process (Øien et al., 2011).

Stressing the collaborative component of the working alliance, physical therapists interviewed by Tracey (2008) view their relationships with patients as a team effort, which enables them to find common ground. Making connections between the tasks and goals of treatment and being in tune to patients' needs regarding adjusting or refocusing treatment encourages shared agreement (Øien et al., 2011). Working together with patients to develop individualized goals that are relevant to their needs and desires similarly influences patient success and goal attainment (Thomson, 2008). A systematic review completed by Hall, Ferreira, Maher, Latimer, and Ferreira (2010) on the relationship between the working alliance and patient outcome in physical medicine settings supports the presence of a positive relationship between a working alliance and treatment outcomes. Patient perception of the therapeutic alliance or therapist/patient interaction was assessed most often with the Working Alliance Inventory (WAI), while other instruments included a sub-scale within another assessment tool, or scales created specifically for the included research study. Outcome measures consisted of patient assessment of pain, disability, physical performance, quality of life, global perceived effect of treatment, or adherence (Hall, Ferreira, Maher, Latimer, and Ferreira, 2010). Once results were collectively analyzed, it was apparent that the influence of the therapeutic relationship on patient outcome was evident even in physical medicine settings.

Providers in medicine, nursing, occupational therapy and physical therapy are finding that attention to relationship development is a concrete approach to improve delivery of care and impact patient outcomes. In general, patients want to trust and like their providers and benefit when they listen empathically in an effort to uncover their individual needs and desires to be happy. Satisfaction may be further enhanced when patients feel their provider is respectful, values their needs and desires, effectively communicates to support comprehension of their injury, and solicits input to facilitate collaboration. Relevant to athletic training, psychosocial strategies are meant to help facilitate creation of personal connections (interpersonal communication, social support) and support autonomy by providing patients with tools to effect treatment and rehabilitation outcomes. We need a clearer picture of how athletic trainers incorporate these psychosocial strategies to form therapeutic connections, encourage patient autonomy, and impact patient outcomes.

Though professional and educational development is outwardly different between psychotherapy and healthcare professions, the foundational qualities and processes that help build a working alliance are similar. Conversely, in athletic training literature, there is limited discussion of a therapeutic relationship and no reference to the working alliance. What follows is a review and analysis of athletic training literature through the lens of the working alliance to uncover how athletic trainers may currently attend to the working alliance in patient care.

The Working Alliance in Athletic Training. Creating a working alliance necessitates appropriate understanding and use of relational factors and foundational counseling skills. Athletic training professional practice embodies providing patient

assistance by recognizing and managing injury and illness, empowering accomplishment of mental health and wellness, and facilitating understanding and exploration through education (NATA, 2011). Despite the importance of patient-provider relationships, development and facilitation of these relationships in athletic training remains largely unexplored. Because so little is known, some literature takes the form of speculative options for future treatment applications. One such work is "Patient-Practitioner Interactions in Sport Injury Rehabilitation" by Brewer, Van Raalte, and Petitpas (1999). The authors suggest a turn to counseling literature to provide an appropriate framework from which to examine athletic trainer-patient interactions and develop skills to improve process and support effective outcomes. This is not an argument to act as a counseling professional, but rather a proposal to inject basic relationship building and interpersonal communication skills into athletic training education and professional practice. Other literature points to the fact that despite athletic trainers recognizing the value of counseling-type intervention (Roepke, 1993; Larson et al., 1996; Raemaker, 2014), they continue to feel unprepared to utilize counseling skills, are unable to recall being educated in these skills, and express a desire for further instruction to enhance counseling skills (Moulton, Molstad & Turner, 1997; Stiller-Ostrowski, & Ostrowski, 2009). Despite athletic trainers recognizing patient relationships are essential in patient care, this may not definitively equate with athletic trainer skill and confidence in creating these relationships and adjusting them to patient needs.

    Emotional bond. A working alliance underpins the relationship between provider and patient. Relationship establishment rests on the feelings and attitudes provider and patient have toward each other and how these feelings and attitudes are expressed. As

such, uncovering and thoughtfully expressing feelings and attitudes emphasizes possession and accurate use of relationship factors. The bond of the working alliance hinges on relationship factors (rapport, trust, and empathy) and interpersonal communication skills (active listening, open ended questions, genuine listening, reflecting, summarizing, and responsiveness) that let patients know they are heard, understood, and valued (Leach, 2005; Sommers-Flanagan, 2015). Athletic trainers also need to responsibly attend to relationship factors and interpersonal communication in patient care to build and cultivate a bond.

Research in athletic training never directly refers to a working alliance or a bond, but frequently discusses establishing a relationship between athletic trainer and patient. Rapport and trust (relationship factors) and interpersonal communication skills (listening, responsiveness, social support) exist within athletic training literature and describe attributes necessary for developing a relationship, promoting adherence or compliance, or as "expert" practitioner qualities. Though athletic training literature does not link relationship factors and interpersonal communication skills to the bond construct of a working alliance, they are nevertheless foundational for cultivating a bond. As such, the bonding-factors identified and discussed below offer indirect support for use in establishing a bond between athletic trainer and patient.

Because of long-term interactions with patients, athletic trainers have many opportunities to meet treatment and rehabilitation needs and initiate successful recovery (Moulton et al., 1997; Ray, Terrell, & Hough, 1999). Establishing trust and rapport between athletic trainer and patient is paramount for treatment and rehabilitation adherence, a sentiment shared by both athletic trainers (Fisher et al., 1993; Granquist et

al., 2014; Tracey, 2008) and patients (Fisher, Domm, & Wuest, 1988; Fisher &

Hoisington, 1993). Every athletic trainer surveyed by Fisher et al. (1993) confirmed that

rapport is essential for rehabilitation adherence, and can eliminate motivation and

adherence barriers. Furthermore, patient perception of a caring athletic trainer approach

and creation of rapport successfully encourages adherence (Fisher & Hoisington, 1993).

While this research directly links rapport and trust to patient adherence, in counseling,

these are relationship factors essential to developing a bond. As such, athletic trainers

may be able to redirect these factors to help establish a bond with patients, as modeled in

counseling practice, to support therapeutic outcomes.

Tracey (2008) qualitatively explored physical therapist and athletic trainer

perception of their role in managing psychological and physical care. Rapport building

was one of the three themes that emerged. Providers agreed that establishing rapport by

being honest, building trust, and establishing credibility was vital and important to

establish at the outset of care Tracey, 2008). Cultivating rapport enabled provider and

patient to find common ground, and view care as a team approach for developing a

treatment plan and supporting patients moving through the care process. This research

directly links rapport building to establishing a patient-provider relationship and

collaborating on patient care. However, only one participant was an athletic trainer,

which leaves athletic trainer perception and use of rapport building in patient care largely

unexplored.

Recently, athletic trainers surveyed by Granquist et al. (2014) also supported the

importance of establishing rapport. In response to a mixed methods study design with

open-ended qualitative-type responses, athletic trainers indicated that not only is

attending to rapport at the outset of therapeutic interactions important, it is their

responsibility to develop rapport. They also indicated that lack of rapport or ineffective

communication promotes non-adherence (Granquist et al., 2015). Athletic trainers

suggested rapport-enhancing practices included one-on-one attention, communicating and

educating regarding treatment and rehabilitation guidelines, and expressly outlining

expectations for patients. Interpersonal communication skills and one-on-one attention

are helpful to creating rapport, offering indirect support for using these skills to establish

the bond construct of a working alliance.

Trust, rapport-building and communication skills are directly related to building a

bond. Though the aforementioned studies provide support for specific factors necessary

to establish a bond, limitations exist. As part of athletic training literature, these studies

do not paint a clear enough picture of how athletic trainers build trust and rapport and

communicate in a manner that supports these relationship factors. Also neglected are

specifics about interpersonal discourse, and how relationship factors directly lead to bond

formation.

Interpersonal communication skills are also vital to forming a bond. Appropriate

use of these skills enables providers to express understanding and comprehension to

patients, and to aid development of rapport and trust. As such, possessing these skills can

help establish a bond that may enhance care. As the following research studies highlight,

athletic trainers hold conflicting beliefs regarding benefits and effective integration of this

listening type of support, yet also indicate an interest in enhancing their listening skills.

Surveying athletic trainers to identify the most frequently-used skills and techniques to

aid in the care of injured patients uncovered that while athletic trainers believe effective

communication is important, they simultaneously recount a desire to further develop

communication and listening skills (Larson et al., 1996). Clement et al. (2013) echoed

these same findings and, in their study, suggested that undeveloped communication skills

may limit athletic trainer effectiveness in uncovering thoughts, feelings, and concerns

related to injury and developing rapport. These findings offer support for the importance

of relational factors needed for bonding during patient care. Moreover, this limitation in

skill application may indirectly link to athletic trainers' ability to establish a bond and a

working alliance with patients.

A working alliance is interpersonal and dynamically reciprocal, and hinges on

contributions from provider and patient. Fostering a sense of partnership in care is also

essential. Though most athletic trainers acknowledge that listening skills and

interpersonal communication enrich patient care when managing responses to injury

(Clement et al., 2013; Larson et al., 1996), disagreement does exist about whether the

patient or athletic trainer should be the listener. Weise et al. (1991) surveyed both athletic

trainers and athletic training students in an early attempt to uncover the skills athletic

trainers use most often to manage injury and rehabilitation. Interpersonal communication

emerged as the most important skill to help manage injured patients. Though this skill

was rated as most essential, athletic trainers did not believe it was necessary to receive

training or education on how to improve listening skills, implying a perception that they

already possess sufficient proficiency (Weise et al., 1991). Additionally, these

participants rated patient willingness to listen to their athletic trainer as necessary for

successful coping (Weise et al., 1991). Expecting patients to simply listen does not

reflect bi-directional communication or effective development of rapport or a bond, thus

limiting athletic trainer effectiveness. Though over 100 athletic trainers were surveyed,

the sample did include athletic training students preparing for certification that had not

yet been employed or practiced without athletic trainer supervision. It is important to

note that Weise et al. (1991) completed their study over 25 years ago, and later sources

such as Larson et al. (1996) and Clement et al. (2013) show an evolution in athletic

trainers' perception in continuing education about interpersonal communication.

However, it is still unclear how this changing perception may have influenced the actual

practices of athletic trainers. Communication and listening skills help develop the bond

construct of a working alliance. These skills can thus be reframed for athletic trainers

and further enhanced to improve bi-directional communication. This would bolster

athletic trainers ability to attend to a bond.

Athletic trainer perception of patient willingness to listen and comply with

treatment and rehabilitation instructions may support a belief that essential knowledge

and communication skills belong only to athletic trainers (Weise et al., 1991). Moreover,

perception that treatment and rehabilitation shortcomings and responsibility for

adherence rest only with the patient does not suggest a collaborative relationship

(Granquist et al., 2014). In the open-ended question responses solicited by Granquist et

al. (2014), some athletic trainers indicated that good rapport caused patient willingness to

do what they were told or what was expected of them. Other responses signified that the

manner in which information was communicated to patients, such as explaining the

theory and reasons why treatment would benefit the patient, was effective in establishing

rapport. While these responses point to a disparity in how rapport and communication

are integrated into patient care, only a small percentage of participants offered responses

to the short answer questions, and participants frequently did not explain in depth how they facilitated relationships with patients (Granquist et al., 2013). The aforementioned research does refer to rapport and communication as a means to encourage adherence, but makes no reference to forming a bond in a working alliance. However, attending to rapport building and communication may enhance care delivery and therapeutic outcomes. Such improvement would take place via the relational construct of a bond, whether the athletic training literature refers to it or not.

Social support. Social support may augment athletic trainers ability to build rapport and foster a bond, as it is a form of interpersonal connectedness, which encourages enhanced interpersonal communication and understanding between provider and patient (Heil, 1993). Emotional support, one dimension of social support, captures listening without judgment (listening support) and expressing caring and support of current circumstances (emotional comfort) (Arvinen-Barrow & Pack, 2013). From a patient perspective, social support has a positive effect on psychological and therapeutic outcomes such as patient satisfaction with care, rehabilitation, and well-being. Patients surveyed by Clement and Shannon (2011) reported that support from athletic trainers was available, satisfying, and influential to their overall well-being. Listening and emotional support during rehabilitation also reduced negative reactions to injury (Clement & Shannon, 2011). Social support also helps patients cope with injuries while offering a buffer for depression and anxiety. Higher levels of patient satisfaction with social support were related to reports of decreased reported levels of depression and anxiety at return to participation (Yang et al., 2014). Evidence for a relationship between patient satisfaction and social support was also found with injured patients surveyed by Barefield

and McCallister (1997). Patients expressed higher levels of satisfaction with care when athletic trainers provided listening support. Maygar and Duda (2000) conclude that athletic trainer provision of social support to injured patients improves patient self-confidence and ability to identify personal coping resources after injury. Recently, Clement, Arvinen-Barrow, and Fetty, (2015) qualitatively explored patient responses to injury throughout phases of injury and rehabilitation. The most common behavioral response patients exhibited after injury and throughout rehabilitation was to seek social support. Patients sought social support from athletic trainers to varying degrees during all phases of rehabilitation and their need for social support remained present during all phases of recovery and rehabilitation. Patients seek social support from athletic trainers and it also has a positive effect on psychological well-being and therapeutic outcomes. Athletic trainer skill in using social support should meet patients' needs, which supports the importance of social support for developing a bond and promoting positive therapeutic outcomes.

Listening Skills. Differing beliefs surrounding the advantage of listening skills, and concern regarding an ability to effectively utilize them with injured patients, may limit athletic trainer ability to develop a bond. These attitudes suggest a need to connect athletic trainers with training and education to improve interpersonal communication and listening skills. Athletic trainers generally believe communication is important in patient care, and desire further training and education to augment their skills (Clement et al., 2013; Larson et al., 1996), yet there appears to be no clear definition of communication or an understanding of the specific effect communication has on outcome (Clement et al., 2013). This disconnect reveals a potential inability to recognize the clinical usefulness of

rapport and bond-building skills. Moreover, perceived lack of adequate educational exposure to communication skills (Stiller-Ostrowski & Ostrowski, 2009) calls attention to whether athletic trainers are effectively obtaining and utilizing communication skills foundational to patient care and development of the bond construct of a working alliance. Listening skills are often promoted as a result of research (Clement et al., 2013; Kahanov & Fairchild, 1994; Larson et al., 1996; Wiese et al., 1991), or as theoretical suggestions (Brewer et al., 1999), to enhance communication and rapport. Non-verbal gestures, open-ended questions, probing, reflecting, paraphrasing, and summarizing are skills advocated to improve athletic trainers' ability to "listen and respond to patient needs….and build effective rapport" (Granquist et al., 2014, pp. 130-131). Clement et al. (2013) posit "without adequate communication skills, the best-trained and most highly effective athletic trainer can be ineffective" (p. 517).

A working alliance underpins the relationship formed between patient and provider. A bond strengthens the working alliance and indirectly strengthens the patient-provider relationship. Attention to establishing a bond with patients rests on creating rapport and trust, displaying empathy, and effectively using interpersonal communication skills. How athletic trainers use these relationship factors and interpersonal communication skills during patient care and the impact of these skills on therapeutic outcomes, are yet unexplored topics. Researching a working alliance in athletic training may facilitate a deeper understanding of ability for bond establishment. Such research may also clarify disparities between acknowledged importance and actual use of bond-forming skills.

In addition to quantitative assessment of athletic trainer and patient perceptions of bond-forming skills, athletic trainers were asked to identify and define qualities and constructs of expertise within the profession. Several factors understood by the counseling profession to be necessary for cultivating a bond emerged. To ascertain qualities that categorize athletic trainers as providing "expert" care, Malasarn et al. (2002) interviewed seven male athletic trainers identified as leaders in the profession. The athletic trainers were asked to identify attributes and values that led to their identification as experts and their subsequent advancement in the profession. Expert was defined as having practiced for a minimum of 25 years, and prospective participants were identified and suggested to the researchers by a focus group of athletic trainers. When asked to share examples of what they believed enhanced their development, the athletic trainers identified various categories. Personal attributes were of specific relevance. Loyalty, generosity, spending time with patients, and listening to and attempting to understand patient wishes and needs were defined as foundational qualities practiced by expert care providers. While these were attributes credited to "expert" providers, one-on-one attention and listening and attempting to understand patient wishes and needs link to responsiveness, an interpersonal communication factor crucial to establishing a bond. Though these findings highlight qualities important to development of experts in the profession, only the views of male athletic trainers were sought, leaving female athletic trainers' perspectives untapped. Furthermore, at the time participants were interviewed, inherent differences in the athletic training profession existed. Specifically, athletic trainers were recognized as healthcare providers by the American Medical Association (AMA) in 1991 (Ebel, 1999), about 10 years prior to the completion of this study.

Professional requirements and education standards have evolved since recognition by the AMA. Results of this study must take this evolving professional context into consideration.

Raab et al. (2011) also endeavored to uncover and promote constructs of expertise that differentiate an entry-level athletic trainer from a quality athletic trainer by interviewing experts in the field. While Malasarn et al. (2002) defined experts as practicing for at least 25 years, Raab et al. (2011) identified expert practitioners as having a minimum of five years of clinical experience. Raab et al. (2011) developed interview questions after an initial round of participants submitted responses to questions designed to uncover descriptors of a successful and quality athletic trainer. After interviews were conducted with 12 athletic trainers, themes of care, communication, commitment, integrity, and knowledge emerged. The athletic trainers perceived that they manifested these qualities in patient care by spending time with every patient and valuing patients as individuals while attempting to understand their perspectives. In addition, possessing knowledge and disseminating information at an understandable level was also important to providing effective care (Raab et al., 2011). These authors concluded that addressing these qualities in educational programming may allow advancement of the athletic training profession by enhancing patient interactions. Yet, it remains unclear how athletic trainers develop these qualities, or, specifically, how the qualities work and are adjusted during patient care. Identifying these qualities as "expert" characteristics merely offers a description of qualities needed to provide expert care. This "expert" designation says nothing on its own about athletic trainers ability to form a bond. However, possessing these characteristics may increase the likelihood of strong bond formation.

Listening, responsiveness, and empathic responding (attempting to understand patient perspectives) are interpersonal communication skills helpful to cultivating a bond with patients. The presence of these factors in reviewed research supports the clinical usefulness of the factors in the bonding construct of a working alliance. Connecting athletic trainers earlier with bond-forming relationship-building and communication skills in educational and clinical practice settings may influence patient outcomes sooner than five to 25 years into athletic trainers' professional practice.

The bond of a working alliance hinges on relationship factors and interpersonal communication skills to uncover patient needs and express patients are heard and understood. Athletic training research refers to bond-forming factors, but does not directly refer to a bond or to a working alliance. Rapport, trust and interpersonal communication skills (listening support, emotional support, social support) are concrete factors that contribute to establishing a bond. In athletic trainer literature, however, they are often linked to athletic trainer-patient relationship development and encouraging adherence or compliance, rather than bond formation. In addition to empathy and other interpersonal communication skills (active listening, open ended questions, reflecting, summarizing, and responsiveness), the skills in athletic training literature can be reframed to support their use in establishing the bond construct of a working alliance.

Agreement on Goals. Goal setting and establishing relevant culminating goals are essential to the therapeutic process. Creation of mutual goals is a cooperative process in which providers listen to their patients' needs and priorities to reach consensus on relevant goals (Bordin, 1979, Sommers-Flanagan, 2015). Though goal setting may automatically generate thoughts of goals that are physical in nature, goals that aim to

relieve psychological factors (stress, anxiety, frustration) can reduce these factors' impact (Bordin, 1979). Emphasizing mutual consensus, as opposed to provider-manipulated expectations to facilitate change, allows providers to uncover patient desires, and together develop physical and psychological goals (Mead & Bower, 2000).

Providers agree that empowering and assisting patients to actively set and work towards treatment goals influences the recovery process (Tracey, 2008) and that incorporating goal setting helps scaffold progression toward return to participation (Shelley, Trowbridge, & Detling, 2003). Due to strong educational emphasis on goal setting (Kamphoff et al., 2010), it is not surprising that athletic trainers identify it as a familiar and frequently-utilized skill (Clement et al., 2013; Hamson-Utley et al., 2008; Larson et al., 1996; Weise et al., 1991). In athletic training literature, goal setting is often called a psychosocial strategy utilized with post-injury and rehabilitation management. Within the field, the cooperative integration of goal setting varies. While goal setting is seen as a useful tool, it is not recognized as a construct of a working alliance.

Although athletic trainers indicate proficiency applying goal setting, collaboration is not always elicited, leaving patient input untapped (Stiller-Ostrowski & Hamson-Utley, 2010; Stiller-Ostrowski & Ostrowski, 2009, Washington-Lofgren et al., 2004). Washington-Lofgren et al. (2004) surveyed athletic trainers to discover current views and use of methods to manage injury recovery, specifically, psychological recovery of collegiate athletes post-injury. The research team developed surveys to assess athletic trainers' comfort with and current use of strategies, including goal setting, when working with injured patients. Goal setting emerged as the most commonly used strategy athletic trainers incorporated into care of injured patients. Just over half of surveyed athletic

trainers believed soliciting patient input in the goal-setting process is important during

post injury-recovery, and a majority of those athletic trainers who involved their patients

in decision-making did so "often" or " almost always" (Washington-Lofgren et al., 2004).

In this study, goal setting is incorporated as a psychosocial strategy to manage response

to injury. However, it is connected to the importance and relevance of goal setting with

patients in general, and as an important construct of a working alliance.

Stiller-Ostrowski and Ostrowski (2009) undertook a qualitative approach to reveal

recently certified athletic trainers' perceptions of educational preparation and ability to

utilize psychosocial strategies, including goal setting. A convenience sample of 11

recently-certified (within six months to six years) athletic trainers participated in semi-

structured focus group interviews. Participants were also asked to rank the level at which

they perceived their educational program prepared them for using psychosocial strategies

(i.e. goal setting, etc). Responses revealed that all educational programs covered goal

setting; however, it was covered only to a certain extent. While one participant felt

extensively prepared in goal setting and integration, others noted learning about short-

term goal setting without accompanying strategies for incorporating the tool into patient

care. Interestingly, when presented with the notion of patient involvement in goal setting,

some participants expressed surprise, believing that responsibility for goal setting rests

with athletic trainers. Though goal setting is being presented in educational programs, it

appears that strategies for integration into patient care are not adequately covered, and

that shared goal setting may be a novel idea to some athletic trainers. The novelty of

athletic trainer-patient agreement on goals presents a barrier to reaching mutual

consensus, which is necessary to a working alliance.

Recently, Stiller-Ostrowski and Hamson-Utley (2010) also reported on the use of goal setting to support patient care. Just over 1700 certified athletic trainers were surveyed with an instrument adopted from the Psychology of Injury Usage Survey to assess perception of educational preparation, comfort and frequency utilizing psychosocial strategies during patient care. Here again, goal setting emerged as the most commonly used psychosocial strategy, with 80% of athletic trainers seeking input from patients at least half the time. While these results are encouraging, patient input is not consistently sought, and it is unclear if providers are uncovering patient desires to reach goal consensus. Though goal setting is incorporated into patient care and patient input is sought, these studies do not explore how athletic trainers gain agreement on goals with patients, whether it is attended to in a cooperative manner, or how it connects to establishing a working alliance. Approaching goal setting from a mutual perspective can provide athletic trainers with a strategy to use with any patient, even one identified as non-compliant or difficult, and help athletic trainers develop a working alliance.

Goal setting is a commonly utilized strategy in patient care. Athletic trainers generally indicate learning and feel comfortable integrating goal setting into patient care. However, it is not always approached from a collaborative perspective. Furthermore, none of the aforementioned studies link goal setting to establishing a working alliance. Goal setting is one of three legs of the working alliance. Athletic trainers are indirectly using this construct of a working alliance in patient care; however, they may be limiting its therapeutic usefulness by not effectively listening to patient needs and desires and prioritizing generation of agreement on goals.

Task Collaboration. Tasks of rehabilitation and patient care are treatments or interventions that are collaboratively selected and integrated to reach agreed-upon goals. Skills used in bond creation, facilitating task collaboration, and gaining agreement on goals are inextricably linked (Norcross & Lambert, 2011). Accurate use of relational factors and interpersonal communication supports collaboration between patient and provider on task selection and integration, and strengthens patient-provider relationships, which impact patient outcome and success. Educating patients about tasks or interventions promotes patient understanding, which enables them to provide informed consent and thereby initiate collaboration. Remaining true to a working alliance necessitates attention to how rather than simply what tasks are selected and integrated (Sommers-Flanagan, 2015).

Adherence and compliance remain a common concern for athletic trainers; a majority report managing patients with poor adherence to rehabilitation (Granquist et al., 2014). Athletic trainers generally assent to learning interventions to support adherence to rehabilitation (Stiller-Ostrowski & Hamson-Utley, 2010; Stiller-Ostrowski & Ostrowski, 2009; Washington-Lofgren et al., 2004), however, the interventions themselves are less important than if they are collaboratively integrated into care. Before we examine the effectiveness of interventions, we need a better picture of how athletic trainers select and integrate these interventions. Need for enhanced collaboration, and lack of skills training to collaborate with patients, can limit effectiveness of task selection and integration and ability to fully establish a working alliance. A working alliance is likely to enhance these skills, yet we know little about how the working alliance manifests in athletic training. Investigating how athletic trainers develop relationships with patients within the construct

of a working alliance may help to uncover if they attend to collaborative task selection and implementation.

Patient education is critical for collaboratively selecting and integrating tasks. Effectively educating patients about interventions, treatment, and rehabilitation promotes understanding and enables them to provide consent, thus generating collaborative relational interactions (Sommers-Flanagan, 2015). Patient education is essential to healthcare and successful injury management and is often initially provided by athletic trainers (Prentice, 2015). Though athletic trainers possess requisite knowledge in healthcare and injury management, limited research exists regarding information delivery and adjustment.

Kahanov and Fairchild (1994) examined the nature of effective communication and education to promote patient understanding by surveying athletic trainers and injured patients to assess athletic trainer perception of and patient understanding of injury and rehabilitation. Discrepant understanding regarding patient perception of their injury and rehabilitation program was apparent, indicating injury and treatment information is not always effectively communicated (Kahanov & Fairchild, 1994). Instead of listening and seeking confirmation to ensure patients comprehend their injury, athletic trainers in this study often believe patients comprehend their injury well, while patients still feel doubt about their understanding (Kahanov & Fairchild, 1994). However, patient and athletic trainer congruency of communication was only assessed once in this study, within 24 hours after initial evaluation, and with a sample of six athletic trainers who took part in the evaluation of every patient.

Moving beyond description toward understanding process, in the qualitative study conducted by Tracey (2008) to discover provider perception of their role in managing patient care, another theme that emerged was that of educator. Participants believed that education encouraged patient responsibility to partake in their care and engaged patients in the care process by encouraging collaborative treatment decisions. While the results of this study directly support patient education for collaborative decision making, only one participant was an athletic trainer. This leaves athletic trainer perception and use of education in patient care largely unexplored. Together, these studies highlight that education can be effective in supporting patient activation and collaboration in care, and that ineffective communication leads to a disconnect in patient understanding. Lack of patient understanding can limit patient ability to provide consent or collaboratively select tasks or interventions as part of a working alliance. Focusing on athletic trainer experience and process of relationship development is necessary to uncover attention to patient education in care and whether it is used to support collaborative decision-making.

When facilitating task collaboration, patient education is the catalyst for by enabling patients to offer informed consent. Athletic training literature outlining the use of informed consent seems to be uncommon. However, sports medicine literature takes the form of speculative options for application to practice. Patient comprehension and knowledge of their injury or intervention is necessary if they are to provide informed consent (Dunn, George, Churchill, & Spindler, 2007), which requires an educational component. Inclusive attention to informed consent includes providing patients with a description of all intended interventions, explanation of benefits or risks should the patient choose to forgo interventions, and an explanation of alternative actions (Ray et al.,

1999). Athletic trainers are encouraged to consider informed consent as a proposition describing every intended action throughout care. Initial description of action does not implicitly include all treatments or interventions considered imperative to, or logically included with, the initial description (O'Neill, 2003). Involving patients in decision-making and checking for comprehension regarding tasks and interventions can also improve the informed consent process (Hall, Prochazha, & Fink, 2012 in Testoni, Hornik, Smith, Benjamin, & MnKinney, 2013), linking effective use of interpersonal communication to collaboration on tasks and interventions. However, there is no mention of task collaboration or a working alliance.

Attention to collaborative task selection and integration necessitates attention to informed consent and patient education. Patient comprehension and knowledge of interventions is necessary to provide informed consent. Offering patients a complete description of all intended interventions throughout patient care supports patient comprehension and ability to provide informed consent. Effective patient education fosters patient understanding and ability to provide informed consent, and enables active collaboration and selection of treatment and rehabilitation tasks. Limited athletic training research exists that explicitly clarifies how athletic trainers provide and adjust education to injured athletes throughout treatment and rehabilitation. Only one study refers to education as a direct link to establishing patient-provider collaboration on care decisions, and a working alliance is not mentioned. While athletic training literature does refer to use of interventions to support care, it is unknown if these interventions are selected and implemented in a collaborative manner. Minimal attention to informed consent, ineffective patient education, and lack of collaboration on task and intervention selection

can limit athletic trainer attention to collaborating on tasks and wholly attending to a working alliance.

The bond of a working alliance hinges on relationship factors and interpersonal communication skills to uncover patient needs and express that patients are heard and understood. Athletic training research refers to bond-forming factors, but does not directly refer to a bond or to a working alliance. Rapport, trust and interpersonal communication skills are concrete factors that contribute to establishing a bond, however, they are often linked to athletic trainer-patient relationship development and encouraging adherence or compliance, rather than bond formation. Gaining agreement on goals is one of three legs of the working alliance. Athletic trainers generally indicate learning and feel comfortable integrating goal setting into patient care. However, it is not always approached from a cooperative perspective, and athletic training research does not link goal setting to establishing a working alliance. Athletic trainers are indirectly using the goal setting construct of a working alliance in patient care, however, they may not be consistently and effectively listening to and uncovering patient needs and desires or prioritizing gaining agreement on goals. Informed consent and patient education enables collaborative task selection and integration. Patient comprehension and knowledge of interventions is necessary to provide informed consent. Effective patient education fosters understanding and ability to provide informed consent, and enables active collaboration and selection of treatment and rehabilitation tasks. While athletic training literature does refer to use of interventions to support care, it is unknown if these interventions are selected and implemented in a collaborative manner. Collectively, these

factors can be reframed and further developed to establish bond, task collaboration, and

agreement on goals constructs of a working alliance.

Acknowledging that athletic trainers are in a position to naturally create effective

relationships with patients due to initial response and proximity during care does not

offer evidence of the experience and process of cultivating relationships, simply that they

may occur. While theoretical reference to constructs of a working alliance appear in

athletic training research, at times minimally and only indirectly connected to a working

alliance, there is no reference to a working alliance. A deeper understanding of the

athletic training profession is necessary to gain a contextual understanding of this gap.

Athletic Training

Professional Identity. Athletic trainers are licensed healthcare professionals that

work with diverse patient populations to facilitate injury and illness prevention,

treatment, rehabilitation, and return to function. These professional responsibilities

necessitate attending to relationship development to support patient care. Developing a

working alliance with patients may support holistic care and positive therapeutic

outcomes. Since 1992, the Board of Certification (BOC) and the National Athletic

Trainers' Association (NATA) outlined and defined standards of professional preparation

foundational for delivering services to patient populations (Ray et al., 1999). These

Educational Competencies, currently in their fifth edition, now are created and released

by the NATA Executive Committee for Education (ECE). Patient education, effective

communication, recognition, and implementation of strategies to maximize physical and

psychological outcomes permeate all aspects of educational requirements and

professional practice (NATA, 2011). The fifth edition of *Educational Competencies* calls

attention to relationship development and provision of holistic care (NATA, 2011) by requiring athletic trainers to understand the intricate relationship between injury, psychological health, recovery and rehabilitation, and incorporate psychosocial strategies to support reestablishment of function and return to participation. Provision of counseling and mental health support is not a new concept in the athletic training profession. Understanding how athletic trainers currently attend to relationship development and creation of a working alliance can inform professional enhancement and training and most importantly support patient outcomes.

Risk of injury is inherent during athletic participation (Hootman, Dick, & Agel, 2007). Often the first to respond to sport related injury, athletic trainers are in a prime position to offer assistance to injured patients (Granquist, et al., 2014; Tunick, Clement, & Etzel, 2009). Athletic trainers identify as consultants who are in close emotional proximity to patients (Fisher et al., 1993; Moulton et al., 1997) and are well integrated into their social support systems. So integrated, in fact, that they are known to influence patients' self-confidence (Maygar & Duda, 2000). Maygar and Duda (2000) collected information from injured patients regarding perceived social support, sources of self confidence, and sources of confidence restoration at three points in time: after injury and within two days of starting a rehabilitation program, mid point of rehabilitation program, and at return to participation. Patients who perceived higher levels of social support from athletic trainers were able to stay focused on rehabilitation, experienced heightened ability to access self-referenced sources of confidence information, and had greater levels of confidence with their rehabilitation (Maygar & Duda, 2000). Daily interaction with patients can enhance athletic trainers familiarity with their individual personalities and

characteristics while facilitating an understanding of unique personal and situational

factors (Wiese & Weiss 1987; Weiss & Troxel 1986). Because of the intimate nature of

athletic trainer-patient relationships following injury, interactions can impact responses to

injury and rehabilitation (Pedersen 1986; Kahanov & Fairchild, 1994). Patients look to

athletic trainers to sustain and foster their confidence; athletic trainers who are

knowledgeable, supportive, and nurturing allow provision of care that goes beyond the

physical to encompass the psychological (Maygar & Duda, 2000). A working alliance

may be the direct link to enhancing athletic trainers' effectiveness to modify care based

on patients' shifting emotional, behavioral, and physical needs. Uncovering how athletic

trainers attend to building relationships and promoting a working alliance can lead to

creation of a framework that can enhance educational and post-professional training to

meet patients' changing needs.

Other disciplines spend a great deal of time and energy making sure patients

experience adequately happy relationships with their providers. For instance, nurses

work to form rapport and liking over the term of care (Burhans & Alligood, 2010;

Williams, 1998). Respectfully listening to and uncovering patients' needs and interests

allowed nurses to advocate for and facilitate patient choices and desires (Lymer & Richt,

2006; Williams & Irurita, 2004). Foundational to the working alliance is attending to the

personal relationship between patient and provider. Assuming relationship building

blocks are already formed at outset of care simply due to repeated interaction and

proximity might not encourage creation of a bond and collaborative development of goals

and tasks. This may lead to a less effective therapeutic relationship (Tracey, 2008) and

consequentially an ambiguous working alliance.

Though emphasis was historically placed on physical rehabilitation (Cupal, 1998), attending to the psychological component of treatment and rehabilitation is central to the patient experience (Mankad, Gordon, & Wallman, 2009). Care must continue to extend beyond the physical to address psychological, emotional, and behavioral consequences of injury in order to provide holistic care (Clement et al., 2013; Smith, Scott, O'Fallon, & Young, 1990; Tracey, 2003; Walker, Thatcher, & Lavallee, 2007). Because of recurring long-term interactions with patients, athletic trainers have many opportunities to develop successful relationships to better meet treatment and rehabilitation needs and initiate successful recovery (Moulton et al., 1997; Ray et al., 1999). A working alliance attends to both the psychological and physical needs of patients through an emotional bond and by collaborating on tasks and gaining agreement on goals important to the patient. An alliance can augment patient care. Therefore, delving into athletic trainers' experience and process of cultivating alliances can identify ways for them to effectively attend to patients' psychological and physical needs.

Role of Psychosocial Intervention for Athletic Trainers. Psychosocial intervention encompasses recognizing abnormal social, emotional, and behavioral problems, creating personal connections, supporting psychological wellbeing and autonomy, and restoring function by applying specific strategies during patient care (NATA, 2011). These strategies in effect somewhat mirror the bond, tasks, and goals of a working alliance. The athletic training profession delineates psychosocial interventions as goal setting, imagery, relaxation techniques, motivation techniques, etc. which are used to restore function and maximize outcome. Providing holistic care involves the capability of athletic trainers to detect psychological factors associated with injury and

rehabilitation and implement strategies to maximize therapeutic outcomes (NATA, 2011; Neal et al., 2014). Underutilizing or ineffectively selecting and implementing these skills may limit the athletic trainer-patient relationship and therefore negatively affect therapeutic outcome. A working alliance independently promotes positive outcomes irrespective of interventions simply by developing a bond and promoting agreement on goals and collaborating on selecting tasks and interventions, yet the working alliance is unknown and untapped in athletic trainer-patient care and could prove valuable to the psychosocial intervention process.

Injury can elicit various psychological, emotional, and behavioral responses (Smith et al., 1990; Tracey, 2003; Walker et al., 2007). Consequentially, effective recognition and management hinges on ability to understand and identify various responses to injury (Arvinen-Barrow, Massey, & Hemmings, 2014; Weiss & Troxel, 1986; Wiese-Bjornstal, Smith, Shaffer, & Morrey, 1998). Appreciating the importance and identifying psychological issues and concerns does not automatically translate to confidence in skill use and application (Stiller-Ostrowski & Hamson –Utley, 2010). When athletic trainers were asked about satisfaction with and educational content regarding psychosocial intervention, confidence applying practical skills such as goal setting, motivation, and communication was evident, whereas confidence surrounding use of counseling and mental health skills to support patient care was less so (Stiller-Ostrowski & Hamson-Utley, 2010). Tenuous connections between educational content and professional application underscore the ethical responsibility to recognize when it is necessary to seek out continuing education to further develop skills and knowledge (NATA, 2013).

Detecting and effectively managing psychological responses is a significant part of providing comprehensive care for patients. Athletic trainers commonly identify that patients experience stress/anxiety, anger, depression, treatment adherence and compliance issues, and feelings of hopelessness or indifference after sustaining injury (Clement et al., 2013; Larson et al., 1996). Tapping into the working alliance's interpersonal nature and value may help athletic trainers uncover, respond, and adjust to various reactions to injury. The working alliance is a practical approach that allows providers to conceptualize and relate to patient experiences thereby positively enhancing relationships. Its capacity to generate positive outcomes regardless of theoretical approach or technique selection can position athletic trainers to better ascertain patient needs, integrate suitable treatment tasks, and develop relevant goals.

Managing psychological responses by incorporating psychosocial interventions into patient care is relevant for a breadth of sports medicine professionals, including athletic trainers. Sports medicine professionals and athletic trainers use of goal setting (Arvinen-Barrow, 2008; Arvinen-Barrow et al., 2015; Brewer, Jeffers, Petitpas, & Van Raalte, 1994; Ievleva & Orlick, 1991; Scherzer, Brewer, & Cornelius, 2001), imagery/visualization (Arvinen-Barrow et al., 2015; Brewer et al., 1994; Ievleva & Orlick, 1991), positive self-talk (Arvinen-Barrow et al., 2015; Scherzer et al., 2001; Ievleva & Orlick, 1991), social support (Barefield & McCallister, 1997; Yang et al., 2014), and communication (Clement et al., 2014; Larson et al., 1996) can attenuate psychological responses and effect positive therapeutic outcomes. While these techniques are in effect tools to support treatment and rehabilitation success, how athletic trainers collaboratively select and integrate them into patient care is unclear. Although

athletic trainers acknowledge a need to pair specific techniques with psychological responses to injury, they often feel unprepared in how to best select and integrate these techniques within patient care situations (Larson et al., 1996; Stiller-Ostrowski, & Hamson-Utley, 2010; Stiller-Ostrowski & Ostrowski, 2009; Washington-Lofgren et al., 2004). Lack of confidence and uncertainty matching appropriate psychosocial interventions with observed psychological responses can limit therapeutic outcome and effectiveness of the therapeutic relationship and working alliance. Uncovering rich information about the experience and process athletic trainers engage in when building an alliance with their patients will not only clarify their psychological responses, but also shed light on possible implementation strategies for future use.

Endorsing psychosocial interventions for injury recovery as an acceptable professional role (Raemaker, 2014) and exhibiting positive attitudes towards psychology of injury and psychosocial techniques (Hamson-Utley et al., 2008) does not automatically imply proficiency and clinical application. Athletic trainers consistently report underutilizing some psychosocial techniques (Hamson-Utley et al., 2008) due to lack of familiarity (Stiller-Ostrowski & Ostrowski, 2009; Washington-Lofgren et al., 2004;) and a prevailing feeling of discomfort in their ability to appropriately implement them (Ostrowski & Hamson-Utley, 2010; Stiller-Ostrowski & Ostrowski, 2009). In fact, Stiller-Ostrowski and Ostrowski (2009) found that athletic trainers within five years of graduation were least satisfied with their educational background in psychosocial interventions. Lack of comfort and satisfaction may be explained by minimal emphasis on psychosocial interventions within educational programs. Hamson-Utley and Stiller-Ostrowski (2011) surveyed program directors (PDs) of athletic training programs (ATP)

to better understand curricular instructional methods and educational preparation to implement psychosocial interventions in patient care. Of specific importance, psychosocial intervention instruction received the least emphasis within educational programs, and often skills were taught within numerous separate courses, or within a lecture/discussion format, as opposed to in an applied manner (Hamson-Utley & Stiller-Ostrowski, 2011). A disconnect between educational preparation and learning goals, and professional application may limit patient care and suggests educational training may not be meeting the standards for competence. Additionally, regardless of expressing interest to develop these skills (Clement et al., 2013; Stiller-Ostrowski & Hamson-Utley, 2010; Stiller-Ostrowski & Ostrowski, 2009), athletic trainers may not be actively seeking further supportive training.   Without possession of sufficient skills to adequately recognize psychological responses, athletic trainers may be ill-equipped to effectively implement suitable interventions. Highlighting a need to emphasize further training in the use of psychosocial interventions but within a context that enhances the working alliance. Exploring how athletic trainers foster relationships with patients can illuminate how they uncover and manage varied patient responses. This exploration can also allow creation of training to enhance selection and implementation of interventions, while attending to the working alliance.

Educating athletic trainers in basic counseling techniques and interpersonal skills is an essential adjunct to patient care (Cramer Roh & Perna, 2000; Moulton et al., 1997; Ray et al., 1999) while remaining within ethical and professional boundaries. Due to proximity and intimacy of the athletic trainer-patient relationship, athletic trainers and other healthcare professionals believe use of counseling skills can be a natural and

necessary adjunct to the provision of physical care (Kane, 1984; Tunick et al., 2009), which can further support relationship development. Though some athletic trainers feel capable in applying counseling skills (Moulton et al., 1997; Misasi, Davis, Morin, & Stockman, 1996), many convey apprehension regarding adequate educational preparation and hold a common belief that further training in counseling skills is important (Moulton et al., 1997; Stiller-Ostrowski & Ostrowski, 2009; Stiller-Ostrowski & Hamson-Utley, 2010), which is not uncommon to athletic training (Hamson-Utley et al., 2008). The ability to recognize and manage underlying stressors and feelings of stress and anxiety can affect how an athlete responds to treatment and rehabilitation (Clement et al., 2013), and ultimately recovery. Increasing athletic trainers' skills and abilities to respond to social and emotional needs necessitates differentiating their role from a counseling role. Nevertheless, connecting with new ways to support patient care is central to healthcare delivery and patient outcomes. Exploring in depth the process of how athletic trainers form relationships with patients will support a greater understanding of how they attend to holistic care and identify educational means that can be implemented to better support patient outcomes.

Though professional and educational development is outwardly different, foundational qualities and processes that infuse patient care (creating rapport and trust, effectively educating, and supporting patient outcomes) are relevant across counseling and healthcare professions. Developing and promoting a therapeutic relationship is foundational to patient care and the quality of the relationship influences outcome (Burhans & Alligood, 2010; Fuertes et al., 2007; Gyllensten, 1999; Øien et al., 2011). Healthcare professionals attend to the therapeutic relationship by providing appropriate

education (Cole & McLean, 2003; Norrby & Bellner, 1995; Tracey, 2008), supporting

collaboration and patient empowerment (Cole & McLean, 2003; Dorflinger et al., 2013;

Fuertes et al., 2007; Norrby & Bellner, 1995; Øien et al., 2011), and through interpersonal

communication (Burhans & Alligood, 2010; Cole & McLean, 2003; Dorflinger et al.,

2013; Gyllensten et al., 1999; Norrby & Bellner, 1995; Øien et al., 2011; O'Keeffe et al.,

2015; Tracey, 2008; Williams, 1998). Athletic training professional responsibilities

require attending to patient education, utilizing effective communication, and

implementing strategies to maximize patient outcomes (NATA, 2011). Moreover, athletic

trainers have a vested interest in supporting outcome and return to participation in patient

populations. Research in the area of the therapeutic relationship and working alliance

specific to athletic training has received minimal attention; therefore the assimilation of

the constructs of the working alliance into the profession of athletic training needs

exploration. Accordingly, developing a therapeutic relationship and solid working

alliance with patients should not be considered separate from other interventions, but

rather as a critical aspect of patient care that facilitates positive outcomes.

Implications for Athletic Training

Despite the suggestion that a working alliance may be universally applicable

across professions (Bordin, 1979; Meissner, 2006), it is unknown if and how this

construct presents in athletic training. None of the aforementioned studies specifically

related to athletic training considered the working alliance in patient care. Although the

components of bond, tasks, and goals are relevant to athletic training, the manner in

which they are addressed is unknown. Athletic trainers actively contribute to building

relationships with patients, with poor athletic trainer-patient relationships being a

potential barrier to therapeutic outcome (Fisher et al., 1993; Granquist et al., 2014). Consequently, additional knowledge of the process and experience of developing a working alliance better positions athletic trainers to support relationship development and therapeutic outcome. Establishing a successful working alliance may eliminate these barriers and allow for accurate conceptualization of patient needs by attending to the emotional bond and generating agreement on goals and collaboratively selecting and integrating tasks.

Empirical evidence exists for the positive influence of the working alliance in healthcare. However, there is limited research on the presence and integration of the working alliance in athletic training professional practice. A review of literature left unexplored the concept of the working alliance in athletic training and made minimal references to a therapeutic relationship. Cultivating a working alliance may provide athletic trainers with an additional tool to increase patient satisfaction, motivation, adherence, and compliance. Yet there is no model that currently unifies athletic training practice concepts with the therapeutic relationship and the working alliance. Research that aims to develop an understanding of the therapeutic relationship and working alliance in athletic training professional practice may enrich appreciation of its role in treatment and rehabilitation and connect athletic trainers with ways to enhance relationships with patients. Identifying the formation and facilitation of the working alliance in athletic training practice allows development of conceptual clarity for professional integration. Attending to relationship development and clinical competence can begin to align athletic trainers with an approach to patient care that is increasingly

relevant across healthcare professions. Most importantly, it provides a foundation to address holistic treatment of patients.

Implications for Counselor Education

Teaching and establishing counseling skills is inherent to the preparation of counselors and counselor educators. Through collaboration and attention to inter-professional relationships, counselor educators and athletic trainers may be able to enhance skill training across disciplines and explore ways to best meet the unique and varied needs of patients. Integrating counseling skills with athletic training education increases breadth and application of these skills across disciplines. This also serves to inform training methods for counselor educators, leading them to effectively collaborate with athletic trainers and other healthcare professionals. Expanding the reach and value of foundational counseling skills and connecting counselors and counselor educators with other care providers serves to augment provision of care and further enhance patient well-being.

As a healthcare provider and counselor education student, patient well-being and positive outcomes are of foremost importance. The lens through which I have come to understand the importance of the athletic trainer-patient relationship, though first informed by my personal and professional experiences, is further substantiated by this review of literature. Exploring ways to enhance athletic trainer-patient relationships to support outcomes not only supports my professional growth, but can also offer a framework that supports patient care across the athletic training discipline.   What follows is a discussion regarding my conceptual context and the sources that inform me about athletic trainer-patient relationship development.

Social Embeddedness of the Author

The implicit lens through which I have come to see the athletic trainer-patient relationship in the collegiate setting guided the focus of this research, question development, and purposeful selection of participants, which is described in further detail in chapter two. Collaboration with participants is inherent in building context and meaning and allows for an interactive bi-directional relationship (Maxwell, 2005). This allows both the literature and the human element of researcher and participants to inform the theoretical concept.

Considering the nature of reality is necessary when formulating new theory. Reality is in effect constructed by the perception and understanding of both participants and researchers. The meanings assigned to phenomena allow us to make sense of, organize, and develop a system of belief that becomes constructed reality (Lincoln & Guba, 1985). Further, an interpretive paradigm demands recognition that I as the researcher am not separate or removed from the phenomena under study. Rather I am inseparable from the phenomena and shape and am shaped by subjective and objective interpretations (Corbin & Strauss, 2008). This calls for my own reflexivity as the researcher to interpret meaning and understand contextual influences of the phenomena, both anticipated and unanticipated (Maxwell, 2005). While bracketing is the goal, it cannot be entirely attained. As best as I could, I remained aware of and bracketed my experience as a collegiate athletic trainer and doctoral student in counselor education throughout the research process (Corbin & Strauss, 2008). My background, values and expectations had the potential to influence and misguide this research, therefore I remained curious and open to what was uncovered in the data, as opposed to what I

would believe or expect to happen. Awareness of these influences allowed me to remain open and focused on what I heard from participants (Maxwell, 2005). The information presented in my theoretical context sheds light on the development of context and builds upon understood and accepted knowledge to come up with a constructed reality that may then be applied to the research problem (Lincoln & Guba, 1985). The following is my conceptual context of relationship development between athletic trainers and patients based on my experiences as a certified athletic trainer, a doctoral student in a counseling program, and an athletic trainer educator.

I am the primary instrument in conducting this research from conceptualization through gathering and analyzing the data and ultimate theory development. Therefore, it was important to disclose and examine my values, in addition to situational and contextual beliefs. This allows readers a perspective on which to judge the research (Corbin & Strauss, 2008) and gain an understanding of how my professional and educational experiences guided conceptual development (Lincoln & Guba, 1985). My experience as a collegiate athletic trainer, my work with injured athletes, and my beliefs about the impact of relationships on outcome were the primary sources of personal information that influenced conceptualization of how collegiate athletic trainers facilitate relationships and develop a working alliance. Additional informative experiences included the impact of a doctoral program in counselor training on my perception of athletic trainer-patient relationships, and study in foundational counseling skills and the working alliance. Finally, educating athletic trainers to attend to psychosocial needs of patients to support outcome rounds out the professional and personal experiences that guided development of this research idea and focus.

Prior to beginning doctoral studies I worked extensively with collegiate athletes as an athletic trainer. During this time I evaluated, treated, and rehabilitated athletes who sustained injuries of varying degrees of severity. It was during these experiences that I began to recognize the significance of holistic care that included attending to the psychological and physical components of treatment and rehabilitation. I had many conversations with athletes about the psychological toll of injury, the presence of adequate social support systems, and the influence of social and environmental factors outside the sporting venue on injury rehabilitation and overall well-being. I began to focus more on acknowledging the athlete as an individual and connecting with the aspects of each patient that made them who they were: personality characteristics, social support networks, and environmental contexts. Recognizing a need and desire to attend to the physical as well as the psychosocial, I decided to seek training to manage and support the psychosocial aspect of sport injury and rehabilitation. These personal and professional experiences of relationship development with athletes and the potential impact these relationships can have on patient care are present with me as the researcher.

As I began doctoral level training in counseling I continued to wonder about treatment and rehabilitation adherence and what would encourage athletes to adhere to rehabilitation and foster a faster return to competition. It was then I was introduced to foundational counseling skills and the impact of a therapeutic relationship on patient care and outcome. Reflecting upon my own bachelor and master's level education, it was apparent that counseling skills, relationship development, and the importance of addressing the psychosocial needs of patients was a small, almost non-existent, component of my athletic training education. While I believed I implicitly knew how to

create an effective relationship with patients to support psychosocial care and therapeutic outcome, it became apparent there are many skills that are necessary and immediately useful to strengthen relationship development. Continuing my education and training in counseling skills precipitated further reflection on the relationships I developed with athletes, and how incorporating counseling skills could have enhanced the care I provided and patient outcomes.

A common belief, and one I also personally hold, is that athletic trainers are in a position to develop, and have meaningful relationships with, patients. In the collegiate setting, this is often due to the amount of time athletic trainers and patients spend in proximity in sport specific settings and because athletic trainers are often the first to respond to sport-related injury. While professional responsibilities include attending to psychosocial needs of patients, educational preparation may be incomplete and only scratching the surface of how to best attend to psychological, emotional, and behavioral needs of patients. Further, it is professionally relevant to question how collegiate athletic trainers go about developing these relationships. This can help uncover areas where athletic trainer education can be enhanced to support holistic patient care, outcomes, and return to participation. My belief that the working alliance is important in patient care highlights my bias towards this construct. Consequentially, to the best of my ability I bracketed this belief by staying curious and open to participants' realities, so that it did not interfere with data collection, analysis, and interpretation.

CHAPTER II

Methodology

Relationship development between patient and provider is increasingly recognized as essential to patient care and successful outcomes (Bachelor & Horvath, 1999; Leach, 2005). A therapeutic relationship is a common factor associated with outcomes in psychotherapy, physical therapy, nursing, and medicine (Fuertes et al., 2007; Gyllensten et al., 1999; Holman & Lorig, 2000; McCabe, 2004; Palmadottir, 2006; Redfern & Norman, 1999a, 1999b; Szybek et al., 2000). A cornerstone of a therapeutic relationship, the working alliance, connects patient and provider by developing an emotional bond, fostering agreement on behaviors and tasks used to attain goals, and gaining agreement on objective goals of treatment (Asay & Lambert, 1999; Gelso & Carter, 1985). Cultivating a working alliance enables the provider to uncover patient desires and collaboratively develop goals and tasks that address both physical and psychological needs (Mead & Bower, 2000).

Providing holistic care requires athletic trainers to detect psychological factors associated with injury and rehabilitation. Though athletic trainers know they must cultivate rapport and trust (Fisher et al., 1988; Fisher et al., 1993; Raab et al., 2011) and understand their role in intervention, their skills may not be sufficient to fully understand the patient's situation. This may leave them unprepared to effectively intervene (Stiller-Ostrowski & Hamson-Utley, 2010; Stiller-Ostrowski & Ostrowski, 2009; Washington-Lofgren et al., 2004; Larsen et al., 1996). Despite the importance of patient-provider relationships and attention to a working alliance, these constructs remain largely

unexplored in athletic training. We know very little about the experience and process of athletic trainer-patient relationship building.

The goal of this research was to understand collegiate athletic trainers' experience and process of patient relationship development. By identifying the experience and process of the working alliance, athletic training programming can focus on enhancing skills to create more effective relationships that promote positive therapeutic outcomes for injured patients. Therefore, my research question for the proposed study was: What is the collegiate athletic trainer's experience and process of developing a working alliance in athletic training? To best examine the experience and process of a working alliance between collegiate athletic trainers and patients, I selected a grounded theory qualitative methodology to capture participants' experience and process of the working alliance in athletic training. What follows is a detailed description of my methodology.

Qualitative Methodology

Qualitative research does not seek causality. Causality places a rigid structure on phenomena that in actuality influence and are influenced by context and events in the moment. These influences have no directionality (Lincoln & Guba, 1985). This complexity belies simple explanations and stresses that events are essentially numerous unanticipated interacting and complex factors (Corbin & Strauss, 2008). As an active participant in the research process and data collection, a researcher hopes to capture as much variation as possible through obtaining multiple perspectives of an event from participants (Corbin & Strauss, 2015; 2008). This is done in an effort to further explore areas not previously researched, while also allowing a comprehensive and holistic approach to the study of the phenomena in question (Corbin & Strauss, 2015). In my

research, this approach was useful in examining and uncovering perceptions of athletic

trainer relationship development and developing a grounded theory of the experience and

process of the working alliance with collegiate athletic trainers and patients.

Assumptions. Qualitative research places emphasis on the concepts and theories

uncovered in the data during the research process, as opposed to any ideas chosen prior to

the research (Corbin & Straus, 2015). Placing attention on understanding meaning

through emphasis on words, perceived reality, and how participants make sense of

physical and behavioral events around them (Maxwell, 2005) informed an inductive

structural description of collegiate athletic trainers' experience and process of developing

a working alliance with patients. As an active participant in the research process, my

own values and experiences served to shape my views of the presence and importance of

athletic trainer-patient relationship development. This ontological perspective influences

the nature of reality in this study, therefore it remained important to recognize and

address its role while the study was conducted. Over identification with my own values

could lead to conscious or unconscious errors in contextual development. Therefore, to

uphold trustworthiness and limit bias in my research it was necessary and important that I

examined my values and judgments while remaining aware of the context of the data I

examined. Bracketing my beliefs about what I would expect to find and what I believe

and know about the working alliance helped me remain open to participant reality.

Reality, as we understand it, is constructed by perception and understanding of those

involved in relevant phenomena (Corbin & Strauss, 2015). The meaning athletic trainers

assign to the experience and process of developing a working alliance allows them to

make sense of, organize, and develop a belief system (Lincoln & Guba, 1985). These

acts of knowing embody perspectives that further serve to influence behavior and perception of truth or reality (Maxwell, 2005; Corbin & Strauss, 2008), and in effect, create a constructed reality (Lincoln & Guba, 1985). My experiences and conceptual context were a part of the research process and interacted with athletic trainer participant experience of a working alliance. These experiences lead to new knowledge and a jointly constructed reality of collegiate athletic trainer experience and process of attending to a working alliance.

Paradigm. An interpretive paradigm demands co-construction of meaning and recognizes that the participant and researcher are not separate or removed from the phenomena under study; rather, they are inseparable and serve to shape (and in return are shaped by) subjective and objective interpretations (Corbin & Strauss, 2008). Acknowledging the bi-directional reflexive nature of qualitative inquiry, in which there is no assignment of direct cause and effect, allows a deeper interpretation and understanding of contextual influences, both anticipated and unanticipated (Maxwell, 2005). My own values and experiences of collegiate athletic training professional practice and education in counseling led me to study collegiate athletic trainer-patient relationship development and gave meaning to my conceptual understanding of this phenomenon. By understanding and accepting my role as a human tool in this process, similar to the participants, together we built upon understood and accepted knowledge and came up with constructed realities that were applied to the bounded research problem (Lincoln & Guba, 1985). From the experiences and processes described by collegiate athletic trainers, we co-constructed the concepts and theories of building a relationship and facilitating a working alliance while making sure that interpretations rang true to

participants and readers. Because I am not separate from the research, it was important

that I remained self-reflective about how I may influence the research process, and how it

may in turn influence both me and the participants (Corbin & Strauss, 2015). Consulting

with other professionals helped bracket my values and experiences in a manner that

enriched interpretations and upheld credibility that participants' realities were accurately

represented. Keeping an open mind to the possibility that data may not fit in an expected

manner allowed me to let go and explore different concepts (Corbin & Strauss, 2015).

By recognizing the interplay of and bracketing the biases, values, and characteristics that

formed my conceptual context ahead of time, and being transparent about trustworthiness

processes, readers are able to judge for themselves if I held myself accountable to the

participants and the interpretive paradigm in concept analysis and theory development

(Corbin & Strauss, 2015). The reader may then make a determination as to whether the

findings are relevant and useful in other situations or with other populations. Through this

determination, the reader is judging trustworthiness and transferability of the information,

deciding if the findings are relevant and important for other athletic trainers facilitating a

working alliance with patients. My approach to this analysis was informed by the work

of Corbin and Strauss (2015) on grounded theory.

Grounded Theory

Grounded theory is an accepted approach to use when theory is not yet available

to help explain or understand a process (Creswell, 2013) and provides a jumping-off

point to further refine ideas (Charmaz, 2006). It offers an interpretation of the studied

phenomenon and contributes to the plausibility and development of new understandings

(Charmaz, 2006). Additionally, creation of knowledge that guides practice needs

conceptual language (Corbin & Strauss, 2008), which can be advanced through stories

constructed by participants and researchers trying to explain and make sense out of their

experiences (Corbin & Strauss, 2008; Creswell, 2013).

Grounded theory offers a way to enhance learning and understanding of how

athletic trainers facilitate a working alliance with patients. Analysis to develop grounded

theory is an inductive process that allows theory to evolve from participants' and

researchers' views, meanings, and explanations of their experiences (Creswell, 2013;

Charmaz, 2006). Examination of collected data occurs simultaneously with collection, as

an ongoing cycle throughout the research process (Corbin & Strauss, 2015). My values

and experiences as an athletic trainer, educator, and counseling student embody the

perspective from which I implicitly and explicitly drew upon when making choices that

drove inquiry and guided the nature of the phenomenon (Lincoln & Guba, 1985). The

purpose being not to concretely define, but rather provide an interpretive view for

emerging ideas and construction of reality (Charmaz, 2006), or of a process, action or

interaction (Creswell, 2013).

The meanings, ideas, and values that collegiate athletic trainers ascribe to

facilitation of a working alliance are essential to understand, and they are the key

component when developing a representative theory (Maxwell, 2005). Grounded theory

methods allow ideas to take root in context and process, rather than being rooted *a priori*,

serving to guide practice or provide a framework for future research (Creswell, 2013).

Readers are provided with a lens through which to observe current practices and

encourage examination and possible transferability (Charmaz, 2006). Further, a

grounded theory approach was useful because theoretical models described in the

literature have not been studied in relation to the participants of interest (Creswell, 2013).

As noted, while athletic trainers may attend to certain aspects of a working alliance, the

literature does not point to their direct support of a working alliance with patients.

Formulating a theory permits exploration of this phenomenon from numerous angles,

allowing a descriptive picture to emerge that offers one explanation of how collegiate

athletic trainers work to build a working alliance. This interpretation can help guide

actions and creation of new knowledge, which can then be modified as further new

knowledge is uncovered (Corbin & Strauss, 2015). Though I am intricately involved

within this research, I took steps to be sure that I examined and presented the realities of

the participants', as opposed to uncritically injecting my own values and beliefs and

unduly influencing the developed theory. Bracketing my values and beliefs through

reflexive journaling, and collaborating with other professionals were steps I took to

prevent tarnishing the ability of both participants and readers to judge the results as

trustworthy and credible.

Inductive process maintenance is driven by a research question that helps guide

qualitative methodology. My research question, *What is the collegiate athletic trainers'*

experience and process of developing a working alliance in athletic training?,

necessitated an approach that best shed light on this phenomenon. To best answer this

question, a grounded theory approach was selected due to lack of a conceptual

understanding in the field of the components of the athletic trainer-patient relationship

and of attention to a working alliance.

I acknowledge my embeddedness as researcher, as described previously in my

conceptual context, and that the foundation of this grounded theory approach is an

interpretive co-construction of reality between participants and myself. These ideals and values remained visible throughout the selection of participants, procedures, and analysis, and informed and protected against threats to trustworthiness. What follows is a detailed description of the procedures that I undertook to explore athletic trainers' process and contribution to the working alliance with patients.

Procedures

Qualitative research emphasizes understanding meaning through participants' description of reality and how they make sense of the events around them. I undertook the following procedures to explore and seek to understand components of the collegiate athletic trainer-patient relationship and the context and process of constructing a working alliance. Throughout the research process, I followed the methodological ideals put forth by Corbin and Strauss (2015) and Charmaz (2006). The procedures that follow are explicitly linked to the conceptual context provided in Chapter one.

In order to construct a grounded theory representative of collegiate athletic trainers' experience and process of developing a working alliance, I purposefully selected participants to account for variation in collegiate athletic trainer experience and process of developing a working alliance, and to support transferability. This variation was informed by my conceptual context, and included elements such as gender-identification, collegiate employment setting, sport profile (Cramer Roh, 2001; Unruh, 1998; Unruh et al., 2005), and identification of the patient-provider relationship as a factor that is essential to patient care. I purposefully selected participants on a continuum of gender-identification, collegiate employment setting, and sport profile, which allowed me to

explore and embrace differences and similarities in the realities of participants throughout

data collection and analysis.

Prior to conducting this study, written approval from the University of Montana

Institutional Review Board (IRB) for the Protection of Human Subjects was obtained.

Once I received permission, access to athletic trainers was obtained by contacting the

National Athletic Trainers' Association (NATA), who for research purposes broadcasts

research requests to a sample of certified athletic trainers that maintain membership in the

organization. This allowed for access to athletic trainers while also indicating that

participants have a strong professional identity. Once I drafted a request for participation

letter and submitted this to the NATA with descriptive information targeting participants,

the NATA sent an email to a sample of 1,000 randomly selected collegiate athletic

trainers requesting participation. The initial request for participation outlined purposeful

selection criteria of identification of the patient-provider relationship as essential to

quality care, a minimum of three years of clinical experience, gender-identification,

employment at an National Collegiate Athletic Association (NCAA) or National

Association for Intercollegiate Athletic (NAIA) institution, sport profile, and ability to

participate in two interviews, member checks, and a review of final theory for accuracy. I

asked interested participants to respond to the email blast and indicate years of clinical

experience after successful completion of degree and certifying examination, whether

they identified the patient-provider relationship as a factor essential to quality care,

gender, collegiate employment setting, and sport responsibility(ies). As I received names

of interested participants, I separated potential participants into gender-identification,

collegiate employment setting, and sport profile categories. I then purposefully selected

participants from these categories in order to obtain maximum variation.

Male-identifying and female-identifying participants were purposefully selected

from four-year collegiate institutions participating in the NAIA, and in athletic

participation Divisions (I, II, and III) sanctioned by the NCAA. Junior college was not

included because it is a two-year institution and my purposeful selection criterion

included athletic trainers at a four-year institution. While recommendations exist for

selection of participant sample size in order to reach data saturation, Guest, Bunce, and

Johnson (2006) conclude that data saturation occurs after about 12 interviews,

particularly if the goal is to uncover shared beliefs or perceptions about a phenomenon.

As it was the goal of this research to explore a shared perception of the experience and

process of developing a working alliance, participants were selected based on the data's

ability to reach saturation. After six participants were purposefully selected and once six

round one interviews were completed, it was determined that six participants allowed for

comprehensive data collection and saturation, therefore an additional one to two

participants were not interviewed. Participants took part in two rounds of interviews.

I selected participants who met the criteria for maximum variation from the

generated list, contacted them via email and invited them to participate in the study. No

form of coercion was communicated in the email or other documentation. I provided

participants documentation describing the purpose of the research, and methods of

informed consent and confidentiality. To support authentic results and address social

desirability, all participants were informed that participation was voluntary and

confidential. Participants were made aware that they could terminate participation in the

study at any time, while also being informed that the research process includes taking part in two rounds of interviews, in addition to participating in member checks. To protect anonymity and confidentiality, I provided participants with pseudonyms, known only to myself as the researcher, and all potentially identifying information was removed from all responses. In the event that additional names were given during the interview, they also were replaced by pseudonyms. I informed participants that I was the only one to listen to audio recordings, and my dissertation committee would have access to complete transcripts. In addition, to support theory development, I informed participants that data in the form of quotes were pulled from the transcripts and were readily available to other readers. After participants accepted the informed consent procedures by signing and returning the consent to participate waiver, I set up first round interviews.

Participants. Constructing a grounded theory that helps explain a phenomenon and its process from multiple perspectives (Charmaz, 2006) involves selecting participants who will shed light on the research question (Creswell, 2013) while ensuring that the population is accurately represented (Maxwell, 2005). Selecting participants who are more likely to have a rapport-building process with their patients will best answer my research question, therefore, participants were asked to identify the patient-provider relationship as a factor essential to care. To embrace a breadth of realities, participant selection also captured differences in gender-identification, collegiate employment setting, and sport profile. This was done to account for differences that may have existed in the ways male-identifying or female-identifying athletic trainers respond to and understand their patients (Sommers-Flanagan & Sommers-Flanagan, 2012). Experiential dissimilarities from common internalized social understandings of gender for individual

athletic trainers, and evidence of differing patient experiences of athletic trainer gender

exists (Cramer Roh & Perna, 2001). This evidence indicates at least one potential cause

of reality being constructed differently based on cognitive notions of gender. Six

collegiate athletic trainers (3 males, 3 females; professional experience = 4.33 ± 1.03

years) employed at athletic participation associations NAIA (1), NCAA D1 (2), D2 (1),

D3 (2) were purposefully selected to allow for maximum variation. Collectively,

participants were responsible for provision of care to patients across high and low profile

sports that included: baseball, softball, volleyball, wrestling, cheer and dance, men's ice

hockey, and basketball, crew, cross country, track, golf, tennis, swimming, and soccer.

Some participants were responsible for patients in one or two sport profiles, while others

were responsible for patients across numerous sport profiles.

Table 1

Description of Participants

Pseudony m	Gender	Years of experience
Aiden	M	6
Maeve	F	5
Keeley	F	4
Liam	M	4
Orlando	M	3
Fiona	F	4

I gathered collegiate athletic trainers at four-year institutions who have exclusive

daily interaction with patients from time of injury to full return to participation. Patient

interaction often increases when instead of attending practices or other events they are

participating in treatment and rehabilitation (Unruh et al., 2005). Of additional note,

patient satisfaction with athletic trainers can vary based on sport profile (high or low) and

NCAA division. Participants in high-profile sports appear to be more satisfied with athletic trainers than those who compete in low-profile sports. Additionally, participants who competed at the Division 2 level were less satisfied with athletic trainers than those who competed at the Division 1 level (Unruh, 1998; Unruh et al., 2005). While this may be due to staffing issues, it is evident that perception of care differs given the profile of sport and level of competition. Within their respective employment setting, participants may be treating patients who participate in either high or low-profile sports. However, this is not always the case. Typically, smaller NCAA and NAIA institutions have a smaller athletic training staff, thereby working with patients across sport profiles. Purposefully sampling participants across NAIA and NCAA sport divisions captured collegiate athletic trainers who work with patients across high or low profile sports. Because I wanted to explore a relationship between collegiate athletic trainers and patients, I did not include athletic trainers working in industrial, professional, or high school settings. Purposefully sampling collegiate athletic trainers on a continuum of gender-identification, NAIA or NCAA Division 1, 2, and 3 employment settings, and sport profile permitted the opportunity to account for differences noted within the literature and allowed maximum variance to emerge. Embracing and exploring these varied realities accounted for both similarities and differences that existed in the shared reality of developing a working alliance with patients.

Finally, participants had a minimum of three years of experience working as an athletic trainer after completion of their degree and certification examination. This allowed for experiential growth and development of an individualized and competent approach beyond experience gained as a student. As mentioned previously, proficient

care does not occur immediately upon entry to the profession (Malasarn et al., 2002; Raab et al., 2011). Of note, the small range of years of professional experience (4.33 ± 1.03) present in this study represents a fairly homogeneous sample of participants in the early stages of professional practice.

Data Collection. Structuring methods of data collection to ensure comparability across settings and researchers can be at the expense of rigidity and focus. In contrast, a flexible or unstructured approach to data collection and analysis permits continuous evaluation and reflection on components throughout the research process (Maxwell, 2005). I continuously compared data collected from each participant, to themselves, to other participants, and to developed concepts, throughout data collection and analysis. This allowed me to pursue concepts that enhanced context, and discover additional relevant details and processes that were important to analysis of my conceptual theory (Corbin & Strauss, 2008).

Semi-structured interviews enabled me to focus on how athletic trainers attend to a working alliance and permitted me to follow the lead of the participant, acknowledging that each participant may provide additional disclosures of interest (Lincoln & Guba, 1985; Maxwell, 2005). Once I solicited a convenient time from each participant to allow interviews to be carried out in a quiet, comfortable location with only the participant and myself present, participants were contacted. Interviews were conducted via Skype or FaceTime and audio-recorded. Memos were taken during the interview to account for observations and verbal and non-verbal cues (Lincoln & Guba, 1985). A semi-structured interview guide was developed based upon the concept of the experience and process of the working alliance in athletic training. Questions were framed in an open-ended

manner so that participants were not led in a pre-determined direction (Corbin & Strauss, 2015). This interview guide allowed for flexibility to pursue emerging ideas and issues, and probes were used to gain additional clarity and insight. These procedures enabled follow up interviews to be conducted based on development of the data and theoretical constructs (Charmaz, 2006). The following questions guided the initial interview:

1. Tell me about the role of building rapport in your work with patients?

   a. How is rapport created?

2. When working with patients, how do you develop goals?

3. Tell me about selecting tasks and interventions during patient care?

4. Describe your experiences attending to adherence and compliance with patients.

After completing the first round of interviews and data analysis and as insight was gained into athletic trainer experience of developing a working alliance with patients, a second round of interview questions was created. These helped focus and develop emerging categories, aided in specifying relationships between categories (Charmaz, 2006), and helped further identify properties, dimensions, context, and process (Corbin & Strauss, 2015). The second round of interview questions allowed me to adjust data collection to ensure relevance to emergent theoretical categories and concepts (Lincoln & Guba, 1985; Corbin & Strauss, 2015). The following questions guided the second round of interviews:

1. When you have, or don't have, a personal connection with patients how does your provision of care change?

2. Tell me about how you facilitate patient buy-in?

3. Help me understand how you seek out and incorporate patient input?

4. Help me understand how patient education changes during the care process?

5. How does your employment setting influence patient care?

   a. How does the coach influence patient care?

   b. Help me understand how these experiences have a direct influence on what you do with patients?

Purposeful questioning continued until no new concepts or categories emerged, all categories were saturated with data, and redundancy of information was met (Lincoln & Guba, 1985; Charmaz, 2006).

Data Analysis. Data analysis followed the strategies forwarded by Corbin and Strauss (2015), which allowed for a more structured approach that helped me develop a general theory of process, action, or interaction. I transcribed all interviews verbatim and then read for initial understanding. Analysis commenced once I conducted all interviews and continued in this manner throughout the research process. I continuously compared data within each interview, and with every successive interview throughout coding and analysis.

Open coding was the first step I used to analyze my data and identify concepts and then further develop these concepts in terms of their properties and dimensions. To account for each piece of data during open coding, I assigned a word or words that best represented the conceptual and contextual meaning of athletic trainers experience of developing of a working alliance (Corbin & Strauss, 2015). During the open coding process I took the data and broke it apart to enable identification of thoughts, ideas, and

meanings. This was done word-by-word, line-by-line, and by looking for natural breaks in a section or paragraph. Each interview was continuously compared to itself and to every previous and successive interview, to identify similarities and differences in the data and concepts by asking questions such as what else is this telling me and what else can I learn from this? Each element included under a conceptually similar concept formed a richness of properties and dimensions. Properties helped to define and describe, while dimensions provided variation and range within the concept and overall category (Corbin & Strauss, 2015).

Once I identified concepts that stood for the data based on my interpretation of the meaning expressed, these concepts were linked and grouped into more abstract sub-categories as open coding continued. These lower-level concepts and sub-categories represent the raw data and formed the foundation of the theory. Sub-categories were then placed into a more abstract category, bringing depth and variation to that category. As concepts move towards higher order categories and increase in abstraction, they gained explanatory power by encompassing more and more detail, leaving a detailed and abstract picture of how athletic trainers facilitate a working alliance (Corbin & Strauss, 2015).

Throughout the open coding process, micro-analysis through prolonged engagement was conducted, which helped focus in on the data while allowing exploration in greater depth, and identifying the underlying meaning and experience (Corbin & Strauss, 2015). By continually checking and rechecking incoming data against previously collected data, my sensitivity to the meanings contained within grew.

Member-checks with participants at the conclusion of data collection and analysis allowed further revisions in meaning and interpretation.

Axial coding was then performed to further explore relationships between previously developed concepts and categories and to construct broader thematic categories (Corbin & Strauss, 2015). The act of breaking the data apart during open coding facilitated axial coding and ascertaining context and process of how athletic trainers facilitate a working alliance when reconnecting and integrating concepts and categories. Identifying action-interaction context between conditions or consequences brought understanding to both participant responses and the driving force behind them. This helped link concepts on a deeper level and improved the ability of the theory to explain and describe. Uncovering process helps highlight changes or responses that occurred in reaction to the conditions or consequences (Corbin & Strauss, 2015). In this step I matched actions and responses done to bring about a desired result, or in response to changing circumstances, and took note of whether these changes were necessary to achieve a desired goal, or were more strategic, random, or even unconscious.

Integration was the final step in data analysis and theory refinement. The purpose was to link and weave categories around the core concept, or main theme identified in the research (Corbin & Strauss, 2015). Being attuned to context and process, and the inter-connectedness between the participants and myself, helped detect relationships and connect categories, resulting in a story that accurately describes their interrelationship (Creswell, 2013). Ultimately, this led to creation of a theory that may help explain athletic trainers experience and process of developing a working alliance.

Memoing and diagramming, which can help integrate categories, was done throughout analysis to encourage asking questions of and exploring the data, reflecting on methods, categories, relationships, and stimulating analytic insights in the moment (Maxwell, 2005, Charmaz, 2006; Corbin & Strauss, 2008). This also allowed me to explicitly reflect and follow the thought process that went into analysis and the process by which concepts were developed and relationships between concepts were created (Corbin & Strauss, 2015). The interplay of open and axial coding, microanalysis, and memoing formed the foundation and structure of the theory.

Because the developed theory is grounded in the co-construction of perceived reality between the participant and the researcher, this can offer experiential credibility (Maxwell, 2005). My experiences as an athletic trainer, doctoral student in a counseling program, and athletic trainer educator lend credibility to this research because of my acquaintance with the settings, participants, and phenomenon I proposed to study. However this familiarity can also detract from the credibility of this research. Throughout the research process I was a primary tool, therefore my bias, values, characteristics, and experiences may have impacted the meaning given to the concepts and categories developed. While my experiences and conceptualization are integral to the process of forming a grounded theory on athletic trainers' facilitation of a working alliance with patients, I had to ensure that these findings were representative of the data and do not influence readers' perception of the believability and truth of the research. Qualitative research is at once both an art and a science; therefore assessing the quality of this type of research necessitates attention to both of these components (Corbin & Strauss, 2015). "Elegant and innovative thinking can be balanced with reasonable

claims, presentation of evidence, and the critical application of methods" (p. 341, Whittemore, Chase, & Mandle, 2001, as cited in Corbin & Strauss, 2015). Because qualitative inquiry is an "open system", the best I can do is provide procedures to "persuade" readers to judge trustworthiness, as opposed to "compel" (p. 329, Lincoln & Guba, 1985). The following addresses trustworthiness, threats to trustworthiness, and how I attended to these within my methodology.

Establishing Trustworthiness

Trustworthiness is not achieved by following a prescribed set of methods, but by how close conclusions are to the reality of the knowledge gathered (Maxwell, 2005). I took steps throughout the research process to help establish trustworthiness and ensure that the data and the possible interpretation and explanation of theory concerning athletic trainer facilitation of a working alliance rings true to readers, participants, and the researcher. As opposed to internal validity, external validity, reliability, and objectivity, criteria commonly accepted to evaluate the quality of qualitative research include attending to credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985).

Credibility. Credibility captures the "truth value" of the findings and the context and process by which the constructed theory was obtained (Lincoln & Guba, 1985). It also indicates the extent to which the findings reflect participants', researchers', and readers' experience with a phenomenon (Lincoln & Guba, 1985). I took steps to meet credibility by conducting purposeful sampling until all variations of participants' realities were represented, while also ensuring that the conceptualization of theory was believable to the participants (Lincoln & Guba, 1985). To enhance the probability that findings are

considered credible, I also incorporated strategies of prolonged engagement, persistent

observation, and member checks.

Achieving prolonged engagement refers to dedicating sufficient time in the setting

that allows me to achieve the purpose and scope of the research (Lincoln & Guba, 1985).

By truly immersing myself, I was able to better see misunderstandings or "distortions" of

information provided by participants or of context development, and build trust with the

participants (Lincoln & Guba, 1985). As an athletic trainer, I am oriented to the

profession and am not a "stranger in a strange land" (p. 302). This permitted me to fully

consider the context of information provided by participants (Lincoln & Guba, 1985). To

cultivate rapport and trust with participants I demonstrated empathy, respect, and honesty,

displayed open body language, and sensitively listened and responded throughout the

interview process (Corbin & Strauss, 2015) to both explicit and implicit meanings. To

further encourage trust, I did not hide the purpose of the research from the participants

and ensured they understood their input was important and desired.

I also utilized persistent observation, which was another way to support the

probability of my research being judged as credible while drawing attention to the depth

of athletic trainer experience of a working alliance. Persistent observation facilitated an

increased awareness and identification of characteristics and elements that were most

salient in the data. Whether typical or atypical, once known these elements were honed

in on to determine relevance (Lincoln & Guba, 1985). In depth labeling and exploration

of these salient elements allowed deeper comprehension or new conceptualization of the

initial analyses. Enhancing my sensitivity to identify relevant and pertinent elements and

concepts related to athletic trainer experience of a working alliance permitted me to make

appropriate decisions that carry purpose for the phenomenon (Creswell, 2013). Persistent

observation coupled with my conceptual context encouraged me to remain open to the

data and the multiple influences that may present (Lincoln & Guba, 1985).

Member checks, considered a crucial strategy to establish trustworthiness, involve

including participants during the data collection and analysis process (Lincoln & Guba,

1985). After each participant interview was transcribed, they were provided a copy of

their interview to offer input and clarification. Additionally, participant feedback was

solicited in an ongoing manner during development of concepts, categories, and

interpretations to check for clarity and ascertain incorrect interpretations. Once the final

theory was developed, it was presented to participants to solicit feedback as a final

member check. Phone conversations were scheduled with each participant. The

researcher presented the final theory and encouraged participants to address any apparent

errors or items that were overlooked, challenge interpretations, and ask for participant

clarification. Additionally, participants were asked to confirm the developed theory.

Achieving participant approval of credibility sets a foundation for persuading other

readers of the believability of the research (Lincoln & Guba, 1985).

Transferability. Transferability, or applicability, relies on the ability of readers

to determine if the findings apply to other situations or participants. It is up to me as the

researcher to provide substantial explanation and description of the data and final

grounded theory to allow the reader to determine whether information is applicable

elsewhere. However, the reader must make the final judgment of relevance to other

situations (Lincoln & Guba, 1985). Rich thick descriptions that encompassed a myriad of

information provided by athletic trainers regarding facilitation of a working alliance were

used to provide explanation and description to allow readers to judge whether comparisons with other situations are possible (Lincoln & Guba, 1985).

Dependability and Confirmability. Dependability seeks to uncover potential instabilities in the context and process of the research process, in addition to methodological design changes (Lincoln & Guba, 1985). An auditor can assert dependability of the research by thoroughly examining and finding acceptable the process of inquiry, and confirming that the product is actually supported by the data, findings, and interpretations. An auditor can also account for confirmability by attesting to how much of the established results are based on participant experiences as opposed to the influence of the researcher (Lincoln & Guba, 1985). Throughout the research process I worked closely with Dr. Murray, my chair, and she served as auditor of data collection, analysis, findings, and formation of theory. Raw data was also made available to the entire committee for review, allowing them to serve as inquiry auditors. During the coding and analysis process, I wrote memos and journaled to allow for a transparent paper trail. This also allowed Dr. Murray, as my inquiry auditor, to comment on the quality of interpretation, accurate conceptualization of concepts and categories, and suggest alternative considerations as necessary. Moreover, Dr. Murray remained aware to researcher bias and determined whether results were grounded within the data collected and that there was adequate support. Feedback received from Dr. Murray throughout the research process was considered and appropriately integrated.

To further support the auditing process, and help maintain transparency I kept a reflexive journal. Throughout data collection and analysis, I journaled about my physical and mental processes regarding participant selection, methodological decisions and ideas,

and logistical planning. Journal entries included diagrams, mental thought processes, ideas, insights, and thoughts on bias. Due to the inductive nature of qualitative research, the interplay of my conceptual context, and the fact that I am a tool in this research, it was important that I maintained self-awareness. Acknowledgement that my values, expectations and assumptions may influence the study (Maxwell, 2005) necessitates taking steps to prevent my unchecked influence, while also remaining responsive to messages contained within the data (Corbin & Strauss, 2008). It is my responsibility to present perspectives of the participants in a manner that seats me firmly within the collection and analysis of the data, while remaining sensitive to participants' experience of facilitating a working alliance. As the researcher, it is my responsibility to present results in a manner that paints a picture of how athletic trainers facilitate a working alliance without being overtly positive or falsifying data or conclusions, while also remaining protective of participants or organizations..

Conclusion

This chapter presented the reasoning for using a grounded theory qualitative approach that embraced an interpretive paradigm to investigate the experience and process of developing a working alliance in athletic training. Two rounds of semi-structured interviews and a member check allowed saturation of categories, while use of open coding, axial coding, and integration identified concepts, properties, dimensions, sub-categories, and categories that included attention to context and process. To establish rigor and trustworthiness in this research, I employed prolonged engagement, persistent observation, member checks, rich thick descriptions, a reflexive journal, and an inquiry auditor. Credibility was addressed through purposeful sampling to embrace a breadth of

realities, prolonged engagement, persistent observation, and member checks. Rich thick

descriptions and discussion surrounding transparency of myself as the researcher and the

research process enables readers to determine whether the results can be transferred to

other situations or participants. Reflexive journaling and an inquiry auditor were used to

help achieve dependability and confirmability by examining both research process and

product for accuracy, and authenticating that focus is maintained on participant

experience and reality, and not researcher bias, interests, or motivation. These strategies

facilitated co-construction of meaning that honored the realities described by athletic

trainers and provided the methodology to explore the experience and process of

developing a working alliance in athletic training.

CHAPTER III

First Round Analysis

This chapter presents data analysis from the first round of interviews. A description of the participants and brief review of the procedures is presented. Emerging relationships and processes between categories is offered and an evolving theory of how athletic trainers utilize a working alliance with patients is presented. Finally, I present a discussion of my context as the researcher in an effort to identify and bracket my beliefs, feelings, and reactions to data collection and analysis. The final section discusses the process of identifying and selecting questions that guide the second round of interviews to further detail a grounded theory of how collegiate athletic trainers utilize a working alliance with patients.

Description of Participants

Upon receiving approval from University of Montana's Institutional Review Board, six participants were selected to take part in round one interviews. Three male and three female athletic trainers currently employed at institutions participating in (1) NAIA or NCAA (2) D1, (1) D2, and (2) D3 athletic participation divisions who indicated a quality relationship was essential to quality patient care agreed to participate in the study. I will refer to the participants as Aidan, Fiona, Keeley, Liam, Maeve, and Orlando. All participants had a minimum of 3 years of experience as an athletic trainer beyond completion of their degree and national certification exam. Aidan has 6 years experience as an athletic trainer, Maeve has 5 years, Fiona, Keeley, and Liam each have 4 years of experience, and Orlando has 3 years of experience as an athletic trainer. Collectively, the participants are responsible for provision of care across high and low profile sports that

include: baseball, softball, volleyball, wrestling, cheer and dance, men's ice hockey, and men's and women's basketball, crew, cross country, track, golf, tennis, swimming, and soccer.

Review of Procedures

Participants discussed how they developed relationships with patients within the context of a working alliance in video-conference interviews lasting from 45 minutes to slightly over an hour. Five primary questions were asked during the interviews: 1) Tell me about how you build relationships when working with patients? 2) How is rapport created? 3) When working with patients, how do you develop goals? 4) Tell me about selecting tasks and interventions during patient care, and 5) Describe your experience attending to adherence and compliance with patients. These questions were expanded upon with follow-up questions to pursue emerging ideas, while also using probes to gain additional clarity to establish the meaning behind participant responses. The researcher then transcribed the audio-recorded interviews verbatim and reviewed them for accuracy prior to data analysis.

Data Analysis

The first round of data was analyzed primarily using open coding, axial coding, and memoing methods. The following chapter will describe my deconstruction of the data into **categories**, *sub-categories*, and <u>concepts</u>, as well as identification of *properties* and <u>dimensions</u>. Figure 1 represents a conceptual map of participants' experiences after completion of round one data analysis. The emerging relationships and processes between **categories** will also be discussed. These experiences and processes will be

ESTABLISHING	NAVIGATING	BUY-IN	CONTEXTUAL FACTORS

Care contract

AT commitments

AT expectations of patients

Defining coach involvement

Connection

Caring

Holistic appreciation

Sharing of self

Responsiveness

Boundarying

Bonding

Trust

Information sharing

Proving

Credibility

Commitment

Advocacy

Environment

Care roles

Director

Partner

Solicitor

Collaborator

Rehabilitation

Early		Late
Short		Long

Severity of injury

Simple		Complex

Relationship

Weak		Strong

Educator

Body awareness

Understanding injury

Purpose of treatment

Patient resistance

Activation

Institutional variables

Patient load

Proximity of patients

Institutional emphasis

Patient variables

Sport valuation

Additional relationships

Athletic trainer variables

Personal influencers

Personality

Professional influencers

Figure 1: Conceptual map of experiences following first round analysis

described and supported with participant interview excerpts in the remainder of chapter
three.

Emerging Experiences

Four **categories** emerged from my deconstruction of the data: **establishing**,
navigating, **buy-in**, and **contextual factors**. The category **establishing** is supported by
five *sub-categories* emphasizing *care contract*, *connection*, *bonding*, *trust*, and
environment. *Care contract* is supported by three *concepts*: *athletic trainer*
commitments, *athletic trainer expectations of patients*, and *defining coach involvement*.
Connection encompasses the *concepts* *caring*, *holistic appreciation*, *sharing of self*,
responsiveness, and *boundarying*. The *sub-category bonding* is not further de-
constructed. *Trust* is further detailed by the *concepts* *information sharing* and *proving*.
Proving is supported by *properties credibility*, *commitment*, and *advocacy*. The final *sub-*
category, *environment*, does not deconstruct further. The second **category**, **navigating**,
is further clarified with two *sub-categories*: *care roles* and *patient resistance*. C*are roles*
is supported by the *concepts director*, *partner*, and *educator*. *Partner* includes *properties*
of *solicitor* and *collaborator*; and varies along a number of dimensions. First is
rehabilitation, both location in the rehabilitation process, which dimensionalizes to early--
---late, and the length of the rehabilitation process, which dimensionalizes to and short----
-long. Second is severity of injury, which dimensionalizes to simple-----complex, and
last is relationship, which dimensionalizes to weak-----strong. Within the *concept* of
educator, three properties arose; *body awareness*, *understanding injury*, and *purpose of*
treatment. The second and final *sub-category* in **navigating** is *patient resistance*. The
third **category**, **buy-in**, encompasses one *sub-category, activation*. The final **category**,

contextual factors, is supported further by three *sub-categories* represented by *institutional variables*, *patient variables*, and *athletic trainer variables*. The *sub-category institutional variables* includes three <u>concepts</u>; <u>institutional emphasis</u>, <u>patient load</u>, and <u>proximity to patients</u>. The <u>concepts</u> <u>sport valuation</u> and <u>additional relationships</u>, further defines the **sub-category patient variables**. *Athletic trainer variables,* the final *sub-category* in **contextual factors,** comprises two <u>concepts</u> encompassing <u>personal influencers</u>, including the *property personality*, and <u>professional influencers</u>. What follows is a detailed account of how the data was deconstructed to identify **sub-categories**, <u>concepts</u>, *properties*, and <u>dimensions</u>, and how these were grouped with attention to context and process to create a detailed and abstract picture of how collegiate athletic trainers facilitate a working alliance.

Establishing

The first **category**, **establishing**, captures how participants create and enter a patient-provider and athletic trainer-coach relationship. **Establishing** encompasses an implicit agreement and understanding for the care process that prioritizes a positive therapeutic relationship and holistic interest in patients. Addressing and determining coach involvement in the patient care process and creating a positive relationship and supportive atmosphere where patients receive quality care at the outset, sets the stage for navigating the care process. Passages capturing the experience of **establishing** are present in the following excerpts:

> M8   So I think, I guess the experience I was thinking about when responding to that was starting a new job last year because it was 200 new patients. Um, so that was kind of like what came to mind first I guess. And I was thinking about how when you're coming into a new place and you have this sort of blank slate with all of these patients that I think the most important thing first of all is that they get to know, you kind of let them in

a little bit I know little bit about you. Um, because you are a stranger to them as much as they are to you. And you know, in my position I was coming into I know I'm going to be working with them for at least several years. Um, so making sure that there's a good personable relationship and also that they know that I care a lot about what I'm doing. Cuz I don't think they necessarily care about whatever the treatment is or something like that until they know that I care about them and their sport and that they're getting better and things like that. So I think, when it's a totally blank slate, making sure that they know that you care about them. You care about their priorities and things like that

F8   One of my first goals when I got there was to meet all the girls on my teams…and I know, knew coming that [one team] in particular had felt like neglected in the past. So when I first got there I really made it a priority to stick my head into [their] practices and um make sure that I knew the girls names…and I wanted to know who they were um and you know what their injuries were.

L9   Connecting with patients starts with finding out, knowing his or her name. I like to get to know them by asking questions about themselves. I always try to ask random questions, almost like 20 questions, about themselves to attempt to understand them a little more. I then create analogies they can understand and relate to. Almost everyone will tell you something about themselves.

O15   Um, for me it's really about being ah, like friendly. …especially like when I started a lot of people were pretty tentative about coming in, and even now freshmen are always real 'ah should I go in there is he okay?' Stuff like that. So a lot of times the icebreaker for that is talking about something that is not anything to do with medical treatment or anything like that. Just how is your day been, how are classes going, how are you adjusting to being at this school, new friends, new people? So that's usually how I do it especially at the beginning of the year, getting to know people to begin with.

Participant experiences surrounding creating relationships with patients and coaches represent the *sub-categories care contract*, *connection*, *bonding*, *trust*, and *environment*. Furthermore, presence of these *sub-categories* is essential at the advent of care, and in some cases prior to patients sustaining an injury or illness that necessitates entering into a therapeutic relationship.

Care contract

      The ***sub-category care contract*** captures expectations of responsibilities and obligations of the athletic trainer, their patients, and the coach during the care process. Acknowledgement of mutual participation and responsibility between athletic trainer and patient is best described in the following passages;

> A502   They [patients] have to be willing to adhere and comply with the program, but it also falls on the athletic trainer. We gotta keep ourselves accountable for progressing them for being, being there and being engaged with them when they have their, their rehab date scheduled.

> A99   It's, it's never my way or the highway anything like that. So, I let them bring in their ideas of what they think might be going on and then I kind of add to that.

> M472   And I think that they [patients] know, like they're in there with me, right, so they know that I'm working on, like I'm busy and there's a lot of them and one of me. So I think that they know that if they, I try to make it really obvious, so like I'm here for you, but you need to help me help you. And so I say that at least three times a day, help me help you….Ultimately it's, it is their [patient's] responsibility to help them, like help me help them, you know. Because it's, it's they're, they ultimately should be more invested than anyone else in this.

      Three <u>concepts</u> surfaced within the ***sub-category care contract***, <u>athletic trainer commitments</u>, <u>athletic trainer expectations of patients</u>, and <u>defining coach involvement</u>. The first <u>concept</u>, <u>athletic trainer commitments</u>, captures participant obligations to patient care.

<u>Athletic trainer commitments</u>

      This <u>concept</u> illustrates participants' dedication and support to their patients and the care process. Also present is an obligation to remain flexible and adapt patient care to support positive progress. Acknowledging patient importance rather than the

participants' agenda, and participant flexibility in managing the care process is seen in

the following quotes:

> L330 It's about the patient, its about them getting better. It's not about you [the Athletic trainer] and providing your agenda.

> L290 And um resetting things. Um 'cause you know you're gonna have issues where you're kinda here's the plan, we're going this direction, all of a sudden hang on we gotta re-evaluate, we had some issues. And now we have to change directions, or how do we reset our course….So if you're wrong, there's not, it's not an issue being wrong, you just have to be able to be like 'alright, I was wrong, lets go this direction'. Or all of a sudden that you missed something. And you know you have to be ok with admitting that.

> O618 I always start with that, um this is what I've seen work and this is what I'm going to try to do. But I will change everything I do based on ah, what the patient reports back to me….And if they aren't making improvement like I thought I would see, or not one at all, then I will go back and think that, you know, maybe I, you know maybe I'm not attacking this the right way. I'll try something different that hopefully will work.

> F253 Um, and if you don't [see results] then that means, maybe I missed something or the doctor missed something, we gotta go back and figure out what's going on.

> A445 you need to be able to tell if something's up, or if there, if something's wrong then you can step in and intervene and work to make things right

Though participants recognize their responsibilities to their patients and

commitment to the care process, they also emphasize patient responsibility to actively

take part in the care process, outlining the _concept_ _athletic trainer expectation of patients_.

Athletic trainer expectations of patients

The second _concept_, _athletic trainer expectations of patients_, is best understood as

participants' implicit expectations of patient accountability to seek, follow through on,

and move through the care process. The following passages give voice to expectations of

patient responsibility and willingness to put forth time and effort to their care:

F582   if they [patients] actually are hurt and have something that they're really concerned about they're gonna realize they need to come in for that. And see the consequences of it on the court if they don't take care of it.

M467   …my attitude is like, it's not my back that hurts, right? So like I'm not gonna go chase you down [at practice] if you don't come in for treatment. And I'll tell them that.

F251   A lot of my girls have chronic shoulder pain, and if they've been having this pain for weeks we're not going to be able to fix it after two treatments. So I tell them you know you have to be patient, you have to stick with the plan, I promise you, you will see results um,if you come in and do what you're supposed to do.

K372   You have to put in work on the basketball court, or football field, or you know wherever. You also have to put in work in here to get better. Like it doesn't just magically happen because you're sitting on the sidelines at practice…it's really up to you if you want to sit on the bench all season, if you want to play in pain all season.

A408   …he wasn't willing to put in the work, and, I mean he's, suffers the wrong word probably, but I mean, he, he did suffer the consequences. He didn't play like to his normal potential or to his, up to his potential ever again really. Um, and that's one I mean, it's, you feel bad for the kid but at the same time you don't because he didn't, he wasn't willing to put that work in ah to get better.

O328   When it comes to adherence I have found that it really has to be, they have to want to go somewhere, to get them there.

M537   And then I think also that, like if I say you know we do whatever the intervention might be, and then I give em [patients], you know either take-home exercises or stretches, or whatever it is….like this is what you need to do before you [practice]. Then you need to do it because I can't run around after you and do treatment on you. I think the idea is like I'm trying to make it like, it's not, I don't do things to you, like, it's all for you. But I can't fix it here, right now, you know. It's a longer-term problem and you have to, you being the student athlete have to help yourself along as well, right. Like what you do in the other 23 hours and 40 minutes a day are also important in your healing process

Maeve highlights patient ownership in their care in the following excerpts, indicating that although she is willing to assist patients through their plan of care, she can only go so far; patients have to make up their mind to meet her at least 51% of the way.

M475   I try to make it really obvious, so like I'm here for you, but you need to help me help you. And so I say that at least three times a day, help me help you…Ultimately it's, it is their [patient's] responsibility to help them, like help me help them, you know. Because it's, they ultimately should be more invested than anyone else in this.

M522   …it is theirs' to own, and I am more than happy to help them with it, and more than happy to you know be part of that process. But, that ultimately it's their process.

Participant experiences outlining expectations and obligations for patient care addressing the role of coach in relation to patient care allowed creation of the third and final *concept* in *care contract*, *defining coach involvement*.

Defining coach involvement

This *concept* characterizes outlining coach role and involvement in the patient care process. *Defining coach involvement* takes the appearance of garnering coach support for the decisions participants make regarding patient care, defining coach role in facilitating the care process, or as a tool for discipline. These experiences are present in the ensuing excerpts:

F568   So I've had several discussions with my coach since coming here…I was like they [patients] know what I expect and they're still messin' around. So I talked with the coach about the like 10 minute rule…I try to explain to him you know, if they actually are hurt and have something that they're really concerned about they're gonna realize they need to come in for that. And see the consequences of it on the court if they don't take care of it….he said you know you're right, like we can't have these girls skipping rehab. It's just as important as their work out, or lift….
there is a freshman this year who was late three times in one week and basketball is everything to her. And so my head coach said she's not participating in any basketball activities next week. This is not acceptable that she was late three times in one week and even after you talked to her the first two times.

L345   I have that conversation with my coach day one, in the sense of I don't want to chase people down. Like if they want to get better they'll be in here and I'll prod them but I'm not here to chase them down. So, that goes in my daily report in the sense of hey so-and-so hasn't showed up for

rehab in you know three days. If you want em better, that's your job as a coach to be on them to get them in because I don't do disciplinary stuff. That's your job. So kinda having that conversation and not that point-blank but it's just kind of within that context of this, my job is to get people better it's not to chase them down.

K348   The coach holds the check so, um, and the starting position and the bench position, so. They are definitely, a very huge tool of mine.

The **sub-category** of *care contract* captures **establishing** expectations of both the athletic trainer, their patients, and the coach prior to and during the care process, and determining coach involvement. Athletic trainers dedication to support patients above their own agenda and adjust care as needed to promote patient progress supports the *concept athletic trainer commitments*. Implicit expectations of patient accountability for their care; seeking, following through, and moving through the care process, captures *athletic trainer expectations* of patients. Furthermore, *defining coach involvement* in the care process; as an athletic trainer support system or tool for discipline, rounds out **establishing** and outlining participant, coach, and patient expectations in the care process. **Establishing** expectations of participant and patient responsibility commences once patients have a need to seek care, and remain present as participants begin establishing athletic trainer-patient relationships. Richness is present in the data as participants speak to **establishing** athletic trainer-patient relationships by attending to *connection*, another **sub-category** within **establishing**.

Connection

Moving beyond commitments and responsibilities for care described in *care contract*, participants place significant emphasis on creating a *connection* with patients. **Establishing** a *connection* entails communicating and displaying to patients they are important, valued, and cared for as a unique individual. Initiating a *connection* begins

with showing an interest in patients, such as learning patients names and being curious

about their life and daily activities outside of their injury and/or illness needs. A

connection also facilitates the ability for patients to relax and discuss medical issues and

concerns. Or in the case of the final passage, establishing a connection allows athletic

trainer participants to provide challenging feedback to patients:

> L540   It comes back to knowing the [patients] name and knowing them as an individual. Um, and then remembering that….. as many things as you can remember about them are huge….Cuz the next time they come in, what you can remember about them from their first visit as far as their personal life go a long way within that. So it's kind of being active in remembering those things I think go along way with building that connection. Because if you remember those the second time they know you're actually interested in them as an individual and who they are. It's just you have to put in the time to get to know them.

> O187   I start to talk about ah stuff that's more like what they would have experienced already. So how was orientation, how are you getting along with your teammates…So that's usually how I start off you, know talk about their teammates, and their school, and the experiences they might have already had, or you know sometimes I just ask them about their major.

> O7   So, with me often I'll talk about not just medical stuff you know. If they want to tell me something about how they're academically doing or you know stuff in their life that's going on, I'm okay with that….They can say whatever they want, and they can come in and share with me whatever they want.....Ah talk about everything except for what's hurting them….Get them comfortable with me first before I get them comfortable talking about, you know, their medical issues.

> L423   If you know your patient and who they are, what they're about, kind of what their schedule is somewhat, you can get a little better read. So yeah there are times where maybe they have family issues, maybe they have you know, um constraints within that. Um maybe they're way too much of a social butterfly and they missed your appointment because they were up watching some TV show all night, like ah or playing video games.

> L229   The opportunity for college students that are figuring life out to ask questions, to you know, push them in different ways. To call them out on different things. I've had a lot of people get mad but that's alright because once you build that rapport and the other end once you say that thing that

really, they don't wanna hear, they'll come back in a couple weeks and talk to you and be like 'alright, I get it"….But that comes back to them knowing that you really care about them, and you cant say that to someone that walks right in the door.

Furthermore, participants clearly recognize the importance of promoting a *connection* with patients by expressing the belief that athletic trainers are in a unique position to develop a *connection* with patients. **Establishing** these connections can even occur prior to sustaining an injury or illness:

K268   I don't like to just get to know my patients when they come into the athletic training room with an injury. I like to kind of know that like, I don't need to know every detail about their life, but I like to kind of know them beforehand. Um, whether it's talking to the coach about them, or you know talking with them just at preseason stuff. Um, just kind of getting to know what their personalities are like a little bit

K594   I mean, I think that as athletic trainers we are just in a really, really unique position. As healthcare providers, you know most, and not all of them, but most healthcare providers are in an office that you see only when something's wrong. If you think about it. And our athletes see us every day, whether they're hurt or not. You know when we're stopping in at practice. And I think that we can definitely use that, and that we should use that.

As participants continued to discuss patient interactions as moving beyond knowing a patients name, the *concepts caring*, *holistic appreciation*, *sharing of self*, *responsiveness*, and *boundarying* became evident. Collectively, these concepts depict various ways participants attend to creating a connection with patients. Expressing *caring* revolves around deepening the **connection** between athletic trainer and patient and expressing patients are seen and appreciated as more than simply a patient or an injury/illness.

Caring

For participants, *caring* encompasses gaining a richer understanding and appreciation for patients as unique individuals and putting forth the effort to learn about and remember unique patient qualities. Caring also embodies athletic trainers presence to recognize and attend to challenges patients may be facing, and patient needs that may be beyond physical injury or illness. This is expressed in the following passages:

M16   [Making sure] that they know that I care a lot about what I'm doing. 'Cause I don't think they necessarily care about whatever the treatment is or something like that until they know that I care about them and their sport and that they're getting better and things like that…..making sure that they know that you care about them. You care about their priorities and things like that

L514   People don't care how much you know until they know how much you care. And it really is um, I've found that to be true. Because if you're not building into their life, you're not getting, willing to get to know them…um that's, it's all about them in some ways when they're injured.

Participants spoke of the importance of recognizing patient experiences, physical or otherwise by displaying to patients they are seen and seeking ways to help patients manage potential negative experiences. Additionally, attentiveness to patient nuances and changes within the athletic trainer-patient relationship further demonstrates *caring*. For example, when a patient misses appointments, addressing this with the patient to uncover underlying reasons and working to identify ways to help patients be successful in their care process. This was evident in the following participant quotes:

A365   A lot starts with just kinda like their body language. If they're normally a chatty person really you know, ah, if they come into the [athletic] training room, you know looking down, depressed, you know not really talking much, ah it's just wondering, I mean I'll go out we'll start ah just start ah having a conversation, just some general day-to-day stuff like so like how was classes, like what's, what's going on in class? And then just kind of work our way into, um, them wanting to finally tell me what's ah what's bothering them, and then kind of work with them at the same time to kind of correct it, or to help them feel better.

L436   If they start missing maybe it's a question of hey what's going on, or you know you've missed three things is everything all right. Is, you know do you have relationship issues? You have this, um but, some of that is a lot of when you call it out sometimes they don't even realize it. And so having that discussion and not being afraid to have that discussion with them is huge as well. Of, you haven't been here for a whole week and now you walk in and you're wondering why you aren't getting better, well you know what can we do? And sometimes I'll ask people point blank ah, how can I help you?

M578   I mean, I think if I sense that there's something else happening as far as like…Whether it's, they feel pressure from coaches to keep practicing when they're not supposed to…. or if I feel like they're you know, there's a underlying mental health problem and so they're just not dealing with other things in their life, or whatever it is. Then I'll usually just sit down with them and be like hey, what's the deal, basically….I'll be like you know, is there something else going on? Do you not agree with the treatment plan, do you not feel good about it? Do you, is it not possible to follow, is there something else going on? What are your barriers and try to figure out what of those I can help with.

O100   You guys ran a lot at practice, man, you know stuff like that. That gets them on the, kind of let their guards down a little bit as far as you know I see what you're going through and I know that you're ah, you might be hurting.

O115   I always try to let them [patients] know that you know I'm paying attention to you, and sometimes it's hard for me because like I said I have a very full athletic training room, and I have people coming in and out. And a lot of times people don't think, you know sometimes they think I'm just busy and stuff like that. So for a lot of them I like to let them know, you know I saw what was going on today, I saw how you were doing, I saw all this and you know. Just like let them know that I'm paying attention even if it may not, even if it may look like I'm a little busy.

Rich undertones of mutual respect and valuation between athletic trainer and patient, were also present in the data. This was best described as *holistic appreciation*, another *concept* necessary when creating a **connection** with patients.

Holistic appreciation

Displaying mutual respect and valuing each other as humans, individuals, and each other's differences and roles characterizes the *concept holistic appreciation*. Here,

there is a distinct undertone of recognizing and appreciating patients are more than just patients; they are unique and multifaceted with distinctive priorities and characteristics worthy of acknowledgement and support.

K96   Like, 10% is an athlete, 90% is a person….I think that in college athletics we attach so much of their worth on their athletic abilities and not enough worth on them as a person. So I think that's something that we need to remind them of.

M745   So a two-way street. So me of the student-athlete and the student athlete of me, I don't see them as someone who just does rehab and [competes], and they don't see me as someone who just attends to their every need. I think like a mutual respect of the fact that we are human beings outside of, like obviously we wouldn't know each other if they weren't someone who [competes] and was injured, and I wasn't an athletic trainer. But so that's obviously like what created you know the interaction between the two of us. But like a mutual respect and understanding that we are human beings outside of that. And then treating each other as such. I think that mutual acknowledgment, respect, comes from being human.

F19   For both of my teams when they come in for rehab for treatment of any kind I just like to get to know them on a personal level too. Because I think too often a lot of coaches and even some athletic trainers just see the kids as an [athlete]. And like they're so much more than that. They're a student, and they've got a family and they, uh several of my girls on the team are working towards being doctors. So it's really fun to like talk to them about classes they're in and what they want to do when they graduate, and just get to know them on that level.

O485   It is not the number one goal for everyone to be back on the field. Um, whether it be because they know they weren't getting playing time before they got injured, or because they aren't particularly happy with how the team's doing in general. Um it's not always been their goal. Their goal is sometimes more to go, be able to go, and ah, you know go fishing with their buddies, or you know be able to swim even if they're a baseball player and stuff like that. They want to be able to do other things.

F634   I try to be supportive of them in both their academic and their athletic endeavors.

K90   I very much have an open door policy, um, if they need to talk to me about anything. Like I let them know, that hey I'm here for you as a person as well.

Establishing a *connection* represents participants exhibiting respect and valuation for their patients, and signifies appreciation for them as unique individuals. Another rich aspect of *connection* emerges as participants discuss the significance of sharing about themselves with patients.

Sharing of self

For the participants, this *concept* elucidates the importance of sharing personal and professional aspects of themselves. Relating with and letting patients into their lives enables patients to understand participants in a more personal and less professional manner. S*haring of self* also represents **establishing** a patient-provider relationship where patients feel comfortable and empowered to share about themselves. The following passages display this:

> M55   But then also that they [patients] know, I guess that they know like somewhat what my, like why I want to be there type of thing you know? Like what my background is. Like they always ask where I worked before, they're always really interested in that kind of thing. And like sharing that with them as opposed to being like, I'm just here to treat your knee, or whatever it is you know. Um, I think that they have some background info on you as a human makes them buy into you more…

> M13   You kind of let them in a little bit, know a little bit about you. Um, because you are a stranger to them as much as they are to you….so making sure that there's a good personable relationship and also that they know I care a lot about what I am doing.

> F26   I try to be as open with them as I can too, um I mean they, they met my sister…when she came out to visit. Um so they know that family is really important to me as well, and that I have a life outside of athletic training. I tell them like I play guitar, and I'm in a basketball league and so like I think that helps them, and, and myself make a better connection on the personal level and then that kind of, what's the word I'm looking for, also like leads into our patient-provider relationship too. And they know that like, they can trust me with things, and let me know what's going on so I can take the best care of them that I can.

For two participants in particular, *sharing of self* includes talking about personal injury experiences, which enables them to create a shared reality and express their understanding of what their patients may be going through:

> F133 A lot of them [patients] ask me why I got into athletic training, um I got into it because I tore my ACL. And so then, them knowing that I went through this significant injury and worked back into it and got back into playing and I have that other level of passion in me to like prevent that injury from happening. But then knowing what it's like to sit out, and wanting to get back that I understand where they're at and I'm, I'm with them.

> K7 I was a collegiate athlete myself. And so kind of sharing that part about myself, I think kinda helps them understand that I'm on their side, I, you know, I'm not as the bad guy. 'Cause I think we get that, kind of, wrap sometimes, of oh the athletic trainers are gonna pull you out. That kind of the, I understand the pressures that they're under. Um, the stuff the coaches put them through, their studies, their scholarship, all things, all sorts of things like that… To know that, I've been where they are, and I know what they want.

Displaying *caring*, *holistic appreciation*, and *sharing of self* help establish **connection** by embodying respectful patient interaction, facilitating understanding, and demonstrating appreciation for the unique differences and needs of patients. Another concept pivotal for **establishing** patient **connection** is characterized as *responsiveness*.

Responsiveness

The *concept* of *responsiveness* emphasizes participants' responsibility to not just listen, but listen respectfully, be present in patient conversation, and respond in a manner that lets patients know what they are saying is important and understood.

> L24 Another quote that I really like, do you listen to respond or do you listen to Understand...so, yea, but, um, and then being able to reiterate that back to them goes a long ways I think

> F201 [being a good listener] that means to me is being present. Um, and just giving your full attention to the person that you are talking to at that time. And, I guess giving certain cues to let them know like, "Hey I'm listening,

I hear you, here's what I think if you're interested." You know giving some feedback on what they're telling you.

Responsiveness was also particularly important for some participants as they recounted experiences with new patients, and the value of being completely present.

> M27 I think making sure, especially the first time you meet them, the first time they come in with either an injury or for whatever it is whether it's for physicals, that you're really focused on them. Because we tend to, in our environment, we tend to be doing four things at the same time, all of the time. And so making sure that if it's somebody that you really don't know and you haven't worked with and you haven't met, that you just sit down for a second. Even if it's only like a minute or so, and make sure that it's just you looking at them without talking to anybody else at the same time. And really just… but it's like you just sit down and you block everybody else out for a minute and, and make sure that they, I guess that you know that they are acknowledging you, and you are acknowledging them, and that you're on the same page.

> F495 She was just a quiet girl anyway and then she was very homesick. Um, so with her especially when she first came in I made sure she was the only one scheduled for that time and like went through each exercise with her and watched her do all of her exercises.

Participant experiences of **establishing** a *connection* with patients also spoke of enacting limitations to provision of care. These limitations represent *boundarying*, another *concept* of the **sub-category connection**.

Boundarying

This *concept* is best defined as trying to find, communicate, and maintain a balance between personal and professional relationship and obligations with patients.

> F366 I do have a bond with them, I've got good rapport, I've got this relationship but it's not quite like friendship, is a little different relationship. Um, in that just because I am their athletic trainer, and sometimes I do yell at them.

Finding a balance between professional responsibility to protect patient health and safety and supporting patient desires to continue doing what they love is seen in the following quotes:

A250   You've got to keep those boundaries of keeping it a professional relationship. But um, yeah I would definitely say I work towards, you know, being almost a friend to them so they can come and feel like they're comfortable talking and opening up and knowing that I can, I can just listen if they need that….Um, and that's, yea, like those relationships that I've been able to form have been right on that line of you know very professional, very friendly relationships, that they get the athletes, again to trust and to know that I have their best interest at heart.

A262   With those professional relationships being, you know you have a hard time sometimes you know separating the two. And like the worst time I think I've had with that is I almost had to ah have the talk with one of my former athletes about a medical disqualification. But luckily we were able to not have to worry about it, and that was one that I really struggled with, as like you know professionally, that's, it's my opinion that you probably shouldn't participate anymore if something else happens. But then me on the, being the more friend relationship part of it, is you know, your ultimate cheerleader mode, trying to, you don't want them to quit, you want them to keep going but. Um, that was something that I just struggled with internally.

The previous passages highlight participants seeking a balance between their personal and professional relationships with patients to strengthen the ***connection***, or protect patient safety. <u>Boundarying</u> is also a function of participants' protecting their personal and professional time and obligations and communicating the presence and importance of participants' values and interests outside of their professional responsibilities.   The following passages display participants setting limits about their personal and processional duties:

F46   I do try to, obviously it's pretty impossible to like leave everything at work and like not answer any emails or text messages or anything at home. But I try to set more boundaries with [patients] too. Um you know I have my phone off from 11 PM to 7 AM, and please don't text me about going first for doctors clinic tomorrow at midnight. Um, 'cause I do have my phone

on, which they know, because for emergencies, I want them to call me. But I'm not gonna be very happy if they wake me up at midnight or one in the morning…like them knowing that I do care about them, but can I just have a little bit of time to sleep. Um, and then them also knowing that I do have a life outside. Um kind of makes them more aware of what they're doing

M46   so I think that, I mean there's obviously a professional boundary because we are healthcare providers. But I think that they know that you are human as well is really important. So that they know, first of all for totally logistical purposes, that they know like that at 9 o'clock I'm home, and I'm like if it's not an emergency don't call me….from a totally logistical standpoint, that they know that you do have a life outside of work I think is important.

A326   It was one where it got to the point where it was bad enough with his [patients] non-compliance that we actually, that following year instituted a, ah athletic training room policy about the compliance of rehab.

F538   Um, she's [patient] always late, and just not committed. So, and we've had, we had a discussion earlier this year, she was 45 minutes late for her rehab appointment and I had left because I tell them at the beginning of the year you know, how long do you have to wait for your teacher not to show up for you to leave class? 10 minutes? Ok, well then you have 10 minutes, if you let me know that you are going to be late, ah, you have 10 minutes, and if you don't show up in those 10 minutes then I'm free to go work with somebody else, or go get lunch, or go eat breakfast.

Participants value more personal relationships with patients as this helps to facilitate care, yet seeking to maintain professional obligations and responsibilities is also necessary to support patient care and outcomes. Therefore, *boundarying* represents transitioning between personal and professional interactions to maintain the athletic trainer-patient relationship and protect participant personal and professional responsibilities and needs.

In sum, **establishing** a *connection* encompasses communicating and displaying to patients they are important, valued, and cared for as a unique individual and patient. **Establishing** patient *connections* can even begin prior to sustaining an injury or illness.

Showing interest in patients and being curious about their lives separate from their injury and/or illness further **establishes** an athletic trainer-patient relationship and enables patients to relax for evaluations and discussion of medical concerns. Furthermore, **establishing** a *connection* goes beyond simply knowing a patients name. Athletic trainers can **establish** *caring* by gaining a richer understanding and regard for patients as unique individuals, being attuned to challenges and needs patients may be facing beyond physical injury or illness, and taking the time to not only pick up on these nuances but address them. Displaying mutual respect and valuation for each other as humans, individuals, and each other's differences and roles, are ways athletic trainers can express *holistic appreciation* and further **establish** a *connection* with patients. Recognizing patients as multifaceted individuals with unique priorities and values, while offering support for diverse patient needs, whether academic, athletic, or personal, establishes *holistic appreciation*. **A** *connection* also necessitates athletic trainers *sharing of self*; sharing personal and professional aspects of their lives to further establish rapport with patients. *Sharing of self* and of personal injury experiences allows athletic trainers to express their understanding of patient experiences and empowers patients to share about themselves, further **establishing** an athletic trainer-patient *connection*. Attending to *connection* also requires *responsiveness* to patients. Athletic trainers can display *responsiveness* by listening respectfully, being present, and responding in a manner that lets patients know what they are communicating is important and understood. *Responsiveness* is especially salient when **establishing** a *connection* with new patients. *Establishing* a *connection* with patients also encompasses setting limitations to provision of care. Finding, communicating, and maintaining balance between personal and

professional obligations and relationships with patients are ways athletic trainers attend to

boundarying. Balancing professional responsibility to protect patient health and safety

while supporting patient pursuit of fulfilling activities, and also encouraging patients to

value athletic trainers time in and out of the professional setting, is an integral component

of building *connection*. Though the discussion and examples within the *sub-category* of

connection speak to **establishing**, participants also give voice to *bonding*, or what a

deeper *connection* with patients looks like when participants have more time and

opportunity to establish patient relationships.

Bonding

The *sub-category bonding* speaks to a deeper and rare athletic trainer-patient

connection, and a deep sense of knowing the patient. Prolonged time and patient

interaction, including attention to **establishing** _caring_, _holistic appreciation_, _sharing of_

self, and _responsiveness_ are necessary ingredients for *bonding*. *Bonding* involves a level

of insight and perception associated with implicitly sensing patient distress and allows

provision of care that resonates strongly with patients. This can be seen in the following

excerpts:

> O170   I think you have to know your [athlete] you have to know who you're
> talking to and what um, you know what will do best with them….And, uh,
> I think that's something you get with time, it's not something you learn
> overnight, they don't walk in and you know right away. But the more
> you're around, of course as athletic trainers we're around people every
> day, our [athletes], so the more you get to know em you kind of know
> what resonates better with them.

> K115   I think the more you get to know them the more they are willing to come
> to you with maybe that little thing that they wouldn't necessarily reveal to
> coach or to anybody else. And that's something you can kind of nip in the
> bud before it becomes a big problem. Or, even some, not necessarily
> athletic problems…. Knowing, knowing your athletes, and if they can, if
> one person will open up to me a little bit and I can, you know, help make

their life a little bit better, or prevent something like that [eating disorder, suicide] I think that's worth it.

A80   If you have a strong bond with an athlete you can almost like, if they're playing and you see them come off during a timeout, if you have that strong bond with them you can almost tell if something's wrong with them without them even saying.

A398   There was days where she would come into the training room, and you know you could just tell that she wasn't, she wasn't feeling right or something was just bothering her. So it was one where if she looked like she was struggling, or if she just needed time, I was willing to you know make changes to her program. Like hey let's just, we'll take a day off today, let's, let's have a mental day or things like that.

Bonding takes significant time and attention, and signifies a rare and deeper *connection* between athletic trainer participants and patients. Furthermore, it represents participants to implicitly sense, understand, and attend to patients needs above those of physical ailments.   While *bonding* is not present with all patients, participants' experience of **establishing** is also understood by **establishing** *trust*, the fourth ***sub-category***. A discussion of participants' experiences **establishing** *trust* follows.

Trust

Establishing has aspects of cultivating and maintaining patients' and coaches' belief and confidence in the athletic trainers ability to act in a supportive and protective manner with patients and that the athletic trainer is competent. This makes up the fourth ***sub-category; trust***. Not only is trust between patient and provider necessary, developing it in a timely manner is beneficial for creating a relationship and supporting the care process. Further, without the presence of trust, provision of care stymies and both athletic trainer and participant activation can wane.

L30   I think it is important to build trust and rapport quickly. Without trust and rapport, the patient will not relax for an evaluation and apply the things that we discuss together. Like, without trust from your patients, it is hard

> to get them to relax for simple things like for a Lachman's, or other joint movements.

> A8   I think the way that I've been building the relationship with athletes that I've worked with both here and at [a previous institution], right now, and in the past it's building a base level of trust. I really work with the athletes to let them know that I have their best interests at heart and that in turn allows them to, or they start to trust me quicker and then that just helps to build that professional relationship.

> A46   [An example of] trust that really was a strong bond and relationship, was a female athlete where I worked previous to this job, um, she was coming off her fourth knee surgery on the same knee. And it was just one where we worked together, and we built that bond and that trusting relationship, and we were able to get her back playing…So that was, that's the best example I have of that that trust, that bond of trust, that really, that really worked well

> M32   And they [patients] know that like, they can trust me with things, and let me know what's going on so I can take the best care of them that I can.

> A29   Trust to me is kind of a mutual thing. Um, it means that I trust in you that you will listen to me when I give you advice and then your trust in me means that you know that I am not gonna steer you in the wrong direction. So it's a very open two-way street, and the thing I've always had with that is it's a hard thing to get but it's an easy thing to lose so I really, I really focus on you know, building that trust and then maintaining it.

In addition to establishing trust between athletic trainer and patient, gaining patient trust in the care process can encourage patient willingness to attend care sessions.

> A337   With the compliance and getting [patients] to agree to come in, again that's, that goes to them trusting you and them believing in the process. Because if you have that then they're going to be more willing to show up every day

As the **sub-category trust** took shape, two distinct _concepts_ emerged that spoke to cultivating and solidifying trust: _information sharing_ and _proving._ While **establishing** trust between athletic trainer and patients holds the most weight in the data, **establishing** **_trust_** also encompasses managing interactions and relationships between athletic trainer, coach, and patients.

Information sharing

Encompassing communication and dissemination of information, this first

concept, *information sharing*, represents what is shared and with whom, and

circumstances surrounding protection of patient information. The following passages

highlight the importance and manner in which participants deliver information to patients

and coaches. Honesty, transparency, and standing by communicated patient expectations

surface in the following passages:

> M105   I think being really open with communication with them, being like hey this is the best-case scenario, this is the worst-case scenario, and like not just, not sugarcoating things but also like being very real with them as far as what is expected both of them and then of outcomes for their injury, right? Um, I think helps develop trust because they know that you're not, um, what's the word, you're not covering anything up, you know you're really putting it out there. This is what I see, this is what I think is gonna happen, this is what could happen. Being transparent.

> L281   I'm a big proponent of once you define that goal you have to really then stick to it. Ah so if you say 'hey we're gonna do you know, um….we're going to do five exercises, you're in you're out and you're on, or you're on you're way. Like so you define that. I always felt guilty about this one because as they're doing their last exercise without fail you come up with another one. You're like ah this would be great today! And then you have to be like, alright, I already told you this is the last one. But, you're free to go, but I would love for you to do this one and this is why. So you have to be a person of your word.

Participant experiences also highlight limits to protecting and sharing patient information,

often with coaches. Participants describe defining for patients what information is or

needs to be shared, and when it may be beneficial in an effort to promote patient comfort

divulging health or other information.

> A487   The biggest way that I am there for them mentally is just giving them somebody to talk to that's completely neutral and everything. I mean if they're having a problem with their professor, or problem with their coach, I want them to feel like they can come talk to me and just get it off their chest. They're not going to have to worry about me, you know, going and

reporting it to anybody. Um, and then they just, I'm not sure just, they realize that they can feel comfortable talking to me about things like that and, being that person to ah, that ear for them, is I think really, really important.

M94   But there are things that it's really helpful if we let the coaches in on X, Y, and Z so that they can make a practice plan. And explaining it that way as opposed to like I'm going to tell the coach you're hurt. Um and making it like, there's a reason for it you know.

O88   As far as being comfortable talking about anything I think, ah, a specific example is a lot of that has, example wise would have to be, ah, problems with coaches that some of our players have. A big barrier with that is them [patients] thinking everything they tell me goes straight to the coach. And so often I like to address that first. Especially if I see somebody's having problems talking to me about stuff, or if they're having problems just with the coach. Like telling them, make sure they know that anything they tell me doesn't always go to the coach. If it doesn't affect your playing time or ability, I'm not going to tell them about that.

Furthermore, in relation to the coach relationship, participants recount communicating and sharing patient information with coaches to facilitate coach understanding of patient ability to practice or compete, thereby working to support clarity in the patient care process.

M592 Sometimes it's just easy miscommunication between them [patient] and the coaches where the coaches don't realize that they're [patient] in as much pain as they are in because they are not saying anything, and so then they're [coach] pushing them harder. Then I'm just like hey, let's just all be in one room at the same time and talk this out.

As data was de-constructed around **establishing *trust***, the *concept* of *proving* professional responsibilities and dedication arose.

Proving

This *concept* represents verifying participants' dedication, professional capacity, and worth to patients and coaches, directly and indirectly.

A476   I think then, once they [patients] realize that you know, that I'm not just there for you know a paycheck, I'm there to make sure that they get better.

> Both physically and mentally. So I think that, once they realize that then yeah they put in more effort.

> O94 You know I've been here for a little bit right now so ah some of the other students, our athletes here will tell them [other athletes] also you know hey if need to talk, [Orlando] will talk to you and he won't tell the coach. So I've got that working for me right now too because a lot of ah the older students who know me better, like to tell the younger students don't be afraid, he's not, he's not going to tell the coach everything you say.

As the _concept_ proving continued to take shape, specific *properties* of *credibility*, *commitment*, and *advocacy* began to appear.

Credibility. The first *property*, *credibility*, represents conveying understanding and establishing professional integrity and ability to patients and coaches. Attending athletic events and practices and communicating understanding and appreciation of patient experiences are ways participants show their desire to support positive therapeutic outcomes.

> F105 I got to travel to a meet with the team. I feel like that really helped especially it being my first year that I went to this meet with them, and I do get to work at least one home meet each year, so that also um, I think helps with my credibility a little bit.

> K25 just letting them know, you know, I've been in your position, and I understand the pressures that you're gonna get to return early, things like that. But, just letting them know that you have someone in your corner and that I want what's best for you as well.

Moreover, former and current patients were also supporters of athletic trainer *credibility*. For patients, seeing and hearing about successful treatments from other teammates and athletes enhances the *credibility* of the athletic trainer. Participant experiences gave voice to the role of patients promoting athletic trainer aptitude and reliability in the following excerpts:

> O594 A lot of getting people [patients] to, I guess, comply and be okay with it

[treatments], is them seeing it done to other people and kind of like you said, you kind of get that one athlete who lets you do almost anything, and then they tell you how much better they felt, and they tell everyone else how much better they felt, and then eventually it gets to a point where people are just like just, just do it. *(Laughing)*. Just do whatever you need to do. And I've kind of gotten to that point here. Um freshmen are a little different, but uh, most athletes here, they'll just, like, "just tell me what you want me to do, and tell me how you want me to lay, or what you're going to do and just do it."

F113   And like those girls now are juniors and seniors um, so it helps them then too that they've known me almost their whole college career and can, you know talk to the younger girls about like really you can go in there, she's fine

L211   Once you have that built [trust and rapport]…as soon as you get a new first year student that comes in or transfer, people [former patients] are gonna be oh go see that person [the athletic trainer] because they'll take care of it. Or they're super cool. You know, go see that person.

In addition to establishing *credibility* with patients, confirming *credibility* in the athletic trainer-coach relationship also benefits patient care by limiting disagreements with coaches and allowing participants to make decisions that protect patients. Sharing personal experiences as an athlete to convey understanding and appreciation of what coaches expect of their athletes encourages coach trust in the athletic trainer participants and their professional decisions and recommendations.

K356   I think getting some of the coaches as well and letting them know, I was a college athlete, you know I know where you're coming from. You want all the players there. And I'm willing to do what you need to get that. But you know, sometimes I'm not going to make the decisions that you want but, just know it's because I wanna get them back out there as soon as possible. So kind of them knowing my history with that a little bit helps them be I guess a little less, always questioning of; does this person really need to be out? Does this person really need to go to the doctor? Kinda stuff like that. I mean you're gonna have your everyday conflicts with stuff like that. But it's definitely a lot less I think.

While confirming understanding of patient experiences and coach expectations, in addition to having former patients as supporters, are ways of *proving credibility* and

gaining coach and patient trust in the participants, another *property* of *proving*,

commitment was also present.

Commitment. *Commitment*, the second *property* of *proving*, captures going above

and beyond usual professional responsibilities to foster a connection that benefits

patients. This is seen in the following passages:

K57   I mean I believe in doing the little things….my view is I have the best seat
in the house, why am I not cheering for my team, why am I not supporting
them, why am I not, you know… They have, a night at Chili's where they
get you know 10% of the proceeds go to those things, like. You know we
always want to be considered part of the team. Well you know you need
to act like it. Um, and showing that you're as committed to the team as
they are in your role.

K92   Um, when they're taking those like biology and anatomy classes or um
kinesiology, I'm, they're more than welcome to stop by during quiet hours
and ask for help.

While *commitment* refers to participants desire to offer more to their patients

beyond typical professional responsibilities, the final *property*, *advocacy*, captures

protecting patient well-being.

Advocacy. The third and final *property*, *advocacy*, embodies promoting and

protecting patient health above all else. Participants' experiences intervening on behalf of

patients, with the coach or with the patients themselves, spoke to supporting positive

health outcomes in both the short and long term.

M89   I think one of the big things I run into as far as trust is that they don't,
especially freshmen coming in, don't know where you stand with the
coaches. As far as, when I think of like trust issues with student athletes
that's the first thing that comes to mind. Because they don't know where
you stand, and you're sort of like, I'm not in their environment all the time
because they're over at the [practice facility], so they don't know if we [AT
and coach] talk, they don't know where I stand in that situation. So I think
that telling them that you're, like just straight up telling them like I'm on
your side, I'm your advocate, that's my job, that's what I do.

M99   Um, and really just being explicit that you're a student athlete advocate and that that's, that's where I stand in that sort of environment, I think is important. Especially for kids coming into college who might not have had an athletic trainer or had one who is part time you know. Um, who wasn't as involved. So I think it's important that they know coming right in like where, what my role is as far as that relationship goes.

K33   Sometimes you have to get between them [patient] and the coach. And sometimes you have to get between them [patient] and themselves because at 18, 19, 20…it's kind of hard to see past your four or five years of, you have this body for the rest of your life. And a college athletic career is only going to last four years, and so few of us have professional careers. And even then that does not last forever. So sometimes, being that moderator between coach, or even, just between, them, the [patient] side and then themselves, um, can kind of help them [patients] build up trust till where they can kind of step away from the initial shock of the injury, and really realize the extent of it and what it could cause for their future.

K224   Sometimes they [athlete] address you [athletic trainer] as a coach, and you know, you [athlete] tell a coach, 'hey coach I need to take it easy today', I mean what's gonna happen your [athlete's] butts gonna get ripped. And, I mean, you [athletic trainer] have to make them understand, you know, that doesn't happen here. You know, we're here to protect your bodies not to, we're here to make sure your bodies are good to go when, when you go out to those practices.

To summarize, *trust* was a vital component of **establishing** a relationship and managing interactions between athletic trainer, patient, and coach, and a lack of *trust* hampers the care process. Moreover, generating patient *trust* in the care process promotes patient willingness to attend care. Athletic trainers can **establish** *trust* by considering how they communicate and *share information*; what is shared and with whom, and circumstances surrounding protection of patient information. Honesty, transparency, and holding to communicated expectations are important when delivering information to patients and making care decisions. Defining and clarifying limits to protecting and/or sharing patient information encourages patient comfort in divulging health or other information to athletic trainers, which can help support the patient care

process. Additionally, communicating patient information with coaches facilitates coach understanding of patients ability to participate and helps clarify patient progression through the care process. **Establishing *trust*** also involves athletic trainers *proving*, or verifying their dedication and processional capacity and worth to patients, directly and indirectly. *Proving credibility* involves athletic trainers conveying understanding and appreciation of patient and coach experiences and establishing professional integrity and ability to support positive therapeutic outcomes. Athletic trainer supporters, former and current patients who share their treatment successes with current patients, also boost athletic trainer *credibility*. Confirming credibility in the athletic trainer-coach relationship by expressing appreciation and understanding of coach expectations can limit athletic trainer-coach disagreements and promote care decisions that best protect their patients. Athletic trainers can prove *commitment* to their patients by going above and beyond typical job responsibilities to foster a relationship that benefits the care process. Finally, promoting and protecting patient health above all else and intervening on behalf of patients to support positive health outcomes in the long and short term demonstrates patient *advocacy*. **Establishing** a ***connection*** and ***trust*** between patient and provider and provider and coach is not limited to rapport building, communication, and interaction. It also relates to the care environment, the final ***sub-category*** in **establishing**.

Environment

The last ***sub-category*** in **establishing** relates to the ***environment*** of the athletic training facility. Creating an atmosphere that patients feel comfortable entering and returning to, and is fun and stimulating contributes to the experience of **establishing** a

relationship with patients. The following passages illustrate participant experiences

regarding **establishing** an *environment* that supports the care process:

> L459   I think adherence also comes down to you know how creative and what you do on a daily basis, so the environment you set. So I think setting a professional environment is huge too, it's not a big party room as far as the clinic. But then, from there of you know when they [patients] come in every day, um I do a lot of dumb awkward things where, whether it's a joke of the day or quote of the day or interesting dumb fact of the day that I've looked up. Like it's, it doesn't matter but it's one of those they'll come back, its weird the people that even hate all the jokes I've found over time they'll come in and be like oh what's the joke of the day, and I'm like every time I tell you, you make fun of them but you still come back for it…. So it's just weird and interesting I found that even though they hate it or even though you know they don't like the question they come back every day just for that. But so is just creating that environment where it's fun, it's interesting, you can dialogue and kind of continue to build that relationship I think helps with patient's adherence as well. Because if they're just coming in and sitting in the corner and doing exercises, I mean they can go to the weight room and do that, so why in the world should they show up. So um. Its kind of putting a little spice in the environment, um helps a little bit.

> O141   I just try to joke around a lot. So, um I mean obviously there is always a time to be serious and stuff like that, but, I'm not one for silence. Especially if I'm in there doing, ah, somebody's hooked up to a stim unit or if I'm doing ultrasound on somebody for seven minutes, I like to talk to them, and I like to make it a little more entertaining. So, we usually joke around a lot. I have one athlete who comes in every day and, and she's always got a joke she wants to tell me about some of the corniest things she's ever heard….But it had to do with like the first time [she came into the [athletic training room], she was real like scared so I told her a real corny joke, and then ever since then she's came in and had her own kinda corny joke to go along with it. I think just building that kind of ah, you know this doesn't have to be a place where you just have to kind of sulk because you're hurt or hurting. Um we can joke around, we can laugh, and I think it helps people get better too, if they're not in there thinking that I'm just always hurt, and this is a bad place to be.
>
> J   *Um, so it sounds like you recognized in your female athlete that she was nervous*
> *and she was scared so, um to break that ice or to like you said, kind of break down that barrier, you did, you used humor.*
>
> O164   that's what I try to do if I feel like somebody is a little apprehensive with ah talking to me or about being in the [athletic] training room.

In sum, **establishing** an *environment* captures ways participants' create a patient care atmosphere that is fun to be a part of, yet professional and comfortable to enter and/or return to when seeking or receiving care. Acknowledging and talking to patients while they are completing treatment and rehabilitation activities, and use of humor in patient interactions helps participants create an *environment* that feels welcoming and confortable for patients to enter and stay. The varied and rich experiences of **establishing** *connection*, *bonding*, *trust*, **and** *environment* set the stage for moving into and through, or **navigating**, the care process. **Navigating** became the second **category** representing participants' experience of how athletic trainers develop and utilize the working alliance with patients.

Navigating

The second **category** that materialized during round one of data analysis was **Navigating**. The personal *connection* and *trust* participants cultivated as they began **establishing** a working alliance with patients and coaches became the foundation on which participants and their patients moved into and through the care process. For participants, **navigating** also comprises addressing barriers encountered with patients during the care process. As participants shared experiences of **navigating** through patient injury/illness and the care process, it became clear that contributions from both athletic trainer and patient were present, mutually or individually:

> K475   You know my biggest thing is, I'm gonna keep you on the court, or field, you know, whatever. But sometimes that means I have to take you off for a little bit. Obviously I don't want to, because I know that's not fun from my past as a college athlete. I know that's no fun.

> M190   She tore her ACL two or three weeks before [a race], and she basically was like I'm just gonna race and then deal with this after. And I was like that's fine, but you just need to know that this is what's gonna happen.

Like X, Y, and Z, you know it's gonna be painful it's gonna swell, you're going to end up with the loss of motion, etc. so, I kinda just went at it from like, if that's what you're gonna do, it's not unsafe to do. So obviously she saw a physician and all that, and got clearance. Um, but I want you [the patient] to be realistic about what your outcomes are going to be, is basically how I went at it. And then from there like, that's your choice.

L356   Okay well let's communicate, let's work through that of maybe if you're super busy we, we, you know work with at home something you do these at home or you gotta schedule time, you can't meet with me anytime I'm in so lets you know, work with someone else or do something in the weight room on your own. Let me give you a plan for that. So it's kind of navigating through that.

As the category of navigating gained definition, so did two **sub-categories**, **care roles** and **patient resistance**. These **sub-categories** added clarity to participant experiences and efforts to realize positive therapeutic outcomes for their patients.

Care roles

The **sub-category care roles** spoke to a process similar to holding a set of keys and determining, based on the situation, which key would unlock or enhance the care process. These keys manifest as varying care roles that participants embody during patient care, ultimately denoting who would be contributing to or directing the care process at that point in time. Three distinct care roles came forth as data was deconstructed and became known as _director_, _partner_, and _educator_.

Director

When in this **care role**, athletic trainer participants unilaterally determine and direct aspects of the care process and make decisions they consider necessary and efficient to progress patient care. These decisions were present during goal setting, and when determining therapeutic exercise and treatment. Though participant decisions when in the _director_ role appear as unilateral, they are geared and adapted to most benefit the

patient. The following passages elucidate participants' experiences navigating the

director role and making care decisions by assuming and perceiving patient needs:

K303   Ultimately you're gonna have to do what you need to do, so….
J   *and those are conversations that you have with your patients, like 'hey this is, this is what we're gonna do and this is kind of why we need to do it?'*
K   Yea, I mean, I've never had a patient particularly like instrument –assisted stuff but they've never told me no. They're like you know, "just get it done." "Just get it done so we can get this over with."

O625   If I do something to you one day I am 100% not going to do it the next day. I do different things, uh I don't do the same thing day after day. Um, so they know I like to try different stuff, but they also know that I have kind of a method, and I start at one place, and uh, you know maybe I get to another place….[patients] don't usually come in and ask me to do like a specific thing to them. They know I'm going to do it based on where they're at, and the injury they have.

F469   A lot of it [selecting tasks and interventions during pt. care], I try to gear it as much towards the individual as I can. Um, so, I have one girl who's got patellofemoral pain for the last year and a half…um, and then I had another girl, freshman, coming in with patellofemoral pain, and she's a freshman. I mean with her it was like no gluteus medius strength whatsoever, so it was like well we're working on the hips first and then we're going to go to the quads. That was like her plan, and it was very much more you know, hip heavy, rather than the quad. And then the other girl, um she's got great strength so with her I tried to focus more on, I don't want to say easy but like easy exercises. She may see as easy but they're really getting to like more neuromuscular kind of issues. Because I know she's working on the strength portion with our strength and conditioning coach and he knows what he's doing and I don't need to make her do more hamstring curls or you know squats in the athletic training room. I'm gonna focus more on the balance aspect and let's look down the kinetic chain at the foot and see if we can't strengthen those intrinsic foot muscles and get your gait more in line. So yeah, it really, really, depends on the athlete.

K148   …their first question is "can I play today, when can I play, can you give me a date?" And you know every body responds differently to every injury and even the same body will respond differently two times to the same, two different times to the same injury. And, I try, the best of my ability I think is, I break it [goals when working with patients] up. Like okay today, let's try to do this. Like let's not think about tomorrow yet, let's try to be able to do this today. I mean obviously there's still a little bit of a pitfall in that because, maybe we can't do that today and then they're

frustrated. Or, they can do that so well today, they're like 'okay so I can play tomorrow right?' But. That's my biggest thing I think that I found that, that works the best….Because I mean obviously they're adults and they can do what they want, but I think that they're more apt to behave themselves, like not go to the gym and shoot after hours when they're not supposed to or things like that. If you really let them know that I'm trying to get you back as fast as possible. That might not fit in your timeline, but it's going to fit in a timeline that works for your body.

F224   So obviously they [patients] come in with an injury, ah we get it diagnosed, and figure out like what we're dealing with, and then I give them an approximate timeframe. Always approximate, this could be shorter this could be longer…But I like to start at the end, first. You know we want to be back by this date, ok so we need to be running by this day, and we need to have full range of motion by this day. Um, and kind of work backwards so that they see, you know, each of the steps and what we're gonna do to get them through each one.

Though participants believe they can most effectively direct the care process based on what they perceive as necessary, decision-making is not always unilateral. This is evident as participants and patients act as *partners* during the care process; the next *concept* in **care roles**.

Partner

Recognizing the importance and value of patient contribution to the care process, this *concept* captures patient involvement in care decisions and athletic trainer participant experiences seeking and integrating patient ideas and feedback to inform and/or guide care decisions. Taking on the **care role** *partner* embodies participants acknowledging the significance and value of patient input, and seeking it out during the care process. Identifying patient desires and values facilitates creation of care decisions that support outcomes significant to the patient, as opposed to participants assuming they know what is more important to their patients:

A99   Anytime that I'm working with any new athlete I try to keep the, you know, the rapport or the communication is a two-way street. It's, it's never

> my way or the highway anything like that. So, I let them bring in their ideas of what they think might be going on and then I kind of add to that. Especially with rehab.

> O511 I think it's realizing what their goals wanna be and then trying to relate what you want your goals to be, to what, where they, what they want. You know like I said, maybe they don't want to play baseball anymore but they are going to want to hopefully reach the top shelf there, with the rest of their life. Not just relating everything back to their sport, relating it to maybe what they, what their goals are, and what they want to be.

Partnership in care decisions also looks like empowering patients to make treatment decisions, which is present in the following quote:

> M442 I use a lot of um, Graston, and then we also use cupping. And some of them like one better than the other and so I'll let em pick. Because ultimately were looking for the same end goal. I mean they're slightly different techniques, right, but like we're trying to mobilize tissue. So, if they absolutely hate cupping I'm not gonna make em do it. So I'll be like hey I think we've done cupping in the past, did you like that, like was that effective for you? And give them kind of the option. If they're like 'no', I'm like alright let's try something else.

While the aforementioned passages offer examples of partnership in care decisions, as participants shared ways information was obtained from patients and used to make care decisions, two *properties* surfaced, *solicitor* and *collaborator*. These *properties* describe who holds power over making care decisions and who is driving the decision making process.

Solicitor. This *property* captures participants asking for feedback from patients, often of a specific nature, to inform participant initiated changes to the plan of care. When soliciting patient input, participants maintain power over care decisions, however changes to the plan of care are based on patient provided input. Ways in which participants requested patient input can be seen in the subsequent excerpts:

> O258 At the very beginning when I'm setting goals it's ah, whenever I'm doing my initial treatment, let's say they sprained their ankle and it's got ice,

everything right there. Ah we kinda talk about, you know, how can you play and what do you want to be able to do to play… So some people wanna, need to be a little different level before they wanna get back on the field. So I kind of let them decide where that level is, and I get them there…

F447   I usually start with the process [goal setting] that I have. Um, but I make clear that it is dependent on them [patients]. So, they have to let me know how they're feeling. But, um, I do want to have their input, so if we're doing exercises I usually have a list, and then let them choose. You know, so I've got, I've got a patellofemoral pain girl, and I know I wanna work on her glute med, and I know I wanna work on her quad, and I know I want to throw some hamstring stuff in there to. But, I've got like several exercises for each one, and say like what do you want to do today from this section? So kind of give them that power, to determine what they want to do that day.

A293   I kind of just select them [tasks and interventions], just kind of determining, or based on what their [patients] needs are at the time. Ah, 'cause I mean every athlete is different so I think that's, that's general thinking I think usually how I go about it is just kinda seeing how they, ah, what their needs may be and how they are responding to certain things. And then just, um, deciding the appropriate course of action from there.

J   you're selecting based on what you see or what you're perceiving. Is that, is that really how you kind of shift what you're doing because of what you see, and how they are reacting or interacting? Or is it the instance where it's a two-way conversation with them about what they want to do or what they'd like to do?

305   Ah, I think it's, again its kind of a combination of both. If I see them struggling with something I will change it as needed. Um, but also I'll take their input on it if they say that they don't like that exercise because it doesn't feel right or it doesn't do anything then I'm willing to make that change.

O591   I decide based on the injury what I do as far as ah modalities, physical/manual therapies and stuff like that. Um based on how they're hurt. Um I do a lot of, I don't want to say the same but slightly similar manual therapies. And so a lot of the selection process is all based on where they are in the injury

J   Is that something that you also kind of discuss with your patients, or is that something that you kind of developed along the way, that hey, you know these types of techniques and procedures work for this injury so this is what, um, I'm going to choose to do.

O618   I always start with that, um this is what I've seen work and this is what I'm going to try to do. But I will change everything I do based on ah, what the patient reports back to me. Um I always tell them, okay were gonna do

this today, you need to let me know how you feel. Or ah, were going to do this this week, you need to, we need to see where you are next week.

M277   So we do usually like either Tuesday, Thursday check-in's or like Monday, Wednesday, Friday or something like that. And so on Monday I write down their plan for the week and whether, and it depends on how far along they are. Because early on in the rehab process for the rib it's pretty structured because you don't want them to like give an inch take a mile type of situation. But then later on when it's like hey you're going to do, you know um erg for you know 3x10 minutes two of the days, and then you're going to do shorter steady state pieces for two of the days…..When there's an opportunity to do so [include the athlete in goal setting/decision-making], if it's you know two days you're gonna do 3x10 and two days you're going to do long steady-state pieces, we're not going to do them on back-to-back days, what days do you want to do them? That sort of thing, like including them in that process. But it's very much like, we sit down on Monday, we make that plan, and then we discuss the goal, the end goal for the week, and then kind of where they're at in the whole recovery process, if they have any questions, etc.

M288   When there's an opportunity to do so, if it's you know two days you're gonna do 3x10 and two days you're going to do long steady-state pieces, we're not going to do them on back-to-back days, what days do you want to do them? That sort of thing, like including them in that process. But it's very much like, we sit down on Monday, we make that plan, and then we discuss the goal, the end goal for the week, and then kind of where they're at in the whole recovery process, if they have any questions, etc.

Collaborator. The second *property* under *partner* entails incorporating

information freely offered by patients and working with them to jointly identify and

integrate care decisions that are meaningful to the patient. Patients hold more power by

being able to direct their care process with the input they provide. *Collaborator* also

represents participants recognizing and tapping into patient expertise to create goals,

guide exercise plans, and brainstorm relevant therapeutic exercises. Participants express

this in the following passages:

A99   Anytime that I'm working with any new athlete I try to keep the, you know, the rapport or the communication is a two-way street. It's, it's never my way or the highway anything like that. So, I let them bring in their ideas of what they think might be going on and then I kind of add to that.

Especially with rehab. Um, I mean I'll be the first to admit I don't know everything about every sport so I'm willing to, when I'm doing the rehabs with my athletes that if they have an idea for a new exercise that's more either soccer specific, volleyball specific I'll let them kind of integrate that into ah, into their rehab…. the rehabs that I've been doing, they seem to have responded well, um, they like the fact that they have a say in their recovery in their rehab. So it makes them feel more involved, more willing to buy in to the whole, the whole process.

A170   About a week or two after [her] surgery because she got her surgery right around a break time so she, uh, she went home. We just brought her in, and we kinda, with her, the surgeon's notes that he gave me for the guidelines as far as the, the rehab program, I kinda brought her in and we just went over what I kind of laid out my goals for her and then I let her set goals that she wanted to achieve for herself.

A305   If I see them struggling with something I will change it as needed. Um, but also I'll take their input on it if they say that they don't like that exercise because it doesn't feel right or it doesn't do anything then I'm willing to make that change….We can kinda modify certain tasks as needed

K199   We were doing stuff every single day, and when we got more into the kind of, heavy strengthening reconditioning phase [the patient] kind of came to me and he said 'you know, this like, doing the running and doing the big lifting is kind of killing me. Can we maybe do like, an agility day, and then a lifting day, take Wednesday off, and then do agility and lifting again so I still have that day off in between and I can kind of switch up what I'm working.

J   *so [the patient] was asking for something that [they] needed and you were completely open to that*

K   Yea

Even in instances were participants express concern about their patients ability to make

beneficial care decisions, participants will work to find a way to empower their patients

to take a direct role in care decisions. This collaboration is evident in the following

passages:

M155   Athlete is ACL deficient, which isn't necessarily problematic for [her sport], but they do a lot of cross training where they run up and down the stadium. Which is obviously more problematic, sans ACL. And so she really wanted to do it….and so, um, we just sat down and said you know, here's a across training plan for the week, cuz she can't do a lot of the running and cutting type stuff that the team does in lift, in their

conditioning sessions. So I said here's what I think, I think if you do you know, bike/cross training three days a week, then on the other two days you could do something a little more dynamic. But I don't think you should do them in back-to-back days. You pick the days type of thing….And so a lot of it was just sitting down and being like, here's an outline of a plan, you plug in the days that you want to do something else, and then we'll go from there.

M175   She knows that, that the outcome won't be great if she just does what she wants to do. But she also realizes that she doesn't make the best decisions without consulting someone. So we just make an outline and then she can plug in what she wants to do and then she knows one, that she's making a good choice because her knee won't blow up like a balloon, but two, she's still making choices.

Embodying the ***care role*** of *partner* manifests as the manner in which patient input and feedback was obtained and empowering patients to jointly identify and integrate care decisions. Whether *soliciting* or *collaborating*, the variation in how and when patient input was sought and integrated manifests along a number of <u>dimensions</u> of *partner*. The experience of **navigating** the ***care role*** *partner* changes based on participant consideration of <u>rehabilitation</u> (location in and length), <u>severity of injury</u>, and <u>relationship</u>.

<u>Rehabilitation</u>. First, is <u>rehabilitation</u>, both the length of the rehabilitation process (<u>short----long</u>) and the timing of patient input during the rehabilitation process (<u>early----late</u>) influence participants experience as a *partner* in the care process. Participants sought patient input <u>early</u> in the rehabilitation process, with the belief that <u>early</u> patient involvement encourages patient activation, as seen in the following quotes:

O248   I'm much more patient driven goals at the beginning [of rehab], and then AT driven whenever, after I get them to that goal. Cuz I think they go a lot faster if they're working toward something they personally, where they personally wanna go. And then once they get, get there and realize they're making progress, then I can take them kind of where I want them to be.

A155   Like ACL, that's the one thing, the rehabs that I've had the most experience with….but it's a long rehab so I try to get them [patients] involved early and let them know it's a process but it's, it's a rewarding process in the end. And then when they are allowed to help set those goals I think that really helps them bring it into focus.

Whereas seeking patient input <u>late</u> in the rehabilitation program allows patients a chance to gain insight into their bodies, thereby developing skills and knowledge that enables them to make better care decisions, and qualifying them to effectively participate in the care process:

K179   [patient participation in goal setting] at first, not necessarily, but as it [rehabilitation] goes along, yes….I think you have to be taught to listen to your body a lot more than you think you would. And I think once they [patients] kind of understand that, you know my [patients] body's not superhuman, you know my body does take some time to recover, my body does need rest, and all this other stuff….I think once they learn to listen to their bodies they can say you know, 'I feel good today, I think we can do a full day's rehab'. Or you know 'you pushed me really hard yesterday, can we back it off a little bit today?' So I think that once they kind of understand that process they are much more, um, involved in setting their goals for that day.

Participants' belief that seeking patient input is more effective with <u>long</u>-term rehabilitation appears to speak to encouraging patient motivation or activation to partake. Completing a <u>short</u> rehabilitation program may encourage patient passivity, presenting as patient preference to be directed and guided through their care process. Moreover, this perspective also appears to influence participants' decision to solicit or collaborate with patients. For example, with <u>short</u>-term rehabilitation, participants act as more of a *solicitor* due to patients not being as forthcoming with information. Whereas with long-term, participants act as more of a *collaborator,* due to patient awareness of the prolonged time they will be partaking in rehabilitation and consequentially increased collaborative opportunities.

O464   I do think it [patient centered goal-setting and um, patient driven decision making] kind of goes more with the longer-term people than the shorter-term. I think the shorter-term, especially if they know they're not hurt as bad to begin with, that they don't, or at least they don't think that. Then ah they don't take to the doing their own stuff by themselves as much. Uh especially if they have a goal of being back within like a week or week and a half.

O472   I think it does do more for the longer-term rehabs to be more kind of self, self reliant, and, ah I think they take to it a little better especially when they know that they're going to be doing this for a longer period of time.

K220   [conversation about 'hey I want to do this today instead' happens more with] definitely with longer-term. The shorter-terms you kind of have to prod 'em more, like you know are you feeling sore today, you know what are you feeling? Um, hey I see a little bit more swelling, is it doing okay, are you sure it's doing okay? Like you have to prod them a little bit more to get them to like kinda really say what's going on.

    <u>Severity of injury</u>. Second, <u>severity of injury</u> represents the significance of the injury patients sustain <u>(simple-----complex)</u>, which also influences participants' experience as a *partner* in the care process. More common or less severe injuries (<u>simple</u>), with a short care process were seen as more "cut and dry" and easy to follow, therefore care was less collaborative and patient input was seen as unnecessary to seek out or incorporate.

A203   Um, play-by-play, and I would say situation-by-situation. I mean if it's something that, it's you know an ankle sprain, um, I mean we'll, we'll set the goals of you know walking without crutches or just walking normally….Um, and then if it's I mean if they're just kind of coming in for like the general maintenance of ice because they're sore, the occasional stretching or things like that then I tend not to um, really work on the goal-setting.

F427   I had an ankle sprain…it was just like a first-degree ankle sprain, I was like all right well we're going to get you back, this is not gonna take very long, you know 7 to 10 days. I want you off the crutches by this day, um, we need to do, then were going to, building on your range of motion and strength again, this, this, this.

Relationship. Lastly, relationship, specifically the strength of relationship between participant and patient (weak-----strong), was especially salient for one participant while recalling specific patient care experiences. A strong relationship, characterized by a deeper and trusting connection and mutual respect, allows the athletic trainer to disclose uncertainty and seek patient consultation and instruction, in effect relinquishing the *care role* of *director*. As seen in the following quote, participant collaboration with patients is well received:

A126   Ah, I kinda let them share if and when they want. Um, and then on rare occasions if it's something that where we've been working together for a long time I'll admit to them like 'hey I'm stuck on a new rehab idea for you, what do you think?' And then that usually, I think the two times that I've done that, that perked em both up real quick and they, they really enjoyed that.

J   *and then how did they then kinda respond and react to you after that*

A   that's a great question, cuz the two that I kind of got that with were the two athletes that I had probably the highest level of relationship with at my previous institution. Um, so I mean I think that just strengthened our relationship and our bond and they, um, I think they both, they responded well, and from what I've heard from others, when they talk to, you know their coach or their peers about me, it seemed like they held me in fairly high regard, and very high respect.

Though participants appear to almost always determine which *care role* they occupied, there was movement between. At times, participants negotiate different goals, or other aspects of care, believing it beneficial for their patients. The following excerpts exemplify participants embodying care roles as both *partner* and *director*. Maintaining these dual *care roles* enables participants to keep patients' best interests in mind and facilitate participants' ability to advocate for patients long-term health and function.

O235   So some, some patients they're only worried about getting back to full strength before they do anything, which, so your goal is you know pain-free everything back before you go, and then we set goals up going there. Um, some it's not about being 100% it's about being able to do that, that one thing that they think they're really good at, and then we set goals

based on getting that one thing. And then, we kinda take, after they get that then we just keep taking em along until they get their full 100%. So I try to get them where they wanna go first before I get them all the way back to, when I set em to like my health goals, medical goals I guess.

O248 I'm much more patient driven goals at the beginning, and then [AT] driven whenever, after I get them to that goal. Cuz I think they go a lot faster if they're working toward something they personally, where they personally wanna go. And then once they get, get there and realize they're making progress, then I can take them kind of where I want them to be

O498 I've had a person who was just okay with their arm just being at 90. And I, you know, I'm okay with kind of letting that be their goal until they get to 90, and then we got to go, and then we got to do more….and you know letting them know like….I said do you really want to go through the rest of your life not being able to reach the top shelf. And you know that kind of spurred them to go a little further cuz you know you're only 20 years old, you definitely want to be able to do more for the rest of your life…. communicating why they need to be healthy for you know real world, real life. Not that playing sports isn't real world but for the rest of your life.

O258 At the very beginning when I'm setting goals it's ah, whenever I'm doing my initial treatment, let's say they sprained their ankle and it's got ice, everything right there. Ah we kinda talk about, you know, how can you play and what do you want to be able to do to play… So some people wanna, need to be a little different level before they wanna get back on the field. So I kind of let them decide where that level is, and I get them there, and then I say, you know just because you are 70%, you know we're still going the extra 30. But it gets them to that 70% a little faster, they see those gains, and then I can get them up to where I want em to be.

In addition to the **care roles** of _director_ and _partner_, participant experiences also speak to the role of patient education and its importance to the care process. The richness of the data around patient education illuminates the **care role** _educator_, the final _concept_ in the **sub-category care roles**.

Educator

This _concept_ speaks to the education athletic trainers offer their patients and the importance of providing patients information during patient care. Education surfaces as

all encompassing; most often based on what athletic trainer participants perceive patient

needs are, or in response to patient curiosity.

> M697 I think I do a lot more patient education now than I had done in the past. And whether that's just because they ask more questions so I have to, or its because I realize there's more value in it, I'm not, or probably a combination of the two, would be my guess.

> M435 I always try to be like consciously aware of like giving them an opportunity to ask questions, especially if they're not doing it on their own. A lot of them will just do it and ask questions and then I just assume that they're gonna ask their questions. Um, but when kids kind of look like they're, they're not totally getting it I always make sure to ask if they have questions. Um And give them that space and time and opportunity.

Consequently, three *properties* surfaced within the <u>*concept*</u> of <u>*educator*</u>; *body*

awareness, *understanding injury*, and *purpose of treatment*. Collectively, these

properties embody the intent of the information participants provide to patients and can

be seen throughout the following passages.

Body awareness. This *property* comprises education about patients bodies,

including anatomy and physiology, body function, and body consciousness.

> K514 As an athletic trainer you are kind of like a professor to your athletes. But you're teaching them about their bodies. Whether it's you know, you're teaching them about an injury, or you're helping them with nutrition, or helping them with sport performance thing, in the weight room, things like that. And I think that the more athletes know, I think the better they perform, honestly.

> M415 One of the things that I think is really important is teaching them, like about their bodies, right? Like it's theirs, not mine. So, um I think teaching them about it is really important. And so for me anytime I'm like teaching them an exercise or prescribing a treatment or something like that I'm also teaching them about it.

> K507 For the most part I actually have like, a lot of the major injuries I've had like people wanna know. Like okay where's your ACL? Where is this, where is that? And that's when I pull out you know the atlases [human body] and say okay, you know this is where this is, this is you know pointing stuff out. You know they want to know what it does, so you pull

out the models and things like that. Um, I would say there's some people that could care less but you still, but you still, I still want to give them you know, well this is what it does, this is what you know this muscle does so we want you to avoid this action.

L127   …educating them of ok here's your issue but its being caused from here. Or you have knee pain, but its really coming from your hip/SI because that's not moving correctly. And um, kind of taking them steps back because that all sounds weird and almost out of the blue like how in the world did you find that. Um so you kinda have to back up and, and just talk them through that. And again I think education comes in huge with this because if they don't know your thought process and what's going in you know, well, that doesn't go a long ways.

Understanding injury. The second *property* within <u>educator</u> attends to provision of information regarding patients' specific injury and the unique characteristics patients may encounter as they move through the plan of care towards return to participation.

F231   I love it if they have questions about, well why is it going to take this long and that kind of thing. Trying to explain to them the nature of whatever injury it is that they might have, and why it's going to take this long, and what's going to happen each week.

L67   If your patients don't know what's going on about their injury and they don't know kinda ok here is your injury and this is basic tissue response and then this is the plan. They're not going to buy into it. So um having them understand that really goes along way because once they buy in they'll do all the work themselves. Like if you don't know about your injury why in the world are you going to stretch at home if stretching's in the protocol. But if you know about it and why its going to help you and what's part of the goals than that goes through.

Purpose of treatment. Presenting patients with underlying reasons as to why they are being asked to complete treatment and/or rehabilitation embodies the third *property* of <u>educator</u>, *purpose of treatment*, supporting patient understanding of why they are being asked to do what they are doing, and how it supports the care process.

M306 I think telling them [patients] what the purpose of each exercise is, not each individual exercise, but I guess of the, the purpose of the progression helps them understand why it's, why it is the way it is.

L381   So that's where the education comes in I think, in the [athletic training] world of hey this is why I want to do this, and if you don't do it this is potentially where you'll end up, and when you end up there, we'll still be here…

L82   So its kinda defining that goal, I think goes a long ways as far as for them as well as for rehab or plan wise. So its kinda saying here's the goal we're working on today. So if its an acute patient our goal is decrease pain, decrease swelling, increase range of motion. So that means when you go home I want you to stretch, I want you ta, whether we have some sort of compression device, compderm, ace bandage, whatever, you know I want you to wear this I want you to do this because these fit back into the goals. So its defining that goal and then teaching them [patients] ways to get to it. I think for me works a lot more efficiently with patients just because they know why you're doing things. Its not just you're arbitrarily making things up and you can explain yourself….but, getting them to buy in and say 'hey this is weird this is crazy' but this is why I'm thinking this, and this is why I think it will help you individually and if you can kinda pitch it that way I think they buy into it a lot more.

In sum, **navigating** into and through the care process and utilizing the working alliance encompasses contributions from both athletic trainers and patients. The ***subcategory care role*** came to represent varying roles participants embodied during patient care, indicating where contributions to patient care came from, athletic trainer or patient. Though three distinct ***care roles*** of *director*, *partner*, and *educator* are evident, it is equally apparent that athletic trainers transition between ***care roles*** as the care process and patient needs dictate. In the ***care role*** of *director*, athletic trainer participants unilaterally determine and steer aspects of the care process, reaching conclusions they regard as necessary and efficient to progress patient care. Making care decisions based on perceived injury needs, and selecting aspects of care such as patient goals, therapeutic exercises and treatments, were ways participants carried out the role of *director*. *Director* embodies the belief participants' decisions are most beneficial to patients and for return to participation. Recognizing the importance and value of patient contribution to the care

process illustrates the ***care role** partner*. Seeking and integrating patient ideas and feedback to inform and/or guide care decisions represents acknowledging the significance and value of patient input, empowering patients, and supporting mutual decision making processes. Ascertaining patient needs and values facilitates creation of care decisions that support outcomes significant to the patient. *Soliciting* feedback from patients, often of a specific nature, to inform participant initiated changes to the plan of care was one way participants sought information from patients and use it to make care decisions. Accepting and incorporating information patients freely share, and jointly working with them to integrate meaningful care decisions represents participants acting as a *collaborator*. Tapping into patient expertise to create goals, guide exercise plans, and create therapeutic exercises were additional ways participants *collaborate* with patients. Whether acting as *solicitor* or *collaborator*, the ***care role** partner* varies over dimensions of <u>rehabilitation</u>, <u>severity of injury</u>, and <u>relationship</u>. First, <u>rehabilitation</u>, both the length of the rehabilitation process (<u>short----long</u>) and the timing of patient input during the rehabilitation process (<u>early----late)</u> influences participants experiences of the role of *partner* in patient care. Seeking patient input <u>early</u> can encourage patient activation, whereas input sought <u>late</u> allows patients to develop additional insight into their bodies and the care process, enhancing their ability to make effective care decisions. Furthermore, <u>short</u>-term rehabilitation compels participants to act as more of a *solicitor* due to patients not being as forthcoming with information. Whereas with <u>long</u>-term, participants act as more of a *collaborator,* due to patient awareness of the prolonged time they will be partaking in rehabilitation, thereby increasing collaborative opportunities. Second, <u>severity of injury</u> represents the significance of the injury patients sustain

(simple-----complex). Care is less collaborative and patient input is seen as less essential

with less severe injuries (simple) and a short care process. Lastly, the strength of

relationship between participant and patient (weak-----strong), also influences

participants experiences as a partner. A strong relationship rooted in a deeper and trusting

connection and mutual respect encourages letting go of the *director* **care role**, thereby

seeking patient collaboration and consultation. In addition to **navigating** **care roles** of

director and *partner*, the **care role** *educator* speaks to the role of patient education and its

importance to the care process. Though education is all encompassing, it is most often

disseminated based on participant perception of patient needs, or in response to patient

curiosity. Three *properties* of *educator*; *body awareness*, *understanding injury*, and

purpose of treatment, embody the intent of the information participants provide to

patients. Educating patients about anatomy and physiology, body function, and body

consciousness enhances patients' *body awareness*, enabling patients to make effective

care decisions. Providing detailed information regarding an injury and its unique

characteristics encourages patients *understanding injury* and can facilitate their ability to

move through the plan of care. Lastly, presenting patients with underlying reasons as to

why they are being asked to complete treatment and/or rehabilitation embodies the third

property of *educator*, *purpose of treatment* and supports patient understanding of the why

behind what they are being asked to do. In addition to **navigating** **care roles**, participants

also spoke to barriers encountered during the care process and how they were attended to

and managed. This became known as the second and final ***sub-category*** in **navigating**,

patient resistance.

Patient resistance

As was evident in the data, **navigating** patient care is not without barriers or challenges; which enabled creation of the *sub-category patient resistance*. For participants, *patient resistance* came to represent a limit to provision of care. Best understood as a threshold at which athletic trainers are either unable or unwilling to manage patient care, or elicit patient commitment and motivation to participate in and **navigate** through the care process. An example of a threshold is offered in the following passage:

> K394 At this level they're all adults. They can do what they want. Like I tell them you know, I'm not going to come chase you down and say hey you need to be here getting treatment if you're, you know [fooling] around before practice. That's not my job, I've got so many other better things to do. So it's really up to you if you want to sit on the bench all season, if you want to play in pain all season.

The following passages highlight an implicit belief that at some point, patients need to elect to be responsible and take an active role in their care process as a whole. In the following excerpts, participants respond to *patient resistance* by waiting for patients to experience the consequences of ineffectively managing their injury:

> M497 All I can do on my end is make sure that they know that I'm there to help them, and that you know, they feel good about their treatment plan and they feel good about where things are headed, then that's ultimately what's going to get them to be compliant. And then if they're not then, I've done what I can, and their back will still hurt….ultimately it's, it is their responsibility to help them, like help me help them, you know. Because it's, it's their, they ultimately should be more invested than anyone else in this….and if they're not, then they're not. But it makes it not my problem.

> L397 …the balls always in their court. Like it's they've got to actively, because otherwise you're not going to get anywhere. You know they'll, they'll drag themselves in every day but they're not going to be engaged, they're not going to be, until they want to. Sometimes as bad as it sounds you have to let 'em hurt themselves even more before they're ready to be like, alright

I'm ready for a change, I'm ready, I've hit rock bottom now let's deal with this issue.

However, there also seems to be an aspect of responding to *patient resistance* that leads to patient collaboration, as depicted in the following quotes:

L436   if they start missing maybe it's a question of hey what's going on, or you know you've missed three things is everything all right. Is you know do you have relationship issues? You have this, um but, some of that is a lot of when you call it out sometimes they don't even realize it. And so having that discussion and not being afraid to have that discussion with them is huge as well. Of, you haven't been here for a whole week and now you walk in and you're wondering why you aren't getting better, well you know what can we do? And sometimes I'll ask people point blank ah, how can I help you?

L353   Now, because I care about people I'm still going to back down from that and be like hey I haven't seen you in like two days what's going on, where are you. You need to get in here and do your stuff. And some of it's all 'I'm super busy' which you hear every single day and then it's like okay well let's communicate let's work through that of maybe if you're super busy we, we, you know work with at home something you do these at home or you gotta schedule time, you can't meet with me anytime I'm in so lets you know, work with someone else or do something in the weight room on your own. Let me give you a plan for that.

To summarize, *patient resistance* represents athletic trainers **navigating** the threshold at which they are unable or unwilling to manage patient care, or are waiting for patients to face consequences of inadequate management of their injury or illness. **Navigating** *patient resistance* is especially salient when athletic trainers are met with patients who may not be committed to and active in their care process. Instituting personal and professional limits to their time, waiting for patients to experience the consequences of not effectively managing their injury and countering with collaborative efforts to help patient care were ways participants responded to *patient resistance*.

Navigating represents participants, patients, and coach moving into and through the care process and addressing barriers encountered with patients during patient care.

Navigating care roles of *director*, *partner*, and *educator* represents determining who contributes to (and how) or directs the care process at any point in time, athletic trainer or patient, and provision of education to patients. In addition to **establishing** and **navigating** the collegiate athletic trainer-patient relationship, participants discussed aspects of **buy-in**. Representing the third **category**, **buy-in** encompasses participant perception of patient actions and attitudes relative to the care process.

Buy-in

The third **category** that emerged in the exploration of how athletic trainers utilize the working alliance in patient care was **buy-in**. Participant experiences define **buy-in** as invested patient attitudes and actions towards the athletic trainer participants, and participation in treatment, treatment tasks, and their care process.

> A337 With the compliance and getting [patients] to agree to come in, again that's, that goes to them trusting you and them believing in the process. Because if you have that then they're going to be more willing to show up every day.

As some of the following passages indicate, **buy-in** is patient willingness to complete treatment and rehabilitation tasks, and perseverance to follow through on care, especially with chronic injuries. In addition, patient **buy-in** is essential to support positive outcomes and return to participation.

> L70 So um having them [patients] understand [what is going on with their injury] that really goes along way because once they buy in they'll do all the work themselves. Like if you don't know about your injury why in the world are you going to stretch at home if stretching's in the protocol.

> F247 I also make it clear to them [patients] that you know, if you want to be back by this date, you don't want it to get longer, I really need you to fully buy in. Especially if, a lot of my [athletes] have chronic shoulder pain, especially [one specific team], and if they've been having this pain for weeks we're not going to be able to fix it after two treatments. So I tell them you know you have to be patient, you have to stick with the plan, I

promise you, you will see results um, If you come in and do what you're supposed to do. Um, and if you don't then that means, maybe I missed something or the doctor missed something, we gotta go back and figure out what's going on.

M68   Especially, especially in my current gig, like everything is long-term, right. Like you don't get a lot of, like short acute problems in [my sport], you get like oh you've been [competing] for three years, and you have like severe back pain and this is going to be like a project, you know. There's not a lot of short-term stuff in my current job. But um, but, there has to be a trust that in the end it is going to get better. And so I think that if they don't buy-in, like I was talking about the buy-in, that's so important for a long-term case because if they don't see, it's hard to see the light at the end of the tunnel, you know, and if they don't buy-in kind of with you and it's a group project that you're working on together, if they're not in it then it's not going to work.

Without patient buy-in, or a lack of willingness to participate in their plan of care and put forth effort, outcomes were not likely to be successful:

F 262   Well we go through her [patients] surgery and she, um, was not compliant whatsoever. I mean from the beginning, was not interested in um, getting range of motion back, wasn't interested in doing the exercises correctly, just going through them, or just showing up, showing up late or not showing up at all. Um, but then at the end of five months she was like 'okay I'm done right?' Uh and the doctor was like 'no'. Um, she's like 'but it's been five months, you said five months.' Um, so that didn't really pan out.

Additionally, participant interaction and communication with patients during the care process initiates patient **buy-in**, which is evident in the following quote:

M59   Um, I think that they [patients] have some background info on you as a human makes them buy into you more, which is going to make them buy into your treatments more, which is going to make them buy into the whole system of what we're trying to do to make them better.

Another aspect of **buy-in** present in the data was patient desire for inclusion in their care process. This came to represent a ***sub-category*** within **buy-in**, *activation*.

Activation

    Activation signifies patient appeal for inclusion in care decisions. The following passages feature patients expressing their desire for inclusion, and in some aspects taking a more active role in dictating their care process. However, participants do not always perceive patient desire for involvement as helpful:

M419   Like the kids [at my institution] are really, really, inquisitive…so I don't think they would necessarily let me get away with just giving something to them with no like background info, you know what I mean. Um, with no sort of, justification

M636   I think the biggest difference I noticed here versus the other two schools, like not that the kids aren't inquisitive at the other two…but the kids here have already looked at the primary literature on their injury….Um, so they're, I don't know, they're I think, I don't know what the word is. They're more apt to seek out all of the information they can find as opposed to just accepting what is or is not given to them for information. And they'll come in and be like 'so I've already researched it and I think that it's one of these two things, can you help me figure out which one it is?'…They're information seekers, I would say. [patients want to take] more of a role in their care. And usually it's good. Like usually it's, there's no negatives, but sometimes it's like, this is not your area of expertise. You are a government major and you are very, very smart, but you don't know anything about back pain so could you just get on board. But it's not usually that way, there are a couple of cases where it's that way. But a lot of times it's just like they, they ask I guess deeper questions than I had experienced at other schools.

M662   I think they're just seeking more information than I had experienced at other schools. They're also, um, they seem to have more of an awareness of like, long-term health problems. And I don't know if that's because they just read what's in the news more, but they'll be genuinely concerned about if they're gonna have osteoarthritis in 25 years. And I hadn't necessarily been asked that much by athletes at other schools. Or of like long-term outcome type things…..I don't know if it's just that they're doing more reading or if it's, a different mindset.

    In sum, **buy-in** encompasses patient attitudes and actions regarding participation in their care process and willingness to complete treatment and rehabilitation tasks, even when facing long-term care. Furthermore, buy-in is essential to supporting positive

outcomes and return to participation. Another aspect of **buy-in,** *activation*, represents

patient appeal for inclusion in their care decisions. Encouraging patients to take an active

role in dictating their care incites patient *activation* and **buy-in**. After transcribing and

analyzing round 1 interviews, it is evident participants would allude to **buy-in**, however

when speaking of **buy-in**, they mostly talked in terms of process. Therefore, a goal of

round 2 is to further explore and define what **buy-in** is, and the processes surrounding

how to achieve **buy-in**. Also influential to how athletic trainers utilize the working

alliance in patient care are **contextual factors**, the fourth **category,** which captures the

impact of employment setting and person variables on patient care relationships in

athletic training.

Contextual Factors

Contextual factors are the fourth and final **category** underlying the experience

and process of how athletic trainers utilize the working alliance in patient care. This

category represents place, person, and environmental factors seen as influencing the

athletic trainer-patient relationship and care process. The *sub-category institutional*

variables describe place and environment factors, and the *sub-categories patient*

variables, and *athletic trainer variables* represent person factors. These diverse place

and person factors illuminate elements that influence **establishing** and **navigating** an

athletic trainer-patient relationship and achieving patient **buy-in**.

Participant experience and process incorporating the working alliance into patient

care brought to light numerous variables effecting relationship development and the care

process. The first *sub-category*, *institutional variables* comprise the impact participants'

place of employment has on relationship development and the care process.

Institutional variables

    Institutional variables elucidate employment setting, accessibility, and resource

factors that directly influence participants' professional responsibilities for provision of

care and attention to patient relationship development. As participants described the

influence of their work environment, factors of institutional size, religious orientation,

and athlete/team accessibility came forth, as seen in the next passages:

      O201 Especially, 'cause you know it's a small school here, so I pretty much know everyone, so it's really easy to talk to them about the teachers they might have or have already had, stuff like that.

      O31   We're kind of a small school here so I also kinda do some psychological stuff, counseling, stuff like that…. And uh, when it comes to counseling, my university is a Christian university too, so they have ah, a lot of people come they have issues not just with family but with where they're at with their religion, and things like that. So especially in this kind of environment we [athletic trainer and on-site counselor] like to make them feel comfortable

      M489 I don't have that face-to-face with them [athletes] because when they go to practice they're off 2 miles [away] doing their own thing. So, um, it's almost more of a, more of like a clinic model from that standpoint in my current job. Um, where like if they don't show up for their appointment, like you're not gonna like go to their house and go get them and bring them in for their appointment, right? So I think, um, it's a little different then a lot…of the other athletic trainers have a different model as far as that goes because they are you know out at practice or whatever it is…it just shifts the responsibility to them [patients].

In the case of the following passage, institutional variables affect patient accessibility to

the athletic trainer participant. Thus creating the belief that patients must assume

ultimate responsibility for their care.

      O393 In my environment I would say probably [compliance or lack of adherence rests more so on the patient's shoulders] just because I'm not there all the time. If it was something where I could be there all the time, if I was with you know like one team…. Here but ah, here definitely where I'm at now it's the athlete has to want to get better and has to wanna comply because I can't be that person every day… they [patients] gotta kinda internalize it

and wanna, wanna get better, and wanna do, wanna go towards their goals. Especially here. 'Cause, I can't, like I said I can't be there every day.

When deconstructing *institutional variables,* _concepts_ representing obstacles and barriers included: _patient load_, _proximity to patients_, and _institutional emphasis_.

Patient load

This _concept_ characterizes the number of patients athletic trainer participants manage due to staffing, or size of staff in relation to number of athletes. _Patient load_ tests participants' management of patients, often due to sheer patient volume and various patient needs. The following passages illuminate participant experiences with _patient load_, which challenges their provision of patient care, but also appears to generate participant expectations of patient responsibility and involvement in the care process:

K327   We're at two people right now for about 550 athletes. Which is a little bit of chaos, so. I mean I kind of cracked down this year and said you know, if you're not coming for your rehab when you're supposed to be coming for your rehab you better find somebody else to do it or you're not gonna complain to me about how it's hurt and you're not going to complain to your coach that you need to miss practice.

O278   Before I got here I was in professional baseball, and that was all very, like those goals are set from a guy I never even met, you know. You say they've got this kind of injury… and they should be here in so many days, and here in so many days, and here in so many days. Which, that was really easy when I had, you know, 30 guys and only five of them were ever hurt. Now I have 170 people, so and ah, probably 20 to 30 hurt on a daily basis that are all trying to do some rehab somewhere.

Proximity to patients

The second _concept_ within *institutional variables* represents location of the brick and mortar structure where participants attend to patient care in relation to athlete practice/competition facilities. This affects patient access to their athletic trainer care

providers and athletic trainer participant access to practice and injured patients. As the

subsequent passages portray, facilities arose as an obstacle to patient care:

> O284   Especially with where I'm at right now, um I kind of, it's one university but I work from two different facilities at the University. So I can't see everyone every day, so I need that, I need a way to keep them [patients] motivated even when I may not see them that day. And that's why I feel the patient oriented goals work a little better, because they know what they want to do and I'm giving them the tools to get there, whether I'm actually present every time.

> M273   Logistically the [practice facilities] are on the other side of the river, um from where the athletic training room is cause that's where all the other athletics buildings is. So it's actually like fairly out-of-the-way for them [patients] to get there [to the athletic training facility].

Institutional emphasis

This final *concept* identifies *institutional emphasis* on academics versus athletics,

sport success versus sport participation. As detailed in the following passages,

institutional prominence placed on sports versus academics impacts participants'

management of patient care:

> M682   I also think there's a different focus on priorities here [current place of employment, than certainly [a previous institution]. But it's just a different environment. But like at [a previous Division I institution], you were there to play your sport, and to win at your sport. Um, and we win a lot [in our] Conference, but they're [athletes] not going, most of those kids [athletes] are not going pro and they are much more aware of it.

> M632   So the three [institutions] I worked at are very different …[my first institution] big-time sports program, right? Where you've got like very elite athletes but they don't necessarily go to class. And then [my second institution], where maybe we're [athletes] not so elite, we [athletes] mostly go to class, sort of. And then here where…I wouldn't call us [athletes] elite, and we [athletes] go to class a lot. So they're [each institution] very different.

To summarize, ***institutional variables*** outlines the impact place of employment

has on athletic trainer-patient relationship development and the care process. Institutional

size, religious orientation, and athlete/team accessibility factors directly influence

participants' provision of care and attention to patient relationship development. _Patient_

load, the number of patients athletic trainer participants manage due to size of athletic

training staff in relation to number of athletes, challenges provision of care, and generates

athletic trainer participant expectations of patient responsibility and involvement in the

care process. _Proximity to patients_, or location of facilities where patient care is provided

presents an obstacle to patient access to care, and athletic trainer access to practice and

injured patients. Lastly, _institutional emphasis_, valuation of sports versus academics and

emphasis on winning surfaced as impactful to the manner in which participants manage

patient care. Beyond **institutional variables** influencing patient care, participants spoke

about unique **patient variables** that influenced the patient care process.

Patient variables

Another person specific aspect of **contextual factors**, *patient variables*,

represents features unique to the collegiate athlete population group and each distinctive

patient. These variables influence how participants understand and interact with their

patients as they establish relationships and navigate through patient care. For the

participants, patient population, age and/or sport, are distinctive aspects:

> L428 They're college students. Well, we all make poor choices, but yeah uh,
> they tend to excel in that area. Depending on the individual.

> L491 Well, the generation we're working with has an attention span that's
> incredibly low as well so you have to always be kind of feeding something
> at them every four minutes or whatever just because they can't, you know,
> they can't function outside of that.

> M337 Especially for my patient population, they tend to have a lot of chronic
> problems
> um that really require corrective exercise of some sort to make the long-
> term problem go away.

As participant experiences were further de-constructed, *sport valuation* and *additional relationships* arose as *concepts* of **patient variables**.

Sport valuation

Denoting patient attitudes towards sport, *sport valuation* characterizes the personal significance and importance patients place on sport participation versus other commitments and activities. The following passages illuminate patient conflict between sport and non-sport activities, adjusting to different levels of competition, and patient changes in perceived importance of sport participation:

M688 It's a different mindset. And they're, you know most of them athletes] are going on to advanced degrees [here] and they're already, they already know that when they come in, right. So they've just got a different, it's not that their sport isn't important to 'em, it is, but, it's a different set of priorities. They'll miss practice to go on job interviews, and you wouldn't necessarily see that other schools.

F616 Like the girl who isn't playing anymore, she just, she wanted the real college experience. She didn't want to be in practice for two hours, and then in study hall. She wanted to be going to club meetings, and being in a sorority, and like go out on a weekend without having to get in for practices at six the next morning.

O51 There's a lot of people who come to us about how athletics kind of, may interfere with, ah their religious life, and ah everything they're trying to do with that. So, we have a lot of counseling on that and ah we try to make everyone real comfortable with that. And obviously there's a lot of counseling with me about how people coming here, and the sports psychology aspect of it, coming here especially as a freshman; new, not the best player anymore, so I get a lot of talking about that.

In addition to describing variation participants perceive in the significance patients place on sport, they also describe how outside factors may be influencing athlete participation, as opposed to them 'playing for love of the game':

K453 I definitely think that there are outside factors, like burnout, are they really

> playing because they want to play, or was it because mom or dad pushed them into this, or do they need to do this to pay for school. Like that's something we need to be cognizant of.

Moreover, participants also spoke about how person interactions influence patients during the care process and are impactful to both participants and patients. These experiences embody the _concept_ _additional relationships_.

Additional relationships

Another **patient variable** present in participant experiences was _additional relationships_. Signifying the contact and interaction patients have with other teammates, athletes, and/or injured patients, this _concept_ represents their effect on patients and the care process. In some instances, athletic trainer participants recruited other athletes or teammates to act as a form of social support and encourage patients to persist in the care process, as seen in the following excerpt:

> O382 It's one of the good things about being about a small school, they all [athletes] like to help and kind of be around each other.

> O340 Since it's such a small school, I usually try to get their friends and or teammates on my side, to help with adherence. Like ah, you know help them, encourage them when I'm not around and talk about how they want them to come back, how they want them to do their exercises, and ah, their rehab so that they can play and be with them and do all the stuff they want to do.

> O348 I have a patient right now who is in a sling and has like zero goal to get out of it because she knows she's not going to play the rest of this year. But, the way I've gotten her to do any of her rehab is by having her best friend basically come with her every day, they're both on the same team, come with her every day and do rehab with her for different things. But you know she'll do her rehab, she'll do her rehab with her friend.

In the next passages, the ability to watch an injured teammate fail to complete the same or similar plan of care and return to participation stimulated patient willingness and

motivation to perform what was asked of them and successfully conclude their plan of care.

> F268   Meanwhile her teammate…I think she saw what happened with the other girl. And so from the beginning she was like 'I want to play again, I don't want to continue to have shoulder instability when I'm done with all this,' and understood the process and why, you know, understood that the range of motion at the beginning, while it seems silly is going to make a big difference down the road. Um, if we do it correctly, um and she was like clockwork. Met every milestone exactly when she should, was cleared in five months.

> F313   She [patient] saw what happens when you didn't buy in. And she's [patient] like I'm not gonna be like that, I'm not gonna do that, I want to play and they need me next year.

The ability to receive support from, or watch and learn from other athletes or teammates successes or failures completing their plan of care are unique aspects of *additional relationships* and **patient variables** that affect patient care.

In sum, **patient variables** capture features unique to each patient and the collegiate athlete population group that affect participants understanding and interaction with their patients, while working to **establish** relationships and **navigate** patient care. Being attentive to *sport valuation*, the personal significance and meaning patients place on sport participation versus other commitments and activities, can help athletic trainer participants be sensitive to distinctive patient situations and needs. Lastly, direct or indirect influences of *additional relationships*, patient interactions with other teammates, athletes, and/or injured patients, can affect the care process. Therefore, remaining mindful of the presence and influence of *additional relationships* was another **patient variable** and relevant **contextual factor** that arose in regard to developing a working alliance in collegiate athletic training. The final factor that surfaced among the

contextual factors linked to creating patient relationships and carrying out the care

process was *athletic trainer variables*.

Athletic training variables

The **sub-category athletic trainer variables** takes into account participants'

personal and professional experiences, including the effect these factors had on their

personal lives and professional practice. Participants spoke of factors emphasizing

awareness of the intricate role and impact athletic trainers have on patient care. Based on

the following excerpts, it is clear that participants value the athletic trainer-patient

relationship, acknowledge the distinct opportunity to develop effective relationships, and

recognize fundamental differences between athletic trainer-patient versus doctor-patient

relationship development. Yet what clearly stands out in the last passage is a curiosity

surrounding why there is such a salient difference between athletic trainer-patient and

doctor-patient relationships. An inquisitiveness of what it is that makes the athletic

trainer-patient relationship so unique, besides a combination between time spent and

ways of interacting.

> L227 We would always have a stream of people coming in just to check in, to chat, to connect, and um. Which is why I love personally, AT. The medical stuffs fun, I enjoy it, but I love the relationships.

> K594 I mean, I think that as athletic trainers we are just in a really, really unique position. As healthcare providers, you know most, and not all of them, but most healthcare providers are in an office that you see only when something's wrong. If you think about it. And our athletes see us every day, whether they're hurt or not. You know when we're stopping in at practice. And I think that we can definitely use that, and that we should use that. Because developing that relationship helps extremely when you get to that point when something is wrong, I think. When you can go to somebody that you trust that can help you, as opposed to you walk into a doctor's office and you don't know this person, and all of a sudden they want to do all this and they want to touch you…and poke on you. You know I think that we need to use more of that to our advantage

M713   I just think it's, I was thinking about it, it kinda got the wheels turning about how it's interesting how, yes we are healthcare providers but our relationship with our patients is so much different than sort of the traditional medical model. Um, and I was thinking like is that because of time spent or is that because of just, how we interact with them, you know? And I think it's probably a combination of the two, but I don't know.

As the data was de-constructed, two very specific *concepts* were present: *personal influencers* and *professional influencers*.

Personal influencers

Personal influencers, the first *concept* within the **sub-category athletic trainer variables** underlines distinct personal experiences that include familiarity with a patient role, experience with injury or illness, and/or previous work with an athletic trainer due to injury. As seen in the following quotes, it was clear these experiences played a role in shaping professional actions and values, and provision of holistic patient care:

F714   My experience going through my injury with my athletic trainers. They knew I was interested in athletic training, um and so, they put up with so many questions from me. But were encouraging the whole way. And I really owe a lot to them for getting me to where I am now.

K119   I myself um, struggled with [a significant health diagnosis] in college and I had two very caring athletic trainers that really, really supported me in that battle. And, I mean I didn't truly get help until after I graduated, but they were there for me in such a way that I trusted them and would do things for them….more than I would, I was willing to do for myself.

K94   The way my athletic trainers treated me when I was an undergrad, very much dictates the way that I am an athletic trainer because they were there for me so much more.

K560   I think I find myself like, more in tune to people who may be more susceptible [to mental health concerns], or maybe have something that's going on, than kind of my colleagues would be just because I've experienced it. Um, but I feel like it's something that, kind of like the athlete thing, helps me with approaching people about that stuff, a little bit.

J   *so more in tune and really, maybe more aware that that is happening or could happen than some of your colleagues*

K   Yea. I mean I know the statistics better than anybody.

One specific aspect of *personal influencers* came to light in participant interviews, giving rise to the *property personality*, adding descriptive elements to how participants integrate the working alliance in patient care.

Personality. This *property* details the impact of participants' personality and interpersonal characteristics on patient communication and interaction. For the participants, personality characteristics drive the manner in which they approach patient interaction, enables them to directly address patient resistance or facilitate patient awareness, or informs their treatment philosophy and how they approach patient care (ie. conservative, aggressive).

F170   I've been told before by my boss even and some other athletic trainers even coaches, they're like, you know you're too nice. Or like, you need to like not let things bother you so much. But I feel like that's, that's part of who I am and like it bothers me because I, I am empathetic, and I really care about what I'm doing and um, I wanna do a good job.

L310   I've had patients before that don't want to work with me before for whatever reason and they wanna work with someone else. That's fine that's great go, like I don't, you can't take that offensively because they're gonna, they wanna get better, and they need to go where they want to go to get better. And that's not personal that's just how life works so.

J   *So in those experiences did you ever explore that with them, as to why they may have wanted to go to someone else?*

L   Umm, yes and no. Ah, I kinda knew what was going on. I'm a young male, I'm ok with that. So I'll push in different ways, ah as far as ah, but I'll tend to be more aggressive and so um, and that's not that females aren't as aggressive don't get me wrong, but it's just I tend to have more of aggressive rehab.

L320   [Because of where I grew up] so um, in that sense well, I don't shy away from talking about things. Um, so sometimes I've had female patients that wanted just basically spill their, what's going on in life, but don't ever want the other end of ah like hey, you point something out and they take

that, I don't want to say personal, but that. And so, I've worked as I've gotten older through those.

M585   Then I'll usually just sit down with them [patients] and be like hey, what's the deal, basically. I'm pretty direct about it because, that's just my personality I think.

Participant descriptions gave rise to the *concept professional influencers*, in addition to *personal influencers*.

Professional influencers

Professional influencers comprise valuable learning from classroom and clinical experiences within the participants' athletic training program (ATP) or other academic program, experience with differing levels of competition (i.e., collegiate, professional), and accumulation of clinical experiences. Academic experiences cultivated participants' appreciation and value of patient education and the patient-provider relationship. This is evident in the following passages:

L64   Patient education is huge. I was blessed, ah last year the school that I worked at, I was able to teach the psychosocial class for an entry-level masters program and I graduated from it but that was one thing, patient education was one topic I had.

L184   I love that in, they [athletic training students] at [where I completed my athletic training degree] they have that class [Psychosocial] at the very end. Which I love in the sense of it's a entry level masters program so kids, they already have the base foundation and it really gives a chance for them as kinda that, right before you graduate with your masters to dialogue through that class. And really kinda apply some of the principles because it is huge. Building that connection, building that rapport and how you know you connect with people and um go the extra mile within that.

In addition, participant experiences with clinical preceptors (CPs) while on clinical rotation as athletic training students were so impactful they either positively or negatively informed the way participants chose to approach patient care.

F710   I remember getting so upset with one of the staff members at my grad school because [they] were so much like 'they [patients] shouldn't know anything about your life, you're there to provide a service, and it just needs to be in, out, here's what they're doing. You're there to get them better and back on the field." And I was just like that is so counter-intuitive to why I went into this field. And my experience going through my injury with my athletic trainers.

A218   I think it's [involving patients with goal setting] something that I picked up along the way. Ah, just having the opportunity to work with a wide population of athletes. I think the thing that got me hooked on it [involving patients with goal setting], was when I was a senior [athletic training student] I had the opportunity to work with an all-American [athlete]…he was coming back from an injury…My CP [clinical preceptor] was great, he gave me kind of full, full rein on his rehab program.

Upon participants completing their athletic training education program and after securing employment, professional experiences and opportunities working with patients competing in various levels of competitive sport influenced patient care. As shared in the following passages, professional experiences shifted participants approach to patient care to better meet the needs of their unique patients. As expressed in the following passages, patient input was sought to encourage patient participation in their care process:

O296   When I first got here I was still kind of in my [professional] baseball mode, where I was like you need to do this, this, and it just was not working. Because when you set a concrete goal of being like this mobile by this date for a college athlete and they don't know how to measure any other way than when you're around. Then they end up doing nothing when you're not around. And, which slows rehab so much. So I found with those patient oriented goals I have a lot more adherence especially when I'm not physically present for them.

O311   I never used it [patient oriented goal setting] before, I'd always just done ah, you know you need to be here, here, or here. And then when I, when I got here I had a lot of, um adherence issues when I first got here. And then it kind of got to, what, what do you want to be able to do? And then when we started working to that goal, my adherence started to get a lot better. So I started using that a lot more.

J   *so you actually, saw, felt, perceived a positive change*

O Yea, that's, and that's, and I knew I had to change, cuz I was not going anywhere very fast the way I was. So, just kind of had to adapt to my surroundings with that.

Placing personal value on the athletic trainer-patient relationship and realizing its influence on the patient care process and patient outcomes cannot be understated as a relevant **contextual factor**. In fact, one participant expresses concern regarding barriers to research about the athletic trainer-patient relationship, and how this topic is largely unexplored:

L623 Most students that are coming up with research projects tend to be younger, don't have that [clinical and building patient rapport] experience. And so they don't understand the key value to this [building patient rapport]. And the people who actually do it well are so busy in the clinic that you don't have time to research it…. you know people who are in the research world aren't thinking about those kind of things. They're just thinking about outcomes, and those kind of things.

This passage may also reflect that professional experience may be the catalyst for cultivating an appreciation for the athletic trainer-patient relationship, as opposed to cultivating this appreciation within academic programming.

To conclude, *athletic trainer variables* are **contextual factors** that epitomize personal and professional experiences and opportunities that influence how participants attend to patient relationship development and patient care. *Personal influencers* embody familiarity with a patient role, experience with injury or illness, and/or previous work with an athletic trainer due to injury or illness. *Personality* and interpersonal characteristics also plays a role in how participants address patient resistance, encourage patient awareness, and approach patient care. Academic experiences, exposure to a psychosocial class, and opportunities provided by CPs while completing clinical rotations became significant *professional influencers*, enhancing the value participants placed on

patient education and patient participation. Diverse places of employment and

opportunities working with patients in various levels of sport competition also impacted

participants' experience of delivery of patient care. In sum, these varied **contextual**

factors came to influence **establishing** and **navigating** a working alliance with patients,

and **buy-in** with patients.

Emerging Experiences

While utilizing open coding procedures during analysis of round one interview

data, process statements began to surface, allowing me to incorporate axial coding

methods. Figure 2 represents an emerging conceptual map of participants experience and

process after completion of round one data analysis. Processes were present within

establishing and **navigating**, as well as between **categories**, linking **establishing**,

navigating, **buy-in**, and **contextual factors**. What follows is a description of the

processes that arose during analysis of round one interviews.

Within **establishing**, *holistic appreciation*, recognizing and valuing patients as

more than simply patients but as individuals with unique and distinctive priorities, incites

athletic trainer commitments to incorporate patient needs and values into the care

process. *Holistic appreciation* of patient needs and *athletic trainer commitment* to

incorporate those needs is seen here:

> M690 So they've just got a different, it's not that their sport isn't important to
> 'em, it is, but, it's a different set of priorities. They'll miss practice to go
> on job interviews, and you would necessarily see that other schools.
> *J*   *yea, different priorities, different mindset, different values*
> 696   And I think all of that helps, it shapes how you treat them as a patient,
> right. 'Cause their values and their priorities very much become a part of
> what your, what your treatment plan looks like.
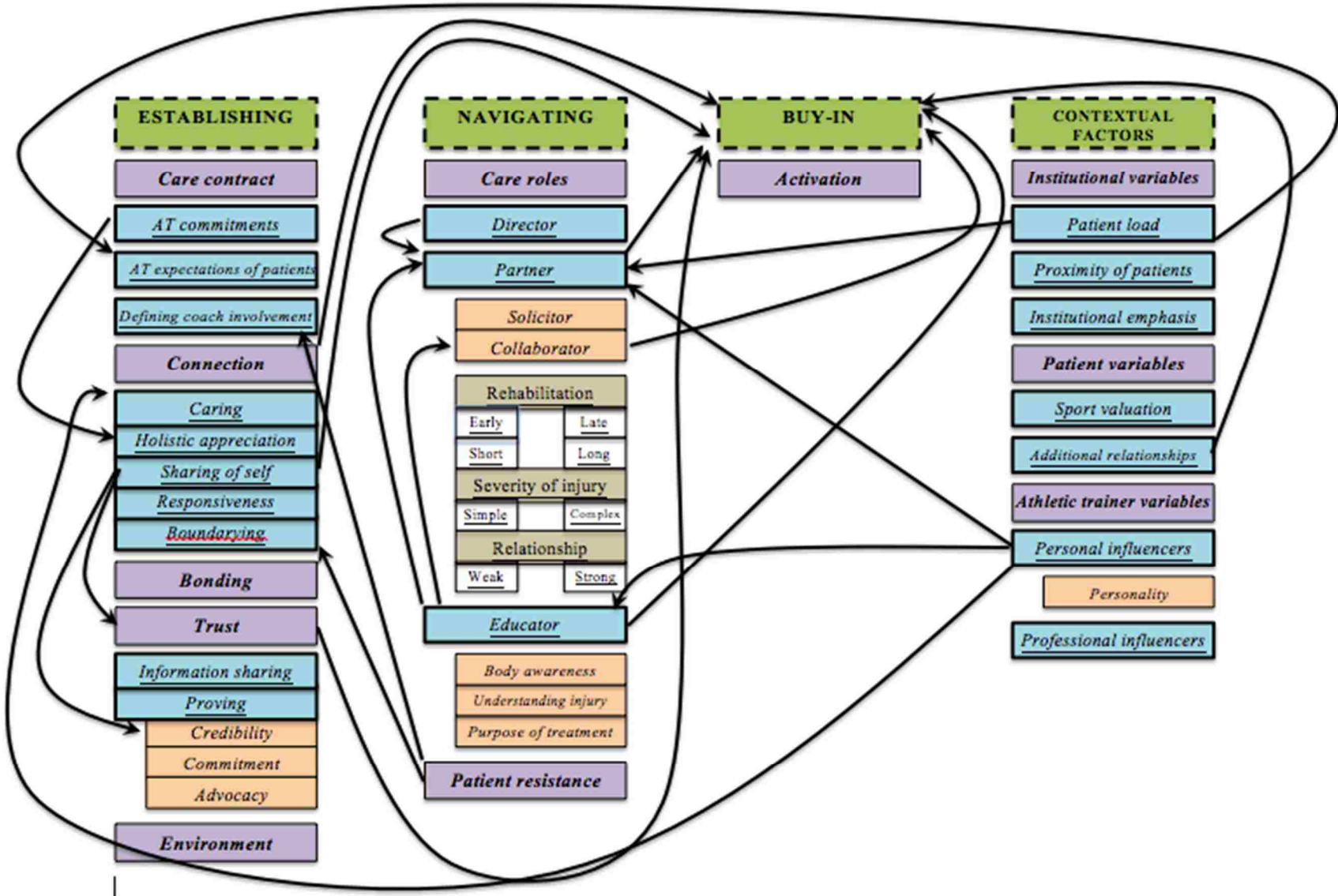
Figure 2 Conceptual map of processes following first round analysis

Establishing *connection* allows participants to offer challenging feedback, with the intent to encourage patients' personal reflection and growth:

> L229   The opportunity for college students that are figuring life out to ask questions, to you know, push them in different ways. To call them out on different things. I've had a lot of people get mad but that's alright because once you build that rapport and the other end once you say that thing that really, they don't wanna hear, they'll come back in a couple weeks and talk to you and be like 'alright, I get it"….But that comes back to them knowing that you really care about them, and you cant say that to someone that walks right in the door.

Sharing personal experiences to establish ***trust*** and ascertain *credibility* with coaches positively benefits the care process. Coach ***trust*** in participants' *credibility* encourages them to accept participants care decisions, therefore benefitting the health and well being of the patient.

> K356   I think getting some of the coaches as well and letting them know, I was a college athlete, you know I know where you're coming from. You want all the players there. And I'm willing to do what you need to get that. But you know, sometimes I'm not going to make the decisions that you want but, just know it's because I wanna get them back out there as soon as possible. So kind of them knowing my history with that a little bit helps them be I guess a little less, always questioning of; does this person really need to be out? Does this person really need to go to the doctor? Kinda stuff like that. I mean you're gonna have your everyday conflicts with stuff like that. But it's definitely a lot less I think.

Within **establishing**, *holistic appreciation* incites *athletic trainer commitments* to incorporate patient needs and values into the care process. With a ***connection***, participants are able to offer challenging feedback to patients to promote growth and reflection. **Establishing** coach ***trust*** in participants *credibility* enables them to accept participants care decisions, positively benefitting the care process.

Process was also present within the **category navigating**. When **navigating** care, participants take on the *director* role in response to observation of patients' perceived

needs, yet shift out of the *director* role when *soliciting* patient input as a *partner*. Acting

as *director* first, then *soliciting* patient input as a *partner* second, facilitates and generates

patient-centered changes to the care process.

O591   I decide based on the injury what I do as far as ah modalities, physical/manual therapies and stuff like that. Um based on how they're hurt. Um I do a lot of, I don't want to say the same but slightly similar manual therapies. And so a lot of the selection process is all based on where they are in the injury

J   *Is that something that you also discuss with your patients, or is that something that you developed along the way, that hey, you know these types of techniques and procedures work for this injur,y so this is what I'm going to choose to do?*

618   I always start with that, um this is what I've seen work and this is what I'm going to try to do. But I will change everything I do based on ah, what the patient reports back to me. Um I always tell them, okay were gonna do this today, you need to let me know how you feel. Or ah, were going to do this this week, you need to, we need to see where you are next week.

A293   I kind of just select them [tasks and interventions], just kind of determining, or based on what their [patients] needs are at the time. Ah, 'cause I mean every athlete is different so I think that's, that's general thinking I think usually how I go about it is just kinda seeing how they, ah, what their needs may be and how they are responding to certain things. And then just, um, deciding the appropriate course of action from there.

J   *you're selecting based on what you see or what you're perceiving. Is that, is that really how you kind of shift what you're doing because of what you see, and how they are reacting or interacting? Or is it the instance where it's a two-way conversation with them about what they want to do or what they'd like to do?*

305   Ah, I think it's, again its kind of a combination of both. If I see them struggling with something I will change it as needed. Um, but also I'll take their input on it if they say that they don't like that exercise because it doesn't feel right or it doesn't do anything then I'm willing to make that change.

Within the ***care role** educator*, offering education to inform patients about aspects

of their care (i.e. treatment, rehabilitation, and other options) enables patients to become

partners in their care by providing input to guide care decisions.

L38   Patient education is important because it enables patients to make a decision or decisions. Furthermore, in all situations, it is important to

provide options to patients and allow them to choose the direction of treatment, and actually have a choice. I facilitate this by presenting patients with my evaluation opinion, treatment options, and/or a suggested plan, but then allow the patient to choose what it is that they may want to do and also answer any questions he or she has.

M423   A lot of times it [incorporating your patients or your athletes in decision-making processes] looks like hey this is what I wanna, this is what you have, this is what I think is going on, go over the anatomy or whatever…And then um, telling them sort of what the treatment is and why it's going to be effective and then talking about you know, if it's a long-term thing, talking about goals and long-term outcomes and things like that. But then having it be more of a conversation then ah. It looks like more like a conversation and less like me talking at them and them just accepting it.

Within **navigating**, taking on the *director* role first, then *soliciting* patient input as a *partner* second, facilitates and generates patient-centered changes to the care process. Additionally, offering education to inform patients about aspects of their care (i.e. treatment, rehabilitation, and other options) while in the *educator* role empowers patients to provide input to guide care decisions as *partners*. Numerous processes were present between **establishing**, **navigating**, **buy-in**, and **contextual factors**.

Establishing a *connection* promotes **buy-in**. Participant responsibility to establish a *connection* that resonates with patients helps them **buy-in** to their care provider.

L526   Sometimes you have to work to their [patients] level, ah to build that connection. Um, If you're all serious all the time, um sometimes they don't buy into that.

Furthermore, *sharing of self*, a concept of *connection*, creates a springboard to facilitate **buy-in**. Participants' sharing about their personal and professional selves allows patients to see them in a more personal and less professional manner, which helps them buy-into participants, treatment, and the care process.

M55   But then also that they [patients] know, I guess that they know like somewhat what my, like why I want to be there type of thing you know? Like what my background is. Like they always ask where I worked before, they're always really interested in that kind of thing. And like sharing that with them as opposed to being like, I'm just here to treat your knee, or whatever it is you know. Um, I think that they have some background info on you as a human makes them buy into you more, which is going to make them buy into your treatments more, which is going to make them buy into the whole system of what we're trying to do to make them better.

Establishing patient *trust* also promotes **buy-in**. Presence of *trust* facilitates patients' belief in athletic trainer participants and their ability to facilitate positive outcomes, and encourages patient willingness to take part in their care process.

A337   With the compliance and getting [patients] to agree to come in, again that's, that goes to them trusting you and them believing in the process. Because if you have that then they're going to be more willing to show up every day.

M71   There has to be a trust that in the end it is going to get better. And so I think that if they don't buy-in, like I was talking about the buy-in, that's so important for a long-term case because if they don't see, it's hard to see the light at the end of the tunnel, you know, and if they don't buy-in kind of with you and it's a group project that you're working on together, if they're not in it then it's not going to work.

A233   We both worked well together with that ah, mutual trust. I think we come circling back to that word again, um, and that just brought the best out of him and it brought the best out of me to be honest with ya.

In sum, **establishing** *connection*, shared reality via *sharing of self*, and *trust* promotes **buy-in** to athletic trainer care provider, treatments, and the care process.

When **navigating** *patient resistance*, participants responded in various ways to mitigate *resistance*. When encountering *patient resistance* in the form of minimally involved patients, participants responded with *boundarying* by constraining involvement and engagement with that particular patient and re-focusing their efforts on other patients.

F524   When I first got here I used to spend hours on her writing plans, and then she would never come in. um and then the next week it would be a new injury, so I would research that and write up a new plan for that and she'd never come in. Um, so now, like she's a senior, and I know her personality. So when she comes in and has shoulder pain, I do an eval, and it's just some biceps tendinitis or rotator cuff weakness, I pull out a more generic plan that I might have already written for somebody else and put that in the folder for her. Because 50-50, or you know 25-75 she will show up, she won't show up. So, um, and there are other girls who have things that they're coming in for who need more of my time and, that sounds horrible but, um.

In some instances, participants establish *boundarying* by instituting consequences in response to **patient resistance**.

A334   It was one where it got to the point where it was bad enough with his [patients] non-compliance that we actually, that following year instituted a, ah athletic training room policy about the compliance of rehab. It [establishing consequences for not showing up for treatment] was just the way we had to do it because at the time we were short staffed, so our time is precious and if you weren't gonna adhere to our, to our timelines that we gave you, I mean, we had other athletes that we had to take care of.

F538   Um, she's [patient] always late, and just not committed. So, and we've had, we had a discussion earlier this year, she was 45 minutes late for her rehab appointment and I had left because I tell them at the beginning of the year you know, how long do you have to wait for your teacher not to show up for you to leave class? 10 minutes? Ok, well then you have 10 minutes, if you let me know that you are going to be late, ah, you have 10 minutes, and if you don't show up in those 10 minutes then I'm free to go work with somebody else, or go get lunch, or go eat breakfast.

In addition to *boundarying*, participants also attempt to reduce **patient resistance** by *defining coach involvement* in the care process. Participants will utilize the coach to aid the care process as a tool to encourage patient commitment to participate, or for discipline.

K348   The coach holds the check so, um, and the starting position and the bench position, so. They are definitely, a very huge tool of mine.

F568   So I've had several discussions with my coach since coming here…I was like they [patients] know what I expect and they're still messin around. So

I talked with the coach about the like 10 minute rule…I try to explain to him you know, if they actually are hurt and have something that they're really concerned about they're gonna realize they need to come in for that. And see the consequences of it on the [playing surface] if they don't take care of it….he said you know you're right, like we can't have these girls skipping rehab. It's just as important as their work out, or lift…. there is a freshman this year who was late three times in one week and [her sport] is everything to her. And so my head coach said she's not participating in any [sport] activities next week. This is not acceptable that she was late three times in one week and even after you talked to her the first two times.

L345   I have that conversation with my coach day one, in the sense of I don't want to chase people down. Like if they want to get better they'll be in here and ill prod them but I'm not here to chase them down. So, that goes in my daily report in the sense of hey so-and-so hasn't showed up for rehab in you know three days. If you want em better, that's your job as a coach to be on them to get them in because I don't do disciplinary stuff. That's your job. So kinda having that conversation and not that point-blank but it's just kind of within that context of this, my job is to get people better it's not to chase them down.

When patients continue to display *resistance*, despite being provided education to support their success and outcomes, *boundarying* is established to protect participants' professional time and other commitments.

L377   If someone isn't doing their things [rehabilitation] and then they come in with further injury it's, there are times where it's like, hey, I gave you the tools, um, my father always uses the line 'you can lead a horse to water but you can't make it drink.' But he always adds 'but you can put salt on the oats.' So that's where the education comes in I think, in the AT world of hey this is why I want to do this, and if you don't do it this is potentially where you'll end up, and when you end up there, we'll still be here, but know that I'm gonna be really ticked off. So, um, and sometimes you have that conversation, because when they understand that they're adults at least you know. I'm working with college students so they're adults, they have a choice in their, in their actual own health. And if they don't want to be proactive in it that's, that's their prerogative. If they don't want to get better you know, you can't shove it down their throat. But you can kind of put salt in the oats and say hey, here's why, this is the reason for everything, you know if you don't want to do it then I'm not going to waste my time putting things together.

Collectively, these passages highlight that participants **navigate *patient resistance***

by **establishing** *boundarying* and *coach involvement*. Responding by *boundarying* their

time and professional commitments to patients, instituting consequences when patients

do not demonstrate commitment to participate in care, and **establishing** *coach*

involvement as a disciplinary tool or to positively support the care process, were ways

participants attended to *patient resistance*.

Navigating *care roles* was also influential to **buy-in**. While in the *partner* ***care***

role, *collaborating* with patients promotes patient investment and willingness to

participate in their care process, inciting **buy-in**.

> A102   When I'm doing the rehabs with my athletes that if they have an idea for a
> new exercise that's more either soccer specific, volleyball specific I'll let
> them kind of integrate that into ah, into their rehab….the rehabs that I've
> been doing, they seem to have responded well, um, they like the fact that
> they have a say in their recovery in their rehab. So it makes them feel
> more involved, more willing to buy in to the whole, the whole process.

> A152   Goal setting, that's another thing that I like to get the athletes input on. It's
> another phase where they can feel that they have some kind of input in
> their in their recovery, and then that helps them again buy-in. Feels like
> they're, you know, they know that they're working towards something.

> O311   I never used it [patient oriented goal setting] before, I'd always just done
> ah, you know you need to be here, here, or here. And then when I, when I
> got here I had a lot of, um adherence issues when I first got here. And
> then it kind of got to, what, what do you want to be able to do? And then
> when we started working to that goal, my adherence started to get a lot
> better. So I started using that a lot more.
> J   so you actually, saw, felt, perceived a positive change
> O   Yea, that's, and that's, and I knew I had to change, 'cause I was not going
> anywhere very fast the way I was. So, just kind of had to adapt to my
> surroundings with that.

As an *educator*, facilitating patient understanding of their injuries and the 'why'

behind the 'what' they are being told/asked to do via patient education can encourage

patient willingness and commitment to take part in the care process, inciting **buy-in**.

F501   I had just come back from NATA and they did, I went to a presentation about patellofemoral pain. And I was like 'oh, well there is this new thing that I just learned, and I want to try it with you'. And like I was like 'here's the research and here's why I'm doing what I'm doing.' And she really bought in, and she, it was great.

L67   If your patients don't know what's going on about their injury and they don't know kinda ok here is your injury and this is basic tissue response and then this is the plan. They're not going to buy into it. So um having them understand that really goes along way because once they buy in they'll do all the work themselves. Like if you don't know about your injury why in the world are you going to stretch at home if stretching's in the protocol. But if you know about it and why its going to help you and what's part of the goals than that goes through

L82   So its kinda defining that goal, I think goes a long ways as far as for them as well as for rehab or plan wise. So its kinda saying here's the goal we're working on today. So if its an acute patient our goal is decrease pain, decrease swelling, increase range of motion. So that means when you go home I want you to stretch, I want you ta, whether we have some sort of compression device, compderm, ace bandage, whatever, you know I want you to wear this I want you to do this because these fit back into the goals. So its defining that goal and then teaching them [patients] ways to get to it. I think for me works a lot more efficiently with patients just because they know why you're doing things. Its not just you're arbitrarily making things up and you can explain yourself….but, getting them to buy in and say 'hey this is weird this is crazy' but this is why I'm thinking this, and this is why I think it will help you individually and if you can kinda pitch it that way I think they buy into it a lot more.

In sum, **navigating *care roles* *partner*** and *educator* promoted **buy-in**. While in the *partner* **care role**, *collaborating* with patients promotes investment and willingness to participate in their care process, inciting **buy-in**. As an *educator*, offering patient education can encourage patient willingness and commitment to take part in the care process, inciting **buy-in**.

Beginning with **contextual factors**, large *patient load* links to **establishing *care contract*** by generating greater emphasis on patient responsibility. With large *patient loads*, participants' *expectations of patient* responsibility to move towards positive

therapeutic outcomes grows, especially when participants are unable to oversee their

daily care process.

O393   in my environment I would say probably [compliance or lack of adherence rests more so on the patient's shoulders] just because I'm not there all the time. If it was something where I could be there all the time, if I was with you know like one team…. Here but ah, here definitely where I'm at now it's the athlete has to want to get better and has to wanna comply because I can't be that person every day… they [patients] gotta kinda internalize it and wanna, wanna get better, and wanna do, wanna go towards their goals. Especially here. 'Cause, I can't, like I said I can't be there every day.

K327   We're at two people right now for about 550 athletes. Which is a little bit of chaos, so. I mean I kind of cracked down this year and said you know, if you're not coming for your rehab when you're supposed to be coming for your rehab you better find somebody else to do it or you're not gonna complain to me about how it's hurt and you're not going to complain to your coach that you need to miss practice.

Processes also began with *professional* and *personal influencers*, concepts of

athletic trainer variables. *Professional influencers*, such as experience with lack of

patient adherence, encouraged participants to modify their approach to facilitating

adherence by *soliciting* patient input as a *partner* to identify patient oriented goals. Once

this adjustment was made, patient participation improved.

O296   When I first got here I was still kind of in my [professional] baseball mode, where I was like you need to do this, this, and it just was not working. Because when you set a concrete goal of being like this mobile by this date for a college athlete and they don't know how to measure any other way than when you're around. Then they end up doing nothing when you're not around. And, which slows rehab so much. So I found with those patient oriented goals I have a lot more adherence especially when I'm not physically present for them.

O311   I never used it [patient oriented goal setting] before, I'd always just done ah, you know you need to be here, here, or here. And then when I, when I got here I had a lot of, um adherence issues when I first got here. And then it kind of got to, what, what do you want to be able to do? And then when we started working to that goal, my adherence started to get a lot better. So I started using that a lot more.

J   *so you actually, saw, felt, perceived a positive change*

O   Yea, that's, and that's, and I knew I had to change, cuz I was not going anywhere very fast the way I was. So, just kind of had to adapt to my surroundings with that.

Continued job experience, another *professional influencer*, augmented participants' valuation of the *educator* care role to support patient outcomes.

M697 I think I do a lot more patient education now than I had done in the past. And whether that's just because they ask more questions so I have to, or it's because I realize there's more value in it, I'm not, or probably a combination of the two, would be my guess.

Moreover, *personal influencers*, such as familiarity with a patient role and experience with injury or illness, were instrumental to generating a caring approach to patient relationships.

K94   The way my athletic trainers treated me when I was an undergrad, very much dictates the way that I am an athletic trainer because they were there for me so much more.

In sum, large *patient load* generates heightened *athletic trainer expectation of patient* responsibility to take part in their care. Initiating from **athletic trainer variables**, *professional influencers* encourage modifications to facilitating adherence by *soliciting* patient input as a *partner* to identify patient oriented goals, and augments valuation of the *educator* role to support patient outcomes. Plus *personal influencers* were instrumental to generating a caring approach to patient relationships.

Last, *additional relationships*, a **patient variable**, encourages **buy-in**. Participants utilize *additional relationships* such as other teammates or athletes to promote patient **buy-in** to the care process.

O340 Since it's such a small school, I usually try to get their friends and or teammates on my side, to help with adherence. Like ah, you know help them, encourage them when I'm not around and talk about how they want them to come back, how they want them to do their exercises, and ah, their

rehab so that they can play and be with them and do all the stuff they want to do.

O348   I have a patient right now who is in a sling and has like zero goal to get out of it because she knows she's not going to play the rest of this year. But, the way I've gotten her to do any of her rehab is by having her best friend basically come with her every day, they're both on the same team, come with her every day and do rehab with her for different things. But you know she'll do her rehab, she'll do her rehab with her friend.

In addition, simply witnessing another patients' lack of success with their plan of care stimulates patient **buy-in**.

F268   Meanwhile her teammate…I think she saw what happened with the other girl. And so from the beginning she was like 'I want to play again, I don't want to continue to have shoulder instability when I'm done with all this,' and understood the process and why, you know, understood that the range of motion at the beginning, while it seems silly is going to make a big difference down the road. Um, if we do it correctly, um and she was like clockwork. Met every milestone exactly when she should, was cleared in five months.

Institutional variables, specifically *proximity to patients*, encourages participants to **navigate** patient care by seeking patient input as a care *partner* in an effort to promote patient **buy-in.**

O284   especially with where I'm at right now, um I kind of, it's one university but I work from two different facilities at the University. So I can't see everyone every day, so I need that, I need a way to keep them [patients] motivated even when I may not see them that day. And that's why I feel the patient oriented goals work a little better, because they know what they want to do and I'm giving them the tools to get there, whether I'm actually present every time.

To summarize, concepts of *institutional variables* and *patient variables* generate **buy-in**. *Additional relationships* enable patients to witness successes or failures of other patients and activate other patients or teammates to support patient participation, which encourages **buy-in**. Moreover, challenges imposed by *proximity to patients* encourages **navigating** care by seeking patient input as a care *partner* in an effort to promote **buy-in.**

In conclusion, although limited, **establishing**, **navigating**, **buy-in**, and **contextual factors** were linked through various processes. The processes that arose in round one interviews and analysis begins to represent the emerging construction of how athletic trainers develop and utilize a working alliance during patient care. **Establishing** *holistic appreciation* links to *care contract* and incites *athletic trainer commitments* to incorporate patient needs and values into care. Large *patient load*, a **contextual factor**, also generates a return to *care contract* by heightening *athletic trainer expectation of patient* responsibility to take part in their care. Moreover, **establishing** *credibility* and *trust* with coaches enables them to accept participants care decisions, which positively benefits patient care.

Processes supporting **navigating** between *care roles* as patient care and needs dictate include taking on the *director* role first, then *soliciting* patient input as a *partner* to generate patient-centered changes to the care process, and providing patient education in the *educator* role to empower patients to provide input as *partners*. **Athletic trainer variables** were also influential to *care roles*; *professional influencers* encourage *soliciting* patient input as a *partner* to identify patient-oriented goals, and augment valuation of the *educator* role to support patient outcomes. Additionally, *personal influencers* were instrumental to generating a *caring* approach to patient relationships. When encountering *patient resistance*, participants **navigate** these challenges by *boundarying* their time and professional commitments to patients or instituting consequences, and by **establishing** *coach involvement* as a disciplinary tool or to support care.

Last, various processes that emerged in round one ended in encouraging **buy-in**. **Establishing** *connection*, shared reality via *sharing of self*, and *trust* promotes **buy-in** to

the athletic trainer care provider, treatments, and the care process. Additionally, *care roles* also generate **buy-in**. *Collaborating* with patients while in the *partner* role and offering patient education while in the *educator* role both incite **buy-in**. Challenges imposed by *proximity to patients* encourage **navigating** care as a *partner* to promote **buy-in** and *additional relationships* with other teammates or patients directly and indirectly stimulates **buy-in**.

Conclusion

To best capture and conclude my findings from the first round of interviews, I will review the emerging grounded theory of how athletic trainers develop and utilize the working alliance with patients. Following my review, I will describe the experiences and reactions I had to the data in an effort to inform readers about my context and impressions while developing the emerging theory. Last, I will describe what remains unknown after the preliminary interviews, which will guide creation of second round questions to further explore and understand the developing grounded theory.

Emerging Theory

The emerging grounded theory of how athletic trainers develop and utilize the working alliance with patients is best represented by experiences of **establishing**, **navigating**, **buy-in**, and **contextual factors**. **Establishing** captures ways athletic trainers begin to create and then enter athletic trainer-patient and athletic trainer-coach relationships. Participants spoke about **establishing** *care contract, connection, bonding, trust,* and *environment*. Entering into patient and coach relationships includes **establishing** a *care contract*, which spoke to responsibilities, expectations, and obligations of the athletic trainer, patient, and coach prior to and during the care process.

Patient expectations in the care contract were implicitly communicated and patients were expected to be accountable and responsible to seek, follow through on, and move through the care process. Entering into an athletic trainer-coach relationship captures outlining and defining coach role and involvement in the care process; as an athletic trainer support system or tool for discipline.

Establishing a *connection* represents what participants do to show patients they are important, valued, and cared for as a unique person and as a patient. **Establishing** a *connection* can occur prior to sustaining an injury or illness, and allows participants to display and communicate their openness, desire, and willingness to connect with and focus on patients throughout care. Attending to *caring*, *holistic appreciation*, *sharing of self*, *responsiveness*, and *boundarying* facilitates **establishing** a *connection*. Participants establish a *connection* by showing interest in their patients lives separate from injury or illness, being attuned and attentive to patient challenges and needs and recognizing and supporting patients unique priorities and values, which are experiences of *caring*. Recognizing and appreciating patients as more than athletes but as multifaceted individuals captures *holistic appreciation*, which has mutual undertones when **establishing** *connection*. *Responsiveness*, listening and responding in a manner that lets patients know what they are saying is understood is important also establishes *connection*. By *sharing* personal and professional aspects of themselves, participants relate with and let patients into their lives, enabling patients to understand them in a more personal and less professional manner. A *connection* also entails finding, communicating, and maintaining a balance between personal and professional relationship and obligations with patients. *Boundarying* experiences include protecting

patient health and safety irrespective of patient desires, safeguarding their time and obligations, and communicating the presence and importance of their values and interests outside of professional responsibilities to patients. With time, **establishing** a *bond,* or a deeper connection with patients creates an ability to sense, understand, appreciate, and attend to needs beyond physical ailments and provide care that resonates best with patients.

Trust is a vital component of **establishing**, and a lack of *trust* hampers the care process. **Establishing** *trust* encompasses cultivating and maintaining patients' and coaches' belief and confidence in participants' competence and ability to act in a supportive and protective manner with patients. Consideration to how information is communicated and disseminated; what is shared, with whom, and the circumstances surrounding protection of information, is important. Defining and clarifying limits to sharing patient information encourages patient comfort in divulging information, which can be beneficial to support the care process. Honesty, transparency, and holding to communicated expectations are important to support care and sensitively sharing information with patients. Furthermore, facilitating group communication to clarify understanding of patient health and participation abilities helps put coach, participant, and patient on the same page and helps establish coach *trust*. *Proving*, or verifying dedication, professional capacity, and worth to patients and coaches, entails *credibility*, *commitment*, and *advocacy*, further **establishing** *trust*. Conveying understanding and appreciation of patient and coach experiences and expectations and establishing professional integrity by attending events and practices *proves credibility*, while former patients promoting participant aptitude further *proves credibility*. Going above and

beyond typical job responsibilities establishes participant *commitment* and holding

patients best interests in mind and making decisions that support positive health outcomes

in the long and short term proves *advocacy*, helping participants further establish ***trust***.

      Establishing is not limited to patient and coach communication and interaction,

but also relates to the care ***environment***. Creating an ***environment*** where patients feel

comfortable entering and returning, and is fun and stimulating helps **establish** a

relationship with patients that supports the care process. Talking to patients while they

are completing treatment and rehabilitation activities and bringing humor into the

environment are ways participants **establish** a care facility where patients feel welcome

entering and comfortable staying.

      The personal ***connection*** and ***trust*** participants cultivate with coaches and patients

as they began the process of **establishing** a working alliance became the foundation

where both participants and patients could **navigate** care. **Navigating** came to represent

ways in which participants move into and through ***care roles***, and manage ***patient***

resistance encountered during care. ***Care role*** represents the differing roles participants

occupy while **navigating** the care process, denoting who is contributing to or directing

the care process at that point in time, participant or patient. Though three distinct ***care***

roles of *director*, *partner*, and *educator* are evident, participants transition between ***care***

roles as the care process and patient needs dictate. Participants embody the *director* ***care***

role when they unilaterally determine and direct aspects of the care process and come to

conclusions they regard as necessary and efficient to progress care. Participants carry out

the *director* role by selecting aspects of care such as patient goals, therapeutic exercises,

and treatments. Acknowledging the importance and value of patient involvement in the

care process, participants seek and integrate patient ideas and feedback to inform and/or guide care decisions, thereby working as a *partner* with patients. Identifying patient desires and values aids creation of care decisions that are significant to the patient, as opposed to participants assuming what is important to their patients. Ways in which participants obtain input and feedback from patients, as a *solicitor* or *collaborator*, describes who holds power over and is making care decisions. Participants act as a *solicitor* by asking for specific feedback to inform participant initiated changes to the plan of care. Participants maintain power over care decisions, however changes are based on input provided by patients. Incorporating information freely offered and working with patients to jointly identify and integrate care decisions embodies *collaborating*. Recognizing and tapping into patient expertise to create goals, guide exercise plans, and brainstorm relevant therapeutic exercises are ways participants act as a *collaborator* with patients. Whether *soliciting* or *collaborating*, the variation in how and when patient input is sought and integrated manifests along a number of <u>dimensions</u> of *partner*. First, is <u>rehabilitation</u>, both the length of rehabilitation (<u>short----long</u>) and the timing of patient input during <u>rehabilitation (early----late)</u>. Patient input sought <u>early</u> is believed to encourage activation. Seeking input <u>late</u> allows patients to gain insight into their bodies, thereby developing knowledge that enables them to contribute to the care process. Seeking patient input during <u>long</u>-term rehabilitation is perceived as more effective than with <u>short</u>-term injury or illness since <u>short</u>-term rehabilitation compels participants to act as more of a *solicitor* due to patients not being as forthcoming with information. Participants act more as a *collaborator,* during <u>long</u>-term due to patient awareness of prolonged rehabilitation and increased collaborative opportunities. Second,

severity of injury (simple-----complex) also influences the *partner* role. Care becomes less collaborative and patient input not seen as essential with less severe (simple) injuries and a short care process. Lastly, a strong relationship rooted in a deeper and trusting connection and mutual respect allows participants to let go of the *director* **care role** and seek patient *collaboration* and consultation. In addition to **navigating** *care roles* of *director* and *partner*, participants exemplify an *educator* role by providing information and education to patients. Though education is all encompassing, participants disseminate it most often based on their perception of patient needs, or in response to patient curiosity. The intent of information participants provide encompasses *body awareness*, *understanding injury*, and *purpose of treatment*. Educating patients about anatomy and physiology, body function and consciousness enhances *body awareness*, enabling them to make effective care decisions. Providing detailed information regarding an injury and its unique characteristics encourages patients' *understanding injury*, supporting their ability to move through the plan of care. Lastly, presenting patients with underlying reasons as to why they are being asked to complete treatment or rehabilitation activities embodies *purpose of treatment*, and supports patient understanding of the why behind what they are being asked to do.

While **navigating** care, participants also **navigate** *patient resistance*, or barriers encountered during the care process. *Patient resistance* became the threshold at which participants believe there was no longer anything else they could or would do, or provide, to their patients in an effort to elicit commitment and motivation. Waiting for patients to experience the consequences of ineffectively managing their injury, instituting

repercussions for those who do not demonstrate commitment or compliance, and countering with collaborative efforts, are ways participants respond to *patient resistance*.

Establishing and **navigating** the collegiate athletic trainer-patient relationship also includes **buy-in**, the third category. **Buy-in** represents invested patient attitudes and actions towards participants, and partaking in treatment tasks and their care process. Patient willingness to complete treatment and rehabilitation tasks and perseverance to follow through on care displays **buy-in**. Patient appeal for inclusion in care decisions and in some cases taking an active role in dictating their care signifies patient *activation*. However, patient *activation* is not always perceived as helpful. Participant interaction and communication with patients can initiate **buy-in**, and without **buy-in** and patient willingness to partake and put forth effort, outcomes are not likely to be successful.

Underlying the experience and process of how athletic trainers develop and utilize the working alliance are **contextual factors**, the fourth and final **category**. **Contextual factors** represent environment, place (*institutional variables*), and person (*athletic trainer* and *patient*) *variables* that influence the athletic trainer-patient relationship and care process. Influential to participants work environment, *institutional variables* characterize accessibility, resource, institutional size and religious orientation factors that affect participant experiences creating relationships and providing care. *Patient load*, *proximity to patients*, and *institutional emphasis* further elucidate avenues of institutional influence. *Patient load*, the number of patients athletic trainer participants manage due to staffing, challenges management of patients and provision of care, and generates participant expectations of patient responsibility and involvement in the care process. Also affecting provision of care is *proximity to patients*, or location of brick and mortar

structures where patient care is attended to in relation to practice/competition facilities, and *institutional emphasis* on sports versus academics, which impacts the manner in which participants manage patient care.

Patient variables characterize person factors unique to the collegiate athlete population group and each distinctive patient, and affect understanding of and interaction with patients while working to **establish** relationships and **navigate** patient care. *Sport valuation* and *additional relationships* emerged as nuances to be aware of and that are influential to care. Awareness of the personal significance patients place on sport participation versus other activities, and the contact and interaction patients have with other teammates, athletes, and/or injured patients, helps athletic trainers conceptualize and adjust provision of care. By activating social support (other athletes or teammates) or facilitating patients' ability to watch and learn from other athletes or teammates successes or failures, participants use *additional relationships* to incite patient willingness and motivation to persist and perform what is asked of them.

Athletic trainer variables were other salient **contextual factors** that link to relationship development and carrying out patient care. These variables embody personal and professional experiences influential to participants' personal lives and professional practice. Participant recognition of fundamental differences between athletic trainer-patient versus doctor-patient relationship development, brings further attention to athletic trainers unique placement. This awareness also generates value of opportunities to develop athletic trainer-patient relationships. *Personal influencers*, such as familiarity with a patient role, experience with injury or illness, and/or previous work with an athletic trainer due to injury, were critical experiences informing how participants

approach patient care and attend to patient needs. *Personality* and interpersonal characteristics also play a role in the care process by shaping participants' approach to patient interaction and informing their treatment philosophy or approach to care.

Beyond *personal influencers*, educational and clinical learning within an ATP and professional job opportunities are *professional influencers* affecting athletic trainers' value and appreciation of the patient relationship and attention to care. Direct learning from differing levels of sport competition and accumulation of professional experiences beyond those gained as a student stimulate athletic trainer openness to learning effective care methods from patients, and to adjust their approach to better meet patient needs. Clinical experiences with CPs enabled ATSs to observe other athletic trainer interactions with patients, thereby adapting their subsequent approach to patient care. These varied **contextual factors** rest beneath all experiences of **establishing** and **navigating** a working alliance with patients, and **buy-in**.

The processes that began to surface during round one interviews represent an emerging construction of how participants utilize a working alliance in patient care by linking the **categories** of **establishing**, **navigating**, **buy-in**, and **contextual factors** in process. **Establishing** *holistic appreciation* incites *athletic trainer commitments* to incorporate patient needs and values into care. Large *patient load*, a **contextual factor**, heightens establishment of *athletic trainer expectations of patient* responsibility to take part in their care. Moreover, **establishing** *credibility* and *trust* with coaches positively benefits patient care.

Within **navigating,** transitioning between *care roles* involves taking on the *director* role first, then *soliciting* patient input as a *partner* to generate patient-centered

changes to the care process, and providing patient education in the *educator* role to empower patients to provide input as *partners*. *Professional influencers*, an ***athletic trainer variable***, encourages *soliciting* patient input as a *partner* and augments valuation of the *educator* role to support patient outcomes. Additionally, *personal influencers*, another ***athletic trainer variable***, generates a *caring* approach to patient relationships. When met with ***patient resistance***, participants respond by **establishing** *boundarying* and *coach involvement*.

Various processes that emerged in round one ended in encouraging **buy-in**. **Establishing** *connection*, shared reality via *sharing of self*, and ***trust*** promote **buy-in** to the athletic trainer care provider, treatments, and the care process. Beginning with **navigating** ***care roles***, *collaborating* with patients as *partners* and offering patient education as an *educator* incite **buy-in**. Last, initiating with **contextual factors**, challenges imposed by *proximity to patients* encourage **navigating** care as a *partner* to promote **buy-in,** and *additional relationships* directly and indirectly stimulate **buy-in**.

Context of the Researcher

As I reflect upon my educational and professional experiences, I find myself looking to fit what participants are saying to the construct of the working alliance I have come to understand. I often find myself using words related to the working alliance construct and those that appear in the literature to fit what the participants are saying. I am surprised at the amount of patient involvement the participants talk about, and I want to continue to explore the level and depth of their involvement with patients. Further, because I am only interviewing collegiate athletic trainers, I have no way of confirming that their perspective is representative of what is observable in professional practice.

I also find myself being protective about some of the things the participants are sharing, not wanting to include passages in my analysis or share with the committee or others for fear of painting a "poor" light on the profession. However, there was enough data already to support concepts, therefore these passages were omitted because of ethical concerns and to protect participant confidentiality. A large amount of these feelings revolve around one participant, as I find some of the things they share are close to crossing, or are over, the line of what I would personally and professionally consider a professional relationship. Further, I find the way this participant answers questions and recounts experiences abrupt, maybe even abrasive, and at times uninformative. I also have a sense that this participant is answering the questions I am asking on a superficial level, without deeper thought that would come with additional years of clinical experience.

As I listen to the participants and immerse myself in data analysis, I reflect on how I provided care to patients in the clinical setting, wondering if I was also incorporating the same values and constructs the participants are speaking about. This also sparks ideas of how I would or could integrate these ideas into patient care. Furthermore, I find myself being surprised and frustrated all at once, wondering why the participants aren't doing more to involve their patients, but also thankful about how involving they are.

Finally, I find myself wondering how I would or could best integrate the concepts of the working alliance into patient care in the collegiate athletic training setting, as this setting is unique in itself. In order to help uncover rich information from participants, during second round interviews I will focus on using probes and being aware of my

responses so as to encourage participants into deeper discussion and reflection. I also believe that the question 'how do you select and integrate tasks and interventions during patient care,' was not adequately grasped by participants, even upon reframing the question. Participants did not seem to really understand the question, and I may not have done an adequate job of explaining or phrasing it in a manner that would be more helpful. I will try to address the potential gap this may have left in the second round of interviews.

Implications for Round Two

After meeting with the chair of my dissertation committee, Dr. Murray, who also serves as my inquiry auditor, we outlined components of the developing grounded theory that needed further exploration and understanding. Therefore, five main questions, with relevant follow up questions as needed, were created to address areas that needed further explanation in the emerging theory.

The first question, "When you have, or don't have, a personal connection with patients how does your provision of care change?" was created to uncover if and how patient care changed in relation to the presence of a personal connection and to learn more about the process surrounding **establishing** a *connection* and how this may affect **navigating** care and **achieving buy-in**.

The second question, "Tell me about how you facilitate patient buy-in?" will be asked to learn what athletic trainers do to influence patient buy-in. This question was also created to uncover process between **establishing** *connection* and *trust*, **navigating** *care roles*, and what participants perceive patient buy-in looks like.

The third question, "Help me understand how you seek out and incorporate patient input?" was included to gain a better understanding of **navigating** the *care role* of

partner and *properties* of *soliciting* and *collaborating* with patients. This question was also added to shed light on processes surrounding **navigating** how participants decide on timing of taking on a *partner* role in patient care, when patient input is helpful or unhelpful, and to discover what barriers are encountered to *soliciting* or *collaborating* with patients and how they are addressed.

The fourth question, "Help me understand how patient education changes during the care process?" was meant to gain a greater understanding of how participants utilized, incorporated, and changed patient education throughout the care process. This question also aimed at gaining a greater understanding of processes between **establishing *trust*** and ***connection***, **navigating** the role of *educator*, and ultimately achieving patient **buy-in**.

The fifth and final question created to guide round two interviews was aimed at gaining a greater understanding of the impact of and processes between **contextual factors**, **establishing**, **navigating**, and **buy-in** on patient care. Questions were asked regarding employment setting ("How does your employment setting influence patient care?"), coach influence ("How does the coach influence patient care?"), and personal and professional experiences that stood out for participants as having an impact on patient care ("Help me understand how these experiences have a direct influence on what you do with patients?").

These questions were expanded upon with probes for further detail during the interview process with the same six participants that completed round one interviews. The chapter that follows addresses my analysis of round two interview data gathered from the five questions above.

CHAPTER IV

This chapter presents data from the second round of interviews. A brief review of procedures and a discussion of data deconstruction during second round analysis follows. Relationships and processes between categories are presented with attention to changes and additions in conceptual understanding, and corresponding implications for an evolving grounded theory of how athletic trainers utilize a working alliance with patients. Finally, I present a discussion of my context as the researcher, bracketing my beliefs, feelings, and reactions to data collection and analysis, and establishing transparency as the co-creator of this theory. This enables the reader to determine what information is transferrable.

Second Round Analysis

Review of Procedures

The six participants from round one took part in a second round of interviews. I continue to refer to the participants as Aidan, Fiona, Keeley, Liam, Maeve, and Orlando. Each participant responded to follow-up questions after the first round interviews were coded and analyzed. The interviews utilized video teleconferencing and lasted 60-90 minutes. Round two questions included: 1) How does your provision of care change when you have or don't have a personal connection with your patients? 2) Help me understand how you seek out and incorporate patient input? 3) Tell me about how you facilitate patient buy-in? 4) Help me understand how patient education changes during the care process? 5) How does your employment setting influence patient care? 6) How does the coach influence patient care?, and 7) Help me understand how personal and professional experiences influence what you do with patients? I asked follow-up

questions to expand and pursue emerging ideas, and gain a richer understanding of participant responses. I transcribed the audio-recorded interviews verbatim and reviewed them for accuracy prior to data analysis.

Data Analysis

Interviews were analyzed using open coding, memoing, and axial coding. Most coding focused on axial analysis. This chapter describes deconstruction of the second round of data and how the framework of **categories**, ***sub-categories***, *concepts*, *properties*, and dimensions evolves with this new information. This chapter also presents and clarifies emerging processes, building upon understanding from round one. Figure 3 represents a conceptual map of participants' experience and major processes evident after round two data analysis. Next, I present emerging experiences and processes, both supported with excerpts from participant interviews. I use this analysis to refine my theory of how collegiate athletic trainers utilize a working alliance with patients.

Emerging Experiences

Four primary categories remain after round two analysis: **establishing**, **navigating**, **buy-in**, and **contextual factors**. The category **establishing** now includes four ***sub-categories***: ***care contract***, ***connection***, ***trust***, and ***environment***. *Bonding*, conceptualized as a ***sub-category*** after round one, shifts to embody a *concept* of ***connection*** after round two. Three *concepts* of ***care contract:*** *athletic trainer commitments*, *athletic trainer expectations of patients*, and *coach involvement*, are upheld, and a fourth *concept*, *role induction*, was added in the second round. ***Connection*** now encompasses the *concepts* *caring*, *holistic appreciation*, *sharing of self*, *responsiveness*, *bonding*, and *boundarying* with *bonding* shifting to a *concept* of
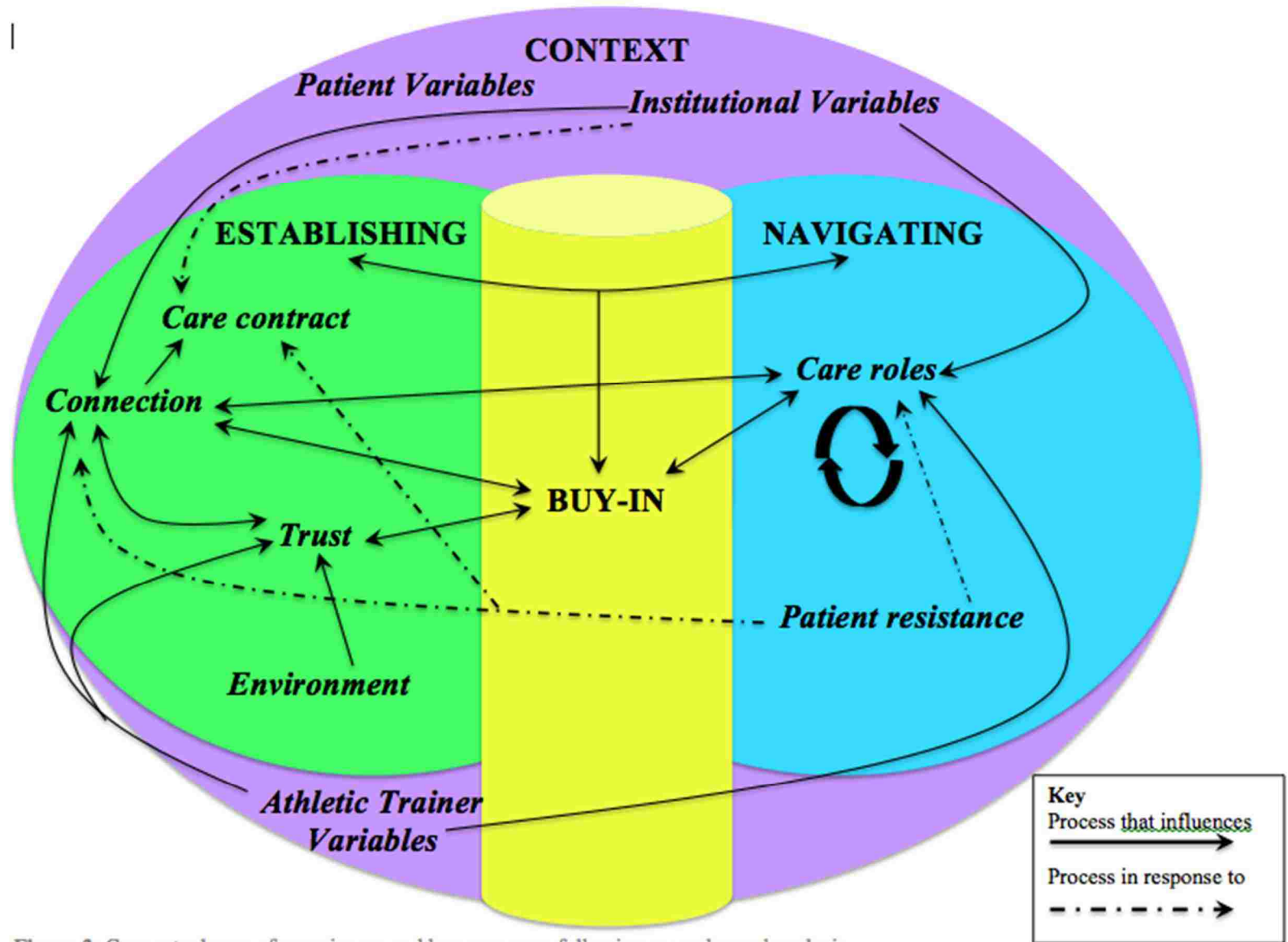
Figure 3: Conceptual map of experiences and key processes following second round analysis

connection. ***Trust*** is further detailed by the *concepts* *information sharing* and *proving*.

Proving remains supported by *properties credibility*, *commitment*, and *advocacy*. The

final ***sub-category***, ***environment***, does not de-construct further. Beginning the second

category, ***care roles*** continues to represent the *concepts* *director*, *partner*, and *educator*.

Partner continues to include *properties* of *solicitor* and *collaborator*; and varies along a

number of dimensions. First is <u>rehabilitation</u>, both location in the rehabilitation process,

which <u>dimensionalizes</u> to <u>early-----late</u>, and the length of the rehabilitation process,

which <u>dimensionalizes</u> to and <u>short-----long</u>. Second is <u>severity of injury</u>, which

<u>dimensionalizes</u> to <u>simple-----complex</u>, and last is <u>relationship,</u> which <u>dimensionalizes</u> to

<u>weak-----strong</u>. Within the *concept* of *educator*, *body awareness*, *understanding injury*,

and *purpose of treatment* remain in round two. The second and final ***sub-category*** in

navigating is *patient resistance*. The third **category**, **buy-in**, changes after round two to

encompass two ***sub-categories: beliefs*** and ***actions***. *Actions* are now understood in

further depth through *concepts* *accountability*, *communication*, *effort*, and *engagement*.

The final **category**, **contextual factors**, remains supported by three ***sub-categories***:

institutional variables, ***patient variables***, and ***athletic trainer variables***. The ***sub-***

category institutional variables continue to capture the *concepts* *institutional emphasis,*

patient load, and *proximity to patients*. The *concepts* *sport valuation* and *additional*

relationships, continue to define the ***sub-category patient variables***. ***Athletic trainer***

variables, the final ***sub-category*** in **contextual factors,** still comprises *personal*

influencers, including the *property personality*, however *professional influencers* changes

to embody the *properties student* and *employee*. Next, I will discuss how second round

data adds to the foundational understanding of **categories** present after round one, and

how it transforms into intricate relationships that shape the abstract picture of how

collegiate athletic trainers facilitate a working alliance.

Establishing

The first **category**, **establishing** continues to represent how participants create

and enter into an athletic trainer-patient or athletic trainer-coach relationship, with

athletic trainer-coach relationship becoming more robust. **Establishing** captures

participant, patient, and coach, expectations and understanding of the care process that

prioritizes holistic interest in patients, positive therapeutic relationships, and a focus on

supporting patient well-being. Determining and addressing coach involvement in the

patient care process and creating a positive relationship and supportive atmosphere where

patients receive quality attention from the outset lays the groundwork for the care

process. As the following passage highlights, first impressions are significant and begin

to lay the foundation for **establishing** a relationship and connection with patients:

> A478 I think some of it comes back to that first meeting. Uh that first impression isn't the most important thing, you can redefine that in some ways but it's a lot harder, and it's an uphill battle to. If you have, for whatever reason, don't have a good first impression, um they come in right when, there's too many other people in there [the athletic training room]…And you cant give them time and it's kind of hey well, sometimes you get to be conscious of being like 'hey, I cant do it right now, come back, can you come back at this time', which I think works out a lot better if you can work them into your situation. But sometimes we want to do everything, we want to help people so, yea I'll just look at you now! And sometimes you can ruin that first impression… Kind of, by not giving the adequate amount of time needed in that first evaluation.

Participant experiences creating relationships with patients and coaches represents

the **sub-categories care contract**, **connection**, **trust**, and **environment**. Within the **sub-**

category care contract, _coach involvement_ receives additional attention and a fourth

concept, _role induction_, arose in the second round. _Athletic trainer commitments_ and

athletic trainer expectations of patients remains unchanged. Second round analysis provides additional understanding and depth to the **sub-category connection** and each *concept* within **connection** (*caring*, *holistic appreciation*, *sharing of self*, *responsiveness*, *bonding*, and *boundarying*). Within **trust**, the concept *information sharing*, and *properties* of *proving* (*credibility*, *commitment*, and *advocacy*) received additional support. Attending to these **sub-categories** remained essential at the advent of care, and in some cases prior to patients sustaining an injury or illness that necessitates entering into a therapeutic relationship.

Care contract

The **care contract** is best understood as implicit and explicit expectations, responsibilities, roles, and obligations of the athletic trainer, their patients, and the coach during the care process. Understanding of **care contract** was deepened as the *concepts athletic trainer commitments*, *athletic trainer expectations of patients*, and *coach involvement* were elaborated on and *role induction* was uncovered during the second round.

> *Role induction*

Through *role induction*, participants express to patients what they do by sharing about responsibilities, knowledge, and skills, assisting patient understanding of their professional role.

> F183 I could make sure just to take time then to introduce myself and educate them [patients] more of my job. I think we're getting better, there's more athletic trainers in high schools, but I think sometimes even if there is an athletic trainer they're not there all the time so they don't, still don't quite understand what my job is and um, so I think just some better education on my part. Um, could help [create comfort].

A706   And sometimes I think because it's that environment, um I don't think all the student athletes know, necessarily what I can bring to the table. And I don't say that as a pride thing, but there's, kind of even like, um. This fall I had a, um, intro to weight training, um course. So basic weight training…but, the one persons a student athlete who's like 'ah yea coach doesn't really help me with the workout program and the strength and conditioning coach doesn't, um, isn't a throw specialist so, I kind of, they just tell me to do the sprint work out and now I want to do something more specific.' And I'm like, "well come and talk to me!" So why? Like, it's like 'ah no, we would never think to come and ask. Like it's, because you just do this'. I'm like "oh, we can do more things to!"

Emerging in the second round, *role induction* encompasses participants sharing about their professional responsibilities, knowledge and skills, to promote patient understanding of who they are as professionals and what they are capable of doing, which can initiate a relationship.

Athletic trainer commitment

Athletic trainer commitment continues to highlight participant obligations to adapt patient care and support positive progress.

O280   …If there is no noticeable measureable improvement, if they, if they aren't feeling any better 'm going to change something. Um, more than likely, um, that's going to come with a change of exercises and in a change in modalities. Um, because you know, I'll, you know it might mean progressing their exercises, it might mean you know, looking farther up or down the kinetic chain at a different aspect of what may be wrong. And ah, modality wise, if I'm doing something and it's not helping, or they're not having any improvement, then I'm probably going to either discontinue that or do it a lot less.

Second round interviews continue to highlight the importance of adapting patient care to support positive outcomes. *Athletic trainer commitments* represents participant dedication and commitment to the patient care process that supports patient agendas, and adapts care to facilitate positive outcomes. In the second round, participants also

emphasized patient accountability in the care process, supporting the _concept athletic_

trainer expectation of patients.

Athletic trainer expectations of patients

Athletic trainer expectations of patients characterizes the implicit expectations of

patients to follow through on care demands, move through the care process, and match

athletic trainer efforts in the care process. Here's an example of the implicit expectation

that patients are responsible:

> M403 I'm thinking back to last fall when you don't know any of them [athletes because I just started at this institution]. And so do you assume that they're all responsible or do you assume that they're all irresponsible? (_Laughing_). Like, which is the safer route to go? Um, I think I tend to assume, better, worse, or indifferent, I tend to assume that they're all responsible because I think just something in my nature assumes that like if you're grown-up, you're going to be responsible. And that's obviously not always true, but, so you get burned that way.

Here, Keeley elaborates on expectations of patients to match her effort.

> K324 Like you get your classic you know, ankle sprain…But um, you know, you have a game in a week. We're looking at getting you some playing time in that. You know we're setting a goal to be out of your boot this day, and be able to walk and then jog you know. For me with things like that, it hinges on how well they follow directions outside of the training room as well. 'Cause nobody likes to be in the boot, nobody likes to be on crutches, nobody likes to wear, nobody like to do any of that stuff or, you know. Nobody likes to you know, stay seated in their dorm all night. So that's kind of a big thing like I tell them I can only do so much for you, you have to, you have to help me out and help me do my job by putting yourself in the best position. So I think instead of having 6 weeks in between each little goal, we've got 24/48 hours instead.

Encouraging patients to seek their own answers, manage their care, and fulfill

responsibilities while promoting accountability were clear aspects of patient expectations

in the second round. Here are some examples:

> F580 I try really hard to force them to take responsibility and accountability. Um, and if I don't have to straight up give them the answer, I wont. I'll

say, oh that's a really good question, what do you think? Like how are you going to find the answer to that?

F590   You know with my athletes it might be as simple as no, I'm not going to go pick up your prescription for you, here's the directions to the pharmacy, here's the sheet to give them cause it's athletic related so you don't have to pay, but you need to be responsible enough to not loose this sheet on the way to the pharmacy, find the pharmacy, and go pick up your medicine.

F594   Um, one of my girls, we were at a tournament., and she knew we had 2 games in a row and her knee always hurts more playing 2 games in a row. Um but not only does she not recover well, or you know think about what food she needed to eat and get her legs up, um, she went and explored. Um but she forgot to take her medicine, um one dose each day, and I was like "listen, I'm sorry that your knee hurts, what, I mean what do you want me to do at this point? We just kind of gotta get through it." Um so then this week I've been, I've asked "are you taking your medicine?" 'Yes, yes, I'm on it, I promise, I wont ever forget again.' So I think part of then too, but letting them make those mistakes and dealing with the consequences and saying "well, sorry, I cant, I cant help you out of this one."

M408   …my sort of clinical philosophy of like I'm going to help you help yourself get better. Like that's how I operate, and so if you're not doing that part of it then you're not going to get better. But, that's more or less the bed you've made. Um, and obviously I don't then drop them off the face of the earth, you circle back you try to pick them up and you try to make it better. Um, but I think that from like initial assumption that I make is that they are going to help themselves get better. And I think most of them do. And then you find out the ones that aren't going to, and you make another strategy.

Interestingly, while participants' foster implicit expectations of patient responsibility, they also recognize the danger this can create. Care becomes difficult without mutual understanding of expectations of responsibility between participant and patient.

M447   I think especially with the freshman who, like I'm thinking of, I have this [patient] who is um, a freshman, from [another country] and [because of how the patient grew up]… just doesn't get it because [the patient] hasn't been in this sort of environment where like there, there are deadlines and there are expectations and you…but like [the patient] didn't ever have like a, like a structured school environment you know? She was one where like I didn't realize how, I didn't realize that that gap was so big, right, between like what I expected and where [the patients] knowledge of expectations at all was…Um, so I think, I mean obviously [that patient is]

an extreme case. Um, but it is true that they don't, they don't always know what your expectations are, and so sometimes with certain kids you've got to be a little more literal.

Establishing _expectations of patients_ prior to patients seeking care may help mitigate

misunderstandings between athletic trainer and patient.

> F173   Um. I think I could probably do a better job of reaching out to them initially when they arrive on campus. Because with [my sport] they'll arrive um, like mid June, so it's really early and they're kind of just. They just graduated and now, now they're on campus kind of like, 'what's going on?? I don't know anything!' So I think I could do a better job of um, kind of letting them know, or maybe putting something together from the beginning of my expectations rather than waiting until the team meeting at the beginning of the year, um when they finally get my athletic training policies and procedures in their binder. Um, put that in their welcome packet.

Second round analysis of _athletic trainer expectations of patients_ upholds the

presence of an implicit expectation of patient responsibility to take part in and move

through the care process and adds richness to participant efforts to support patient

responsibility and ownership. _Athletic trainer expectations of patients_ is now understood

as participants' implicit expectation of patient responsibility and willingness to follow

through and match athletic trainer efforts, and take ownership in the care process and

treatment outcomes. The final _concept_ in **care contract** to undergo changes in round two

analysis is _coach involvement_.

Coach involvement

Coach involvement outlines the coach role and their involvement in the patient

care process. As one participant puts it:

> O73   By having the coach help me with everything I'm trying to do… that's how I utilize the coaches ah, to help me ah stay on top of them [patients] and doing things when I'm not around. So my coaches, while they're not like super great at rehab or anything like that, they are pretty good motivators. So if I can get them on top of it and staying on top of somebody [patient]

to do things, which my coaches are really easy to work with like that, then that's how I use them as people to keep motivating them [patients] to do rehab and do exercises and continue to work towards their goals.

Participants also recognized and sought coach knowledge and expertise to assist in care decisions. Collaborating with coaches on the importance of certain races over others and sport specific rehabilitation informed important contributions to the care decision-making process.

M668 I think the biggest influence that comes to mind from my coaches and how I use them to help make decisions and things like that. Um, is just in expectations for what, what event's they'll [patients] be [racing] in, when they'll be [racing], things like that. So, if I'm looking at like a long-term outcome for a kid and they're like, like this happened a couple times this fall, um, with some of the chronic back cases where…I think they had three or four actual races in the fall, um, but two of those are much more like competitive than the other two.… like, the coaches were like we don't really care. Like race, don't race, great. So I think that sort of information is really helpful when you're deciding like, we had two of the back cases that we decided we were going to do injections and rest at some point in the near future. When that's going to be is somewhat flexible…And you know different decisions were made for each kid based on a variety of factors but I think that's mostly how I use the coaches. Because I wouldn't know that otherwise, right, like I would assume that everybody wants to [race] this weekend but like, they're [coaches] like 'whatever, this race is inconsequential, it's basically a scrimmage.

A741 I like to involve the coach and get a lot of coach feedback on different things. Because the coach does have a lot of good input on that athlete. Um, so, I use an example, I'm with men's hockey right now and my concussion patients when I have them return to play um, so we do phase 1, or step 1 is you know on the bike, step 2 is a higher level, and for step 2 higher level aerobic I try to get them out on the ice by themselves just on the rink skating around. But I'll try to solicit feedback from the coach as far as how you know what are some things they can work on as individuals. You know what part of their game do you want them to get better. "Well they need to do better stick handling." Well ok, I'll send [the patient] out and I want [the patient] to stick handle for the next you know 30 minutes, and you work on that. So we have that 2 days, so we can build kind of that stick handling into the rehab or the return to play for concussion, um. Or maybe they need to work on their shooting, um so we can, you know go out for 40 minutes and just work on shots.

Garnering coach support for the decisions participants make about patient care is still

present, and becomes more robust in the following passages:

> O149   Um a couple of my other coaches, a lot of it just kind of, I don't know how to put it, kind of a grinding a constant reminding them [patients] to do stuff over and over and over again. And ah [coaches] motivating them [patients] [by saying] you know like 'we want you to play, we need you to do this stuff, you know [Orlando] told you to do this stuff, ah do it. So a lot of that kind of continually reinforcing that they need to do it and it will help them get on the court or field faster and playing like they need to play.

> F118   Um, and some of the girls um, I think we talked about this before, some of the girls respond really well like if um, or they did respond well if they were in trouble with me and then the coaches were looped in and got on them...

> K134   I mean like my consequences that I give are more, ok well you didn't show up and it's not gonna get done, and I tell coach. And if coach is like, 'yea ok that's fine'. Then that's not a consequence, you know. If you know I say you didn't show up, sorry there's no time before practice, and I'm gonna have to tell coach. And then coach has a standing consequence you know, you run 10 suicides, or you know depending on the rehab obviously. Or you have to be the one that films or does the laundry, or whatever. Then there's a consequence. So I think it has to be both. Cause obviously if I tell a kid to go run 10 suicides, they're gonna be like 'yea, ok' (*sarcastically*).

Coaches can have positive and negative influences on patients. Here, the importance and

expectation of coach support is stressed:

> K104   The coach says you need to jump off a bridge, you (athlete) may need to jump off a bridge, you know. Obviously not to that extreme, but, you know. When someone holds your tuition check, they have a pretty powerful influence over just about anything that you do.

> M694   I had [an athlete] hurt [their] back really early on in the fall and was really struggling just with like adjustment to college and all sorts of other factors and then back pain on top of it was not great. And the coaches were like, we're just going to plan on you not rowing in the fall and that's fine. You know, and then that sort of, using them to help set expectations for like, don't worry about it take the entire fall off, get healthy, get better from like a mental and physical standpoint, and then come in strong in the spring. Um, which are expectations that even if I set them I don't think they mean

as much to the kids as if the coach says it's okay if you don't [participate] this fall. Like that's better, it just means different things you know. It's huge, it means the world to them when they're, you know they feel like the walls are caving in on them, right, they've got, they're hurt, and they're not going to be able to race…And it's almost like permission from the coaches to like, relax. Um, so I think that's mostly how I, how they influence decisions.

Coach actions, such as demonstrating caring or acting as a motivator, can positively impact patients. These excerpts underscore the influence of coach actions, highlighting their obligations to patients:

F453   Well I think it's, if they [coach] show an interest in what's going on with the student, that helps [influence the care process]…You know if somebodies out, um, somebody was just out this weekend. And 2 of the coaches texted her and were like 'just want to make sure you're ok, let us know what we can do. Um if you just want to be left alone we'll leave you alone.' Um and that meant a lot to her. And she was just talking to me today, she was like 'yea well, this coach and this coach contacted me. This coach didn't say a thing. The whole like, he knows things aren't going well, but he didn't reach out to see how I was doing.

F472   Um so that, that helps a lot [coach checking in on patient]. Even if it is just stick their head into the athletic training room and, you know see somebody doing rehab or if I have the opportunity to do rehab with someone on the court during practice, or off to the side, um and they know, the coaches see what they're doing, and that they're not just sitting on their butt, injured.

O142   You know if somebody is hurt to the point where they can't do some of the stuff um, that the team is doing, they have them do their exercises, like on the practice court. My volleyball coach is really good at that, having them kind of with the team still cheering on but doing all their exercises and ah you know off to the side or whatever they're doing. And that way whenever he's going through practice he's also watching them and being like, "now keep doing your exercises", and the other girls can actually help and motivate them as well. You know, 'we want you to play', stuff like that, 'keep going.'

Due to imbalance of power between coaches and patients, it is unhelpful when coaches attempt to dictate patient care, as opposed to supporting participant care decisions. This

can lead to wavering patient trust in the athletic trainer's credibility and impedes their

responsibilities and obligations to patient care.

> K92   So, but I know, some of my coaches, thinking of my basketball coaches, they played at really high levels, and this really irks me, but they'll come in and be like 'well when I did this, they did this to me.' I'm just like, "ok, so can I call the next play then? You're trying to do my job"…But, I think they get it in the kids head that this is what the kid needs and the kid comes in and like 'this is what I need' and then, I mean, yea, maybe there's a little bit of merit to it, but when there's not, you have to say no, this is what we're doing. They [patients] sometimes think 'oh, I'm not going to get better if I don't get this.'

Use of coaches to help participants better understand their patients aids rapport building

and the care process:

> M458 [This patient] was one where like I didn't realize how, I didn't realize that that gap was so big, right, between like what I expected and where [the patients] knowledge of expectations at all was. And so I talked to the coaches, because I was just like I just feel, like we're not connecting and something's off there and I just don't know what it is. And they were like 'oh it's not you. They were like she's struggling on all levels.'

> L76   Um I mean I take that input, I take input from you know coaches if they see or hear things that maybe the athletes want changed then I kind of take all the information that's available to me to, you know, build those relationships and provide the best treatment.

> M423   I like once a week or so we'll either have a meeting, or, meeting sounds formal, it's usually more like the coaches stop in and we like, little side meeting type of thing. And just go through whoever [patient] is on their list and talk about um, you know, where people are at. Just sort of like a check-in meeting on the injured kids. Um, and often times it will come out that like, because they know them better generally speaking, unless they're a frequent flyer in my office and I happen to know them better. They'll be like, yeah [they're] pretty irresponsible about just like life, right, like [they're] late for practice and [they're], um you know whatever it might be. And so then you're like oh well I probably should have harped on [them] more or just followed up with [them] more often or whatever it might be. But, I think a lot of times it's not just that they're um a little bit irresponsible at treatment it tends to be like that's how they are as a human…so sometimes it's, sometimes it's that you know I just didn't know the kid well enough to know that my expectations should be lower.

Coach involvement is understood as outlining the coach's role and involvement in the patient care process. *Coach involvement* has expanded in the second round. Participants described ways of involving coaches (selectively seeking coach knowledge and expertise, collaborating over care decisions, gaining a better understanding of patients, and managing coach power to support care decisions) that are most helpful to the care process. C*oach involvement* is a critical factor in the **care contract** experience; round two data suggests that participants are very intentional about managing coach involvement to support patient well-being.

Care contract captures **establishing** roles, expectations, and obligations of the athletic trainer, their patients, and the coach prior to and during the care process. *Role induction* embodies promoting patient understanding of who participants are as professionals and what they are capable of doing, which can initiate a relationship. *Athletic trainer commitments* are grounded in supporting the patients' agenda and flexibly adapting the care process to facilitate positive outcomes. *Athletic trainer expectations* are largely implicit and emphasize patient responsibility to follow through on tasks, take ownership in the care process, and match athletic trainer efforts to create positive outcomes. *Coach involvement* outlines and communicates expectations of the coach to support patient well-being and the care process. Selectively seeking coach knowledge and expertise, collaborating about care decisions, reaching a better understanding of patients, and soliciting coach support are helpful examples of involvement in patient care. These *concepts* round out **establishing** participant, coach, and patient responsibilities in the care process. These **care contracts** begin when patients seek care and remain present

as participants navigate athletic trainer-patient and athletic trainer-coach relationships throughout the care process.

Connection

      Connection, another **sub-category** of **establishing**, places emphasis on creating a *connection* with patients. **Establishing** a *connection* can occur prior to sustaining an injury or illness, and is about showing patients they are important, valued, and cared for as unique individuals. Initiating a *connection* takes work and begins with displaying and conveying interest and value in patients. Time and continued interactions can promote *connection*, encouraging patients to seek care and facilitating better care management. A *connection* generates patient comfort to share concerns and enables athletic trainers to provide feedback that evokes change. Further, when a *connection* is present, participants become more willing to respond to patient requests outside of normal professional responsibilities, participant-patient interactions become less formal, and participants' are considered and included as a part of team successes. In the second round, participants expanded on experiences when *connection* was absent, and the effects on patient care.

      Establishing a *connection* takes energy and time. The following passages highlight the presence of time and continued interactions that promote *connection*:

> F113   Seeing them at practice helps. Um, because then I see them in an environment different from the athletic training room and when they're on the court, seeing how they respond to their teammates and the coaches. Um, whether just in general or when they're being praised or when they're being scolded. Um, and how, and then how they react to that kind of, I try to use that to guide me to what they may or may not respond to on my end. Um, and some of the girls are juniors now, when they were freshman, were pains in my butt, and now they are, they are great. So I think some of it [learning what patients need in relation to care process] just kind of comes along with time and just learning about each other and that comfortable, that level of comfort that comes with that.

F134   I think um, some of the girls, so some of them, taking a look at this freshman class that I have now, some of them came in with injuries so they were forced to spend time with me. All summer. Um, and so I think that [comfort between AT and patient] happened a lot faster than um, the girl right now who hurt her ankle, we just finished up with her ankle injury and just started showing up to the athletic training room late November.

F138   Um, versus there's another girl…. Um, and she's kind of, I think she's like probably in the middle of those two groups. Um I've had a lot more interactions with her than some of the other girls but still we're not, like, ah, where I am with the girls who have been in since the summer. Um but all the same, she, thinking about her in particular, I still, I try to just make, let them know that I support them regardless of whether they're in the training room for injuries or not.

M69   I mean there's definitely, there's athletes you get to know better just because, because of situations, right? Like, a kid tears their ACL you get to know them really well. A kid comes in with you know um, whatever it might be, a tendonitis that you treat for a couple weeks and then they're back you might not get to know as well….I think in some aspects yea, you get to know them better…Like in my mind there's still like student athletes that come in that it's just like strictly professional all the time, you don't really know them very well. And then there's one that you know more on a personal level.

Since time and opportunity to get to know patients can allow for **establishing** a *connection*, it is important to take advantage of these opportunities to create a *connection*:

F173   Um. I think I could probably do a better job of reaching out to them [athletes] initially when they arrive on campus. Because with (my sport) they'll arrive um, like mid June, so it's really early and they're kind of just. They just graduated and now, now they're on campus kind of like, 'what's going on?? I don't know anything!' So I think I could do a better job of um…make sure that I talk with each of them when they do come in for their physicals…I could make sure just to take time then to introduce myself and educate them more of my job…. And then like I said I do the ACL prevention program every day before practice, so I think I could use that opportunity too to talk to some of the girls that I don't see every day.

When mutual relationships and *connections* with patients and coaches are present, participants are considered and included as part of the successful team unit.

L698   …you know, the relationships I've formed outside of rehab um, you know I've been on a couple of conference championship teams where, you know the basketball team let me cut down a piece of the net, or where the soccer teams come out and they get you in their championship picture and things like that. So, I mean, that comes when you have those good relationships with those coaches and those players. That's what I strive for, because those moments are few and far between.

In the absence of a ***connection***, patient and provider may be unable to communicate effectively, and participants will refocus efforts on other patients, impacting patient care.

A19   When I don't have a personal connection with a patient and they aren't doing what they are supposed to be doing, I don't have as hard of a time moving on from them and focusing efforts on patients who I do have a personal connection with.

While the absence of a ***connection*** does not have to negatively affect patient care and outcomes, it left one participant feeling as though there was something missing in their patient-provider relationship:

F19   I'm thinking of one girl in particular on my team who's a freshman…. And um, I tried like when she first got here to obviously, to be welcoming. Recently she's had an ankle injury and she's been in the athletic training room more and so I've been trying really hard to be more personable because I don't want her to feel like. I know she's had some trouble with her teammates, so I don't want her to feel like um, she can't act like herself when she's in with me. Um, but it's hard when like, I'm, I'm not really receiving anything back from her. So making an effort just to like [ask] "how's your day?" and she's just like 'good'. And, "ok". 'Can I get taped?' kind of thing? So um, but then, I mean at the same time she's doing wonderfully, she's progressed really well through her ankle sprain and, um back to full um, and all of that. I mean she, she did well. I just feel like something was missing when I was working with her.

A ***connection*** was previously understood as communicating and displaying to patients they are important, valued, and cared for. This continues to be true, and second round analysis added more depth, focusing on the importance of time and continued interaction when facilitating ***connection***. When ***connection*** is present, patients readily seek care, feel comfortable sharing concerns with participants, participant-patient

interactions become less formal, and participants become more willing to go above and beyond professional responsibilities to facilitate patient care. When a mutual relationship and ***connection*** with patients and coaches is present, participants' are considered and included as a part of team successes.

<u>Concepts</u> of ***connection:*** <u>caring</u>, <u>*holistic appreciation*</u>, <u>*sharing of self*</u>, <u>*responsiveness*</u>, and <u>*boundarying*</u> all remained present in the second round, and were further elaborated on.

<u>Caring</u>

<u>Caring</u> encompasses gaining a richer understanding and appreciation for patients as unique individuals and putting forth the effort to learn, remember, and respond to unique patient qualities and challenges. Here are some examples of how participants came to understand their patients better:

A501   Yea and, like I said some of it comes back to that first meeting of trying to get to know them as an individual. Ok, where are you from, what's your major, and as they're answering that, for me I get a lot of feedback of, you know is this person more outgoing or are they going to be quiet and reserved. Do I have to pry to get questions out of them, or are they just gonna, you know voluntarily tell me everything that's going on in their life and. And everyone's different so trying to kind of understand their personality then goes back to how you deliver those other things.

K49   Um, I mean I think for me it's getting to know the athletes like before they get hurt. Kind of just reading into their personalities a little bit. Seeing them on the court, on the mound, on the field, you know whatever. Whatever sport they're engaging in, kind of seeing how they behave there, you can kind of predict what they end up needing if they do get hurt. Like you know, some people when they get hurt are just like don't touch me, leave me alone, let me sit. Some people like really want you to be there and sit with them, or hold their hand.

F113   Seeing them at practice helps [*figure out what they need in relation to the care process*]. Um, because then I see them in an environment different from the athletic training room and when they're on the court, seeing how they respond to their teammates and the coaches. Um, whether just in

general or when they're being praised or when they're being scolded. Um, and how, and then how they react to that kind of, I try to use that to guide me to what they may or may not respond to on my end.

Caring also became about having the presence to recognize and attend to experiences and

challenges patients may be facing, physical or otherwise.

> A151 … I think sometimes as individuals we [athletic trainers] only see them [patients] for 2-3 hours every day, but they have to be able to deal with whatever they have going on for 24 hours. And then a student-athlete or athlete, patient that can be the worst thing for them cause they're not able to do what they can normally do, and so then the frustration of performing at a higher level and now not being able to perform at that level is you know, they live with that all day long…So, how can we kind of address that and talk about some different things so that at least they have someone to talk to and someone that hears them, understands it, and they can kind of get that off their mind off their shoulders and move on.

Recognizing patient effort, adjusting or changing requirements for the day, and

connecting patients with additional resources are also ways participants show *caring*.

The following passages add a richer understanding of this aspect of *caring*:

> F832 You know you are, you're a division 1 [athlete], not very many people get to say that they get to do that. Um, you've worked really hard to get where you are. And I see what you're [athlete] doing, I see the work that you're [athlete] putting in, and it doesn't go unnoticed or unappreciated.

> L216 I would look for ah, you know any kind of body posture, if they're, obviously your [participant is] looking for limping or any kind of compensating, um. I would say those are the 2, 2-3 biggest ones that I look for. Facial expressions every once in a while you can tell if they're coming and they're talking to you, if they just look like they're frustrated or down. So you kind of look for those cues.

> F146 I mean I do an ACL warm up with them every day. And I correct their mechanics, and this girl I was talking about works, tries really hard to like change what I tell her. And a couple older girls were making fun of her for trying. So then you know after practice I was like listen, I see what you're [athlete] doing and I appreciate that you're [athlete] putting work into this. I know that they laugh, but you're [athlete] helping yourself by doing what you're [athlete] doing and I see what you're [athlete] doing and I appreciate it. Um, whether that meant anything to her in the long run I don't know but um, I felt like it needed to be said.

A98   If they're [patient] frustrated, I think a lot of it is sometimes they just need someone to hear and understand that they're frustrated with things or that they're not happy….Um, and try to get that kind of information out of them so you can kind of discuss and say ok, lets break things down. You know, it's going slower then what you'd hoped. Yes, we were kind of trying to be aggressive with treating this but your body's not you know, adapting to the aggressive so lets slow things down and these are the goals we're going to work on.

F856   Um, and then, I mean, right now there's a girl who's [grandparent] just died last weekend, and she's…here for 4 years [from another country]. So her family's, her [grandparent] lived in [another country]. And she's not a very emotional person, she doesn't like to talk about, she doesn't talk very much ever, um, but she came to my room this weekend when we were on the road and I found out her [grandparent] passed away, and she was like 'I just don't know where else to go, I didn't know who would listen." So then just facilitating that… just facilitating getting to counseling and making sure the coach's are aware of what's going on and um. So I've, I look out for their mental health too.

Showing _caring_ can also be as simple as participants asking what it is patients need and

seeking a richer understanding:

K62   You could also just ask, like what do I need to do for you right now, what will help you? I mean obviously you're gonna do the basics of, rehab, prevention and care, stretching, but, what else do they need from you? Is it support, is it, do they need just 5 minutes alone to ruminate? You know whatever they need. Just talking to them.

A546   There's a lot of questions I'll start to ask of "ok, how do you feel like things are going?" So kind of be brief and understand where they are as kind of an individual of, how do you think things are going, do you think things are going slow or are they not going slow and sometimes it's related to the treatment course of plan or treatment plan. Some of it's just totally unrelated of "well hey, there's problems going on at home, or schools really bogged down right now and I'm [patient] busy with that," or you know, there's a lot of other factors you know, "we're having financial issues, I'm trying to find a way to pay for this." Or they are removed from the team and there's multiple roommate issues….So I think some of that is breaking it down, asking questions of how are things going, what's going on, um, you know.

After integrating data from the second round, _caring_ continues to represent deepening the **connection** between athletic trainer and patient by showing patients they are seen and appreciated as more than an injury/illness and putting forth effort to gain a richer understanding and appreciation of their qualities and challenges. Greater understanding of ways participants display _caring_ (recognizing patient effort, adjusting or changing daily care requirements, or connecting patients with additional resources) were new discoveries.

Holistic appreciation

Holistic Appreciation, another _concept_ of **connection** is about appreciating and supporting patients' distinct priorities, respecting that patients are more than athletes. In the first round, athletic trainer's ability to acknowledge, appreciate, and support patients' multiple priorities was critical.

> A624   Sometimes there's underlying goals of what they have besides sport. Which I like to tie those in personally because, it gives them a little extra motivation of, hey we're finishing your ACL rehab you're gonna be home, what other things do you want to do? Well I wanna run a 5K in the summer. Alright well so, lets start to build some endurance aspect as well as the strength so that we can kind of prepare you for that and you can do that in addition to what you're doing.

In the second round, coach recognition and respect for patients as more than simply athletes was also an important part of the _holistic appreciation_ experience:

> M647 I think they're [coaches] pretty understanding um, of, like understanding and also respectful of the fact that like they're not trying to ruin their [athletes] bodies to play the sport. Like that's not, they just have different goals.

Holistic appreciation now shifts slightly to include coach interactions and displays of mutual respect, valuing, and appreciating patients beyond their role as athlete. _Holistic appreciation_ continues to be about appreciating one another as unique

individuals with unique roles and needs. Formerly located in the athletic trainer and patient dyad, the experience of holistic appreciation now encompasses the triad of coach, athlete, and athletic trainer.

Sharing of self

Sharing of self, a third _concept_ of **connection,** continued to be present in the second round. Here, participants share personal and professional aspects of themselves to relate to patients and enable a better understanding of who they are and what their experiences have been. Here's an example:

> A834　Last week I had a, ah track [athlete] come in….But um, [they] came in and was like 'I didn't really want to like come in and see you because, I felt like you were going to hold me out from running.' And it's like whoa, hang on. Um. So, I actually ran cross country in college so having that experience, I play that card all the time. And even though it might not mean anything at all in regards to what I'm going to do professionally as an athletic trainer, but having them understand, hey, like….But, having, letting them know you understand the whole 'I need to run every day cause if I don't run every day I'm not going to be successful'. Which there's a lot of truth to that as runners. You have to put in the time and the mileage. So, it's…letting them know hey, this is my personal experience. I know you have to be out there and I'm not here to hold you out, it's I'm here to keep you going. And we're going to do everything we can to get you out there and to get you going. But having them understand that you, you know their sport is huge. Of trying to understand that and having that personal experience.

Sharing personal injury experiences is the only aspect of the original conceptualization of *sharing of self* present in the second round. *Sharing of self* now embodies participants sharing across broader experiences to relate to patients and convey understanding of patient experiences.

Responsiveness

Responsiveness, yet another _concept_ of **connection** describes participants' responsibility to listen respectfully, be present in patient conversation, and respond in a

manner that lets patients know that what they are saying and feeling is important and

understood. The following passages add richness to the *concept* of *responsiveness* by

highlighting the importance of being present, actively listening, and demonstrate

understanding and appreciation of what patients are sharing:

M200   I think showing, especially kids you've never met before, or have met in physicals and then never again, um like showing, showing a genuine interest in them even if it's only for a of couple minutes. In a busy room where there's a lot happening, just sitting down and eye contact, paying attention to them and what they have to say. Even if it's like that's all, like you take their history while looking at them and the rest of it is you're doing 3 things at the same time. I think even those few minutes of like really like active listening, um can really help

M225   Even if it's like a situation where there's not a lot to do, right. I'm thinking of our rib cases, we have a lot, in [my sport] [athletes] get rib stress fractures, they're out for a really long time, there's not a lot you can do. There's not anything. So, even if it's just like 'today my ribs still really hurt and I'm really frustrated about it', being like " I get that you're frustrated. Like, "I understand you, and I am sorry and I wish that there was more I could do." Like just say, like, taking that time to be, to like acknowledge that it's a frustrating situation as opposed to just being like "yup, rest, I'll see you in a week." Them, acknowledging their [patients] feelings, acknowledging what's happening and them [patients] knowing that you're listening to them. Even if it's cause, like I said, even if it's not something where like I can fix it, per se, you know, I think goes a long way to build relationships.

M246   Um, I would say active listening is probably the biggest thing (to learning about patient needs and desires). Um, because everybody, especially on a team that's so big. Everybody's goals are a little bit different…And so like I think getting a little bit of their [patients] story, like within the team, um. I'm thinking of like in the spring when we're, when they're racing every weekend and how things are managed a little bit different. Um, but you don't know, like you don't know how to use their [patients] goals to make treatment goals, to make rehab goals, to make you know ultimately return to play goals if you don't know what they are. So like, you have to ask. Um, but I would say, yea I think listening's probably the biggest thing…but also, I consider asking questions part of listening, you know what I mean. Directed questions and then active listening.

De-construction of second round data offers a more robust understanding of

responsiveness. Responsiveness <u>continues</u> to describe participants' ability to be present in

patient conversation, actively listen, reflect understanding, and respond in a manner that

lets patients know what they are saying and feeling is appreciated and understood.

Bonding

Bonding, the next *concept* of **connection**, speaks to participants having insight

and knowing their patients, enabling them to facilitate care that resonates with patients.

Bonding embodies a deeper **connection** with patients.

> K11   Um, I think when you have that personal connection and some knowledge
> about, kind of their inner self, you can sometimes tailor more of the care.
> Like um, acute injury happens, they're very upset, you know them and
> know they're very close to their mom, 'hey do we want to give mom a call
> right now?' Um, or you know, if maybe moms not necessarily the person
> that they want to talk to when they're like that, maybe that would make
> someone more upset that you weren't, didn't really know them as well.
> Little things like that.

Knowing patients enables effective communication and assessment of the patient

truthfulness and work ethic. For one participant, a deeper connection promotes ***trust*** in

patient responsibility:

> O9   The better I know a patient, the more likely I am to know if ah…but if
> what they're telling me is truthful. Like if they have a high or low pain
> tolerance, stuff like that. The better I know them, you know, do I know
> how hard they're working to get back to sport and things like that. So ah,
> like I have patients who ah, I kind of talked about before I'm at a small
> school, so a lot of things I have them do are at-home programs. So the
> ones I know better, and the ones I know who are actually doing their home
> programs, I know I can kind of advance them in a way that is kind of
> consistent with, ah if they were doing rehab every day. Whereas I have
> other patients where I do know don't do that, and so I cant advance them
> without kind of testing them first because I know they aren't doing what
> they're supposed to be doing at home so I've gotta re-evaluate where they
> are, and if they can even progress. Whereas if it's a person who I never, I
> don't have a relationship for I kind of have to do everything with what I
> see since I don't know what they're going to do away from the training

room. So, the better the relationship is and the more I can trust them to do stuff that, really the faster they can progress through ah, through my treatment programs because if they're doing stuff at home and I know that they and I trust that they are then we can kind of get through things, whereas if I don't know them then I'm not really sure where they are and I have to continually recheck and reassess and see where they're at and if they've been doing stuff and if they are having any gains, stuff like that.

K39 Um I would say maybe if you, you don't know them, you don't know, how kind of they operate, what kind of learner they are, some of your stuff can maybe get lost in translation. Like something you think…like ok that meant 'this'. They may not end up picking that up. Um, and obviously it's, if it's really anybody's fault it's your fault for not explaining it but, just knowing how they, not knowing how they learn can be kind of a hindrance in care.

Second round data highlights participants' knowing about their patients', enabling effective communication and assessment of patient responsibility. *Bonding* continues to represent a deeper **connection**, inherent in knowing and implicitly understanding patients.

Boundarying

Boundarying represents the final concept of **connection** and captures trying to find, communicate, and maintain a balance between the personal and professional relationship with patients when **connecting**. One participant touched on this as it relates to maintaining patient trust and respect:

M37 I hope that the kids that I know on a personal level still think of me as a professional and I think that they do because that's what's established first. Um, and I think of how like, like I know what you're saying like, there's a, they co-exist right, like the personal and professional. But I just am not sure, I think it's how they, especially with college kids, I think it's how they frame you. Like you are a professional, like there's like coaches and you and like adults in their life, and so I think once you sort of put yourself in that, like adult bubble for better for worse, then as long as you don't cross lines into you know. When I think of crossing lines I think of like when they start to think of you as a pal, like they see you at the bar or you are talking to them about, I don't know. Um, but, when you, I think if you keep yourself in that sort of like bubble of professionals, adults, people in charge, then you can kind of cross into personal conversation but still stay a professional in their mind.

In the first round, *boundarying* captured many experiences influencing *connection*: maintaining a balance between personal and professional styles of relating, navigating the tension between patient health, safety, and desires, and protecting participant time and energy. Second round data expanded on navigating professional and personal styles of relating in ways that maintain patient trust and respect. In sum, **establishing** a patient relationship on professionalism foremost can help maintain a balance between personal and professional and maintain patient respect.

Establishing patient *connection* takes time and begins with displaying and conveying interest and value of patients as unique individuals. Effectively utilizing time and having continuous interactions further supports *connection*. When *connection* is present, patient interactions are less formal and participants are more responsive to their patients. Concepts of *connection* (*caring, holistic appreciation, sharing of self, responsiveness, bonding, and boundarying)* all garnered more support from participants in the second round. Namely, that *caring* is further established by understanding patients through observation, recognizing patient challenges (physical or otherwise), helping patients manage negative experiences, acknowledging patient effort, and connecting patients with resources. Using *holistic appreciation* to value differences and roles beyond that of athlete and *sharing of self* to establish rapport and relate to patients in a more personal manner supports a *connection*. **Establishing** a *connection* also requires *responsiveness*. This is recognized as being present during conversation, active listening, and responding in a manner that lets patients know what they are saying and feeling is appreciated and understood. *Bonding*, or a deeper *connection*, enables implicitly understanding and knowing patients. Last, **establishing** a *connection* requires

boundarying, specifically in the second round, referring to intentionally navigating personal and professional ways of relating. **Establishing *connection*** is a critical aspect of patient care for participants. Just as critical is the **establishment** of *trust.*

Trust

    Establishing *trust* requires cultivating and maintaining patient and coach beliefs in the participant's competency and ability to support and protect athletes. Experiences of **establishing *trust*** between participants and patients were well formed in the first round. **Establishing *trust*** from coaches, however, became richer in second round analysis. The following passages highlight how important *trust* from coaches is for participants:

F428   Um, but my head coach is, has been phenomenal. Um, from the moment I got here, just supporting me and he's always sure to say you know, 'I have faith in what you're doing, and yea I want them on the court, but I want them on the court healthy.'

F494   I actually just had a conversation with my head coach on Friday about things that have been going on and I did tell him in that conversation how much I appreciate him and his support of what I am doing. Just because I know a lot of athletic trainers don't have that support from their head coach.

For one participant, coach *trust* is inherent because of his longevity in the system:

O93   um, they don't, I wouldn't say that they [coaches] don't bother me they just don't you know, kind of, they don't get mad about whether I tell somebody they're out or they don't question my decisions I guess on health. And ah, I guess that is kind of a trust thing. We have a lot of turnover in coaches, I think it's more, you know kind of a respect thing. I've been there longer and I not only have the respect of, I tried to gain the respect of my coaches but I have the respect of, kind of the administration where I'm at. So it's one of those things where I don't think they [coaches] question me because, you know kind of in the totem pole of their minds I'm above them. So. Even though I have a good, like friendly, relationship with all of them, I think that's how it all starts. Because they all kind of perceive me as a superior in the pecking order.

Whether receiving support when beginning a new job, or because of seniority, or for

institutional backing, a coach's *trust* is critical when **establishing** care. In participants'

experiences, coaches express *trust* by encouraging patients to seek care from them,

advocating for the types of care provided, and supporting care decisions. Undermining

care decisions and dictating patient care, however, are ways coaches display a lack of

trust in participants.

> K112   I think when they [coaches] can circle to the athletic trainers side and say 'hey, she knows what she's doing, she's not stupid, you need to listen to her, you need to respect her, what she says goes….I think when they step onto our side and back us, that helps tremendously. Because if the coach goes around and says, 'you know [Keeley] doesn't know what she's doing, I don't trust [Keeley], don't go see her.' What are the players gonna do? But if the coach goes and says you know 'if something's bugging you, you can go to [Keeley], she can take care of it, you can trust her, I want you to get better. If they tout you in a positive light, you're gonna have a lot more compliance with your rehabs and stuff.

> L603   If you have a good relationship with [the] coach, they're [coach] more willing to tell the athletes 'hey, you gotta go in, you gotta get treatment.'. Again, along the same aspect like if they, if you have a good relationship with the coach, they don't question you when you say like oh, "so and so's gonna be out for a couple of weeks." And they say, 'ok, keep me, keep me updated, keep me in the loop when you think he's ready.' Whereas on the other side, if you don't have a good relationship with your coach, you're always butting heads, you're not, you just don't get a long. Then they might not be willing to tell the athletes 'oh you need to go in, you need to get treatment.' And they might question you when you tell them like oh, "he's gotta be out for a couple of weeks," they might, see that athlete and say no you can be back faster. They might try to even go above and beyond and try to get them to see a doctor or someone outside of the university or the athletic training departments care.

When coaches *trust* participants, this also encourages patient *trust* in participants,

preventing patients from having to choose who they are going to listen to.

> A753   Um I think getting the coach to buy in and being on the same page as the coach is a huge aspect cause it's, I don't want to say it's a husband wife relationship, but it is kind of a parent relationship to that student athlete in the collegiate setting. Especially of, if coach is saying one thing and

you're saying another, and you're not on the same page that, the student athletes only going to buy into the person they trust. A lot of the times they say we're recruited by the coach, so they're not going to buy into your system if, you know coach wants them to do something else.

Trust from the coach became more robust during second round analysis, highlighting how coaches display *trust* (encouraging patients to seek care from and supporting participants care decisions) influences patients and the care process. *Trust* continues to embody confidence in participants' competency and ability to act in a supportive and protective manner with patients. Without patient and coach *trust* in participants and the care process, patient care can be negatively impacted. While **establishing *trust*** between participants and patients held the most weight during round one data analysis, **establishing *trust*** between participants and coach has a strong presence and is further elaborated on in second round analysis. To further understand experiences of *trust* from the second round data, the *concept* of *information sharing,* and *properties* of *proving (credibility, commitment,* and *advocacy)* are explored next.

Information sharing

Information sharing represents how information is delivered to patients (honesty and transparency) and establishes limits to information sharing with the coach. Delivering information to patients in an honest and transparent manner remains important when achieving *trust*, and garners more support in second round interviews:

L552   When you're educating them [patients] or you're telling them what's wrong and not you know, putting any kind of weird spin on it, you're just telling them the blunt truth, the blunt truth and the truth in general, they're more willing to buy in and trust and things like that. Whereas if you're kind of feeding them some false information or putting a positive spin on a situation that doesn't need it, they might not, they might not take what you have to say seriously all the time.

When and if information is shared with the coach is central to **trust**. Coach respect for

limits of sharing and patient trust in participants' ability to hold information confidential

is critical.

> F434 Um, [coach] kind of sees where I am a healthcare provider and there are
> some things that they [coaches] don't need to know and he's [coach] said
> you know I'm more concerned with when are they [patient] going to be
> back and are there any limitations and, what do we need to do to get them
> back on the court faster, kind of thing. Um, so sometimes I think that
> dynamic [athletic trainer-coach relationship], sometimes, I mean definitely
> I think the girls can sense there's some, some tension, and that might be a
> barrier if they feel like I'm not keeping that confidentiality. Which I hope
> they, I hope I've made clear that I'm not gonna like go [and tell coach
> what patient shared]. That's probably the thing that's most important to
> me.
>
> J *Their trust in you?*
>
> F Um hm.

Communicating and sharing patient information with coaches to facilitate understanding

of patient ability to practice or compete, was also reinforced. This was done to incite

coach support for care decisions and to encourage the coach to offer input on patient care.

> A760 For me, I try to spend extra time to hey, you know talk with the coach,
> 'this is where so and so is, this is where I want to go with them. What
> ideas to you have?' And you know to get them to understand where things
> are so they have kind of the patient education in care, and so you know so
> you can map out this is, this is my plan for them so that they can either
> reiterate that, um and to the student athlete or they can say 'no, have you
> ever thought about this?' And it's oh ok, like I don't do that because of
> this. Um, so there's aspects where they influence what you do, and I think
> it should be more of a collaboration.

Information sharing encompasses what information is shared with who, and why.

How participants deliver information (being honest, transparent, and standing by

communicated expectations) and protecting patient information were significant

experiences informing **trust** in the first round. Second round data focused primarily on

limiting sharing with coaches, and when sharing, doing so purposefully. For example,

facilitating coach understanding of patient ability, inciting coach support for care

decisions, or soliciting coach input.

Proving

Proving, another *concept* of **trust** was expanded upon in the second round via its

properties: *credibility*, *commitment*, and *advocacy*.

Credibility is the experience of establishing and conveying professional integrity,

knowledge, and ability. Participant experiences establishing *credibility* in their care

decisions, patient outcomes, and knowledge of sport demands is seen here:

> A866 I also think um, you know being able to tie in your professional experience as well of you know, earlier I referenced eccentric training for tendinopathy. Of hey, I've used this before with multiple, you know student athletes…and you know, them knowing, ok it works for other people. Um even though there's, some of them care about the research um and you can cite the research and say hey the research is pointing in this direction right now. But a lot of it is they want to know does it work. Like, I don't care what the research says. It's hey, this is what research says is going to work right now, and I've used it with other people and it works with other people, this is what I want to do. Um I think that helps buy-in a lot of um. And obviously everyone's an individual and specific, you have to tailor it to that but. Um I think that's huge to tie things in and help them understand.

> A858 I mean I work with hockey right now, I've never played hockey in my life and the kids all know it but it's one of those saying, 'hey, I don't know hockey, but I can break down movement. So, I can understand you know, been here you know, read enough and watched of your film to break down your movements and understand how you need to move so when you aren't doing that I can be like hey, what's going on? Something's wrong.

> A805 With cross country track and field….coaches have by default learned how to treat their own kids, which is a terrible situation, but um, I think a lot of that from my aspect is ok coach, like I know what I'm doing, I have confidence in what I'm doing with those patients, but I also have to understand you're used to treating them, so there's going to be a transition process. There's going to be a, you have to trust me with your kids cause you're used to doing everything. So. Um and how to kind of build that, um, kind of, be like "hey coach, this is, you're having an issue too? This

is what I do for it." "Oh that works? Oh good." Like you know send me your kids, cause I can help them too.

Participants also go about establishing *credibility* with coaches in varying ways. Refraining from over-reacting to injury, supporting patient ability to practice and compete, and considering coach input about patients are ways participants **establish** *credibility* with coaches.

> O108   A lot of coaches, I've learned in the past they really don't like when, you know, people get really into you know, little bumps and bruises and stuff like that. And so ah, I'm kind of um, I'm pretty laid back as an athletic trainer and I think my coaches like that. I always give patients I guess a moment to try to walk it off I don't run up to everyone right away and I think my coaches like that a lot and they don't perceive me as babying them or anything like that. And they just know that you know, I'm there and I'll be there when something happens, but they know I'm not going to, you know take Susie out because she hit her knee or something like that. And I think they really appreciate that.

> O125   Coaches like whenever you try to get people to play. And that's a big thing I think they like, is ah I'm big in having my athletes practice even when they are hurt, and I like them to practice at least in a limited capacity. Which that means that they're always around the team and I think that's important to a lot of coaches is that people aren't, you know kind of away from the team, they're still with them and participating in whatever way they can.

> O116   …and they [coaches] appreciate the fact that I listen to them whenever they say you know so-and-so doesn't look right or so-and-so has been in the training room a lot but they play, like they don't have any injuries and stuff like that. And they like the fact that I talk to them about athletes, about how they're doing, or I always ask them you know how they're doing at practice, if they look like they're hampered or not, stuff like that.

Coach belief and *trust* in participant *credibility* helps establish a precedent where patients seek out and receive care from participants when they are hurt.

> L622   At my job here, we've had instances where we've had a couple of athletes complain at practice that, like 'oh, I'm hurt, I cant do anything.' And then the coach will ask them, 'like well did you go see [Liam]?' And they say no. So then they get, they get chewed out by their coach, and then they know they need to keep coming in to see me. So, yea when they're, when

that relationship's [coach-participant relationship] good and they advocate for what you do, that's a huge tool and um, in my tool box anyway.

M188 Um, I think um, I'm fairly lucky in that all of my 4 head coaches and then their staffs have pretty well bought in. Like they are, we have a really good relationship, and they really trust in both me and like the department in general. So like the resources that we have, our physicians, our dietitian, our chiropractor, like they [coaches] have great relationships with everybody and they really trust that we collectively will take care of the kids. And so I think part of it is when they come in as freshman, a lot of times like it's they'll say something hurts or whatever, my back hurts or whatever, and if they say it within earshot of the coaches, then they get directed to me immediately. Which I think really helps, I think that's huge because they know, then it becomes like that's what you do right. Like, something hurts you go see [the athletic trainer]. Like, this is the logical progression. So I think that's a big part of it from my end. Because I don't see them [athletes] all every day. So they, the people they [athletes] see every day are the coaches and if they [athletes] know that me and them [coaches] are on the same page then it just sort of becomes the logical thing to do.

In sum, *credibility* embodies establishing and conveying professional integrity, knowledge, and ability with patients and coaches. Second round analysis did not change the understanding of *credibility*, but provided additional ways participants *proved* *credibility* with patients and coaches. *Credibility* is integral to participants *proving* themselves, and developing **trust** with patients and coaches.

Commitment is also essential to *proving*. *Commitment* characterizes going above and beyond usual professional responsibilities to foster **trust** that benefits the patient care process.

K665 If something happens, like something major happens off hours, it doesn't matter what it is, like I'll usually drop everything like, someone just had to go to the hospital because they got in a car wreck or whatever, I will usually turn the stove off or whatever and go sit in the hospital. Or when the kids transferred to, we're in a small town, so usually it's serious they go to [a different hospital] which is about 45 minutes away. And I will, you know be following the ambulance or the helicopters or whatever, with them.

These levels of *commitment* continued to be present in second round data

analysis, and support the initial understanding of *commitment*.

Advocacy, the final *property* of *proving*, captures protecting patient well-being.

Protecting the patient and advocating for their health above all else, with patients and

coaches, was reiterated in round two:

K345 I guess, they're [patients] always like 'Can I play this day? Can I play this day? So you're saying I can't play this day? So you're saying I can't?' "You know what, I'm not saying anything. This is a day-by-day thing. In a perfect world yes, I would like you to be able to play in this game, but you know there's, we've gotta go through so many steps and you're talking about step 20 and we're on step 2 here. So we can't skip all these steps first."

A767 Um, I tell my coaches at the end of the day, like I still have to make the decision. Same as like you're the head coach, you have to make the decision on certain things. But I'm not going to compromise care and patient safety, but I'm still open to input and you know, kind of your thoughts on a lot of things because we can tailor things to that. And um, the more you can get them to buy in kind of the more um, they're going to also reiterate that to the student athlete and I think that's huge.

Second round data analysis strengthened the first definition of *advocacy*:

promoting and protecting patient health above all else and intervening as needed (with

the coach or with the patients themselves). *Advocacy* is the final way participants *proved*

themselves and **established *trust*** with coaches and athletes.

To summarize, ***trust*** is a vital component of **establishing** a relationship and

managing successful interactions with patients and coaches. One way participants

establish *trust* is by attending to how they *share information*. Honest communication and

transparency about what is shared, with whom, and under what circumstances inspires

trust about how patient information is protected and shared with intention.

Communicating pertinent patient information with coaches about patient ability fosters

clarity about the care process and future planning. *Properties of proving*, a *concept* of *trust,* garnered further support in the second round. C*redibility* (establishing and conveying professional integrity, knowledge, confidence, and ability with patients and coaches) continues to occur when participants convey an understanding of sport demands, do not over-react to injury, and support patient participation (even if in a limited capacity). *Commitment* (also a property of *proving)* captures actions that go above and beyond usual professional responsibilities. Last, *advocacy* promotes and protects patient health above all else by intervening on behalf of patients, *proving* participant investment in patients and **establishing** *trust*.

Establishing a *care contract, connection,* and *trust* within participant, patient, and coach relationships provides a foundation that allows progression through the care process and supports patient outcomes. **Navigating** remains the second **category** and continues to emphasize how participants and patients move into and through the care process.

Navigating

Navigating, the second **category** representing participants' experience of how athletic trainers develop and utilize the working alliance with patients, highlights ways in which patients and participants move through the care process. Determining who contributes to the care process (participants or patients) and addressing barriers remains present. *Sub-categor*y *care roles* and *patient resistance* remain present in round two, and clarity is added to participant and patient efforts to **navigate** the care process and realize positive therapeutic outcomes are clarified.

Care roles

Care roles continue to specify varying roles participants and patients assume

during patient care, and reflect who is contributing to or directing the care process at that

time. Although second round analysis did not expand upon the ***care role*** <u>director</u>,

<u>concepts</u> of <u>partner</u> and <u>educator</u> remained present and were further developed.

<u>Partner</u>

The <u>partner</u> concept embodies the importance and value of patient involvement in

the care process and captures participant and patient contributions. Importantly, decision-

making is not always unilateral, and participants and patients act as partners to varying

degrees while navigating patient care, however participants retain power to make final

decisions.

> A546 There's a lot of questions I'll start to ask of 'ok, how do you feel like things are going? So kind of be brief and understand where they are as kind of an individual of, how do you think things are going, do you think things are going slow or are they not going slow and sometimes it's related to the treatment course of plan or treatment plan. Some of it's just totally unrelated of well hey there's problems going on at home, or schools really bogged down right now and I'm busy with that, or you know there's a lot of other factors you know, we're having financial issues, I'm trying to find a way to pay for this. Or they are removed from the team and there's multiple roommate issues….But um, you kind of, be a little more creative of trying to solicit that information from them and, you know, and from that point, for me it's changing things up of ok, like do you want more feedback [from the patient], or do you want more input from them [patient] of hey pick 3 exercises, or you know would they rather do stuff on their own if you can trust them to do that, instead of coming in because it's poor timing of when they can actually be there. And kind of, I think it's kind of being flexible and adjusting, and um, kind of at the end of the day saying "hey, I'm here to help you." It's not about me, it's "How can I help you better? Or how can I help you?" I ask that question a lot to people and I think it takes, takes a lot of kids by surprise. Cause it's like 'ah, I'll be good I just need to push through this' and it's "no, how can I help you?"…it's, stepping back, kind of debriefing, reassessing, and saying ok, like, what do you think about the plan? Is it working is it not working, um, what do you think will work better?

Participant experiences in round two continue to emphasize the significance and value of

patient input to the care process, as evident in the following passages:

> F614   I tell them [patients] that I want them to be talking to me throughout the
> whole process because if I don't know how they're feeling, um I'm not
> going to be able to provide the best care.

> O335   Oh I definitely take into account what they say very heavily into what I
> do. Because I mean at the end of the day we're trying to make the patient
> feel better, not I mean, we can do everything the book tells us in the world
> but if they don't feel better, it doesn't really matter.

> L72   Ah a lot of times it's just going out and just talking with them [patients]
> and like if they're out there doing rehab you're out there with them….I'll
> be out there just chatting with them [patients], just seeing how they feel,
> seeing what they want done. Like if they're frustrated with anything or if
> they want to try anything new. Um, I mean I take that input… I kind of
> take all the information that's available to me to, you know, build those
> relationships and provide the best treatment.

Despite the perception that patients may want to be directed, participants actively

encourage patients to provide input into their care process as a *partner*.

> F535   So I've been like, the first few days teaching them how all of the exercises
> go and choosing for them what they're gonna do. And that's what they
> expect, I think that's what they expect when they come in. But then I like
> to throw in the, 'k, here ya go, you know what these all are, which ones do
> you want to do today? You have to choose one from this group, one from
> this group, one from this group.' …..Um, but, I think I, I see a little bit
> more, ah, I think ownership, and ah willingness to do the exercises. If
> they get to have some, some input.

Second round data continues to support the **care role** *partner* *concept*, which

embodies acknowledging and valuing patient input, identifying desires and values that

are significant to patients, and utilizing patient input to inform care decisions. To further

understand experiences of *partner*, in the care process, two *properties* (*solicitor* and

collaborator), and two dimensions (rehabilitation and severity of injury) of this *concept*

are explored next, adding depth to ways these inform the care process.

Solicitor. The property *solicitor* represents participants asking for specific

feedback from patients to inform or modify the plan of care. Participants maintain power

over care decisions but patient input stimulates changes.

> L102   If it looks like they're [patients] struggling with something or they're, you
> know maybe kind of not putting full effort in, then I would be a little bit
> more apt to go out and talk to them and see, and work to get that input. I
> mean I've had some cases here where the athletes really enjoy when you
> go out and talk to them and get their input, and other ones want to just
> come in and get their stuff done and leave. Um, so I kind of base it on an
> individual, or um case-by-case basis. But I just kind of look for the subtle
> signs of maybe they, they want to talk or they want to get something new
> out of their rehab or their treatment in general.

> F614   Well, I tell them [patients] that I want them to be talking to me throughout
> the whole process because if I don't know how they're feeling, um I'm not
> going to be able to provide the best care. So I had one girl come in doing,
> she's got low back problems. So I put her on this core program, and one
> day she came in and was doing the exercises and I walk over and she's
> just crying while she's doing the exercise. And I said "What is going on?"
> And she said 'It really, it just really hurts.' I was like "Stop, please,
> please, stop. Just because I tell you to do something, I'm here to help
> eliminate pain, not cause pain. So please tell me if something hurts, even
> if it doesn't hurt, if it doesn't feel right, or if you have a question about
> how to do it right. Um, I want to hear your input and because then I need
> to change it."

Here, participants determine when to seek (daily, before or after appointments, or at

points throughout care process) and how to utilize patient input and feedback:

> L181   … I just talk to them every day. Well like, "How are you feeling?" It's
> like 'oh I'm good, this exercise is feeling, you know a little easy', if they
> say that they can ramp up the weight or the intensity, I'll do that, and then
> really when the return to play comes into effect, when I'm doing a lot of
> the sports specific stuff, um, I'm constantly in their ear. I want feedback
> constantly. Does this hurt? What's this feel like? Like, does this feel
> weak, does this feel weird? That way I can always try and change
> whatever exercises they're doing. And then kind of adapt their, their
> exercises so we can get 'em back to return faster.

> L155   …like say if they're coming in right before their scheduled time, if they're
> just heating beforehand, that's when I'll go out and talk to them when
> they're sitting doing something very um, very static, when they're not

moving around a bunch. Where you have them sitting still, because then you can really get the back and forth going. Um, so that's usually when I seek out, before they're doing their rehab, or any exercises, or afterwards when they're doing their post treatment. Cause then I can either get, if I'm doing it before I can get feedback with what they want to change before they start, or if it's after then I can get feedback of anything they want done different or they want to try next time, after the fact.

O216   …you know as they're doing it I kind of get their input of how something feels, how difficult it is, if they can do it, if they think they could of done it, you know whether they were hurt or not. You know, so I seek that input the first, you know, kind of the first time when I'm teaching them the exercises, when it is me with them I get a lot of that input there. And then kind of after…they've been doing them for a while I also kind of go back and ask them you know, what do you think helped, what exercises did you do the most or did you think you were most compliant with? Stuff like that because I do often times get a lot of 'I think this exercise helped me more than this exercise.'…But knowing that you know, those exercises are important, the ones that they think are helping more and the ones that ah, you know are kind of a little more difficult that everyone kind of thinks are helping a little bit, I try to incorporate those at least, you know have them do one that they feel a lot and they think helps, along with the other ones that maybe I think are more important, as far as that.

The timing of *soliciting* feedback is significant, here, waiting a few days before *soliciting* feedback allows patients to more accurately determine the intervention's effect and provide feedback most relevant to adjusting care decisions:

O238   So whether it be modalities or any kind of modalities or manual therapies, a lot of the input is just ah, as I'm doing it, what they think. And then really about 2 to 3 days later how they feel and how they think it's helped them. So a lot of things like, you know with ultrasound a lot of times when you first do it they say they don't feel anything. So you know that's one of those things where people aren't very into it then but then maybe you get one person who says they feel better after a couple days or you know bruising goes away, something that's very obvious, and then they start to believe in it a little bit more. So you get that input from them a couple days later to see how they're feeling after it happens. Um, same thing kind of with everything I do. I do cupping too, I get a lot of you know that it hurts a lot but ah, in the initial treatment, but for a lot of people then a couple days later I get you know how much better they feel now compared to before. Even though you know it wasn't the most comfortable treatment the first time they had it.

Providing exercise options and encouraging patients to select those they prefer is one way

participants *solicit* patient input as a <u>*partner*</u>:

> F271 Um I try to keep the rehab plans um exciting. Or like at least put some variety in with the exercises so that they're not coming in every single day and um, alright start with, we're going to do ankle pumps and then towel scrunches, or with theraband, balance, ice, done. Um, cause that's just as boring for me as it is for them. (*laughing*). So I try to have um, a list of exercises and change it up each day so I mean there's 3 or 4 exercises targeting each area that needs work, and then I pick the exercises you know for the first 3 or 4 days they come in and then I start to ask them, 'ok you can do this, this, or this, what are you feeling like today?' Um and try to give them some um, some ownership in their rehab so that they feel like they get to have some say in how they're progressing. It's not just me standing over them, counting 4-way theraband reps.

> A144 Obviously it [seeking patient input] changes each person so that's the hard, so like, so there are times like in rehab I'll try to do, like when we get to the core exercises, you know give you "hey I wanna work this muscle, we can do this exercise or this exercise." And sometimes I'll just give them a snippit of the exercise, so they have to kind of pick and it's still an unknown of what they're actually gonna do but they still have a little bit of a choice. Um, but so there is still an element of surprise if you will. Just um…trying to give them options within that of um, picking you know between 2 exercises, we're gonna do one today, which one do you wanna do?

Though patient input is *solicited*, participants retain power over care decisions by

deciding if and when to integrate feedback into the care process, as seen here:

> K367 You know you have to gauge, ok what we did yesterday, was it too much, was it too little, do we need to back off today and just do some feel good stuff? Like you have to, you really have to teach them how to give you the proper input. Not put the words in their mouth but say ok, you're sore? Ok, that's ok, is it hurting? And when, I guess when you're getting into more phase 2, phase 3, where you're doing some heavy conditioning, more lifting, more things like that, um you know they gotta tell you ok, 'little bit overworked me today, I think we need to, you know, maybe cut this day in half or move, you know move things around a little bit. 'Cause this thing kind of put me over the edge.' Like that's something I wanna know….I mean, I tell them like, yea, I'll listen to what you have to say, that doesn't mean I'm necessarily going to do it.

A126   Um….personally, if I have time I would prefer to seek their input every day if I can. Reason being is I don't always, we're not always going to address it and incorporate it. And when we incorporate it I really can't give you a specific every other day, but at that same time I think getting their input helps you kind of redefine "hey, I feel good today" alright well let's try to you know, really push a, you know a max squat if we're an ACL rehab, so we're gonna get the leg press, we're gonna really go hard today and, cause you feel good. But if they feel you know terrible, you're gonna have a little bit more of a stability and functional day and, you still have to hit your goals and stick to the rehab plan but you can kind of tailor it a little bit to how the individual, um what other things are going on in their life.

Solicited input also includes patient feedback via non-verbal cues, as seen here:

L194   If I ask them [patients], they're, some of them will give me almost too much information. And then other times the ones that maybe don't talk as much they'll be like 'yeah, this feels fine.' Sometimes I gotta try to press them a little bit to elaborate, to get a better understanding. Yeah, it's usually pretty feely exchanged information. Sometimes it's too much, sometimes it's not enough, but…. There's always, I mean you'll always have the ones that don't like talking, but they, I always find a good balance of them, you know willing to open up. A lot of it too um, I look for non-verbal cues, things like that from the ones that don't want to talk. Like if you're watching them do something and it looks like they're struggling, then you can kind of try to guide them or figure out, or try and get them talking about it.

Second round data upholds understanding of *solicitor* from round one, and highlights how *soliciting* patient feedback informs patient initiated changes to the plan of care. While participants maintain power over care decisions, changes are initiated based on patient input. Round two analysis expose varying ways patient input is sought (daily, before or after appointments, or at points throughout care process), what input is solicited, and how participants integrate solicited patient input into the care plan.

Collaborator. *Collaborator*, the second *property* of *partner*, addresses patient control on care decisions. Participants illustrate collaborating with patients as a care

partner when they jointly identify and integrate meaningful care decisions, and when

patient requests catalyze a change in the plan of care, as shown here:

> K418 …my volleyball coach had me kind of redesign their dynamic warm up as well as their um, they do um, bands every week for their shoulder. And he had me redesign that. And a couple of the girls have come up to me about the bands and just said 'hey, instead of doing um, this many reps and this many sets, can we do a few more sets but can we do some less reps just so we can try to um go up a band in resistance?'…So I said yeah, let's do that. And you know, it worked.

Collaborating encourages patients to feel as though they have power over aspects of their

care, which remains present in round two.

> L340 They [patients] all respond really well [when they get to collaborate on sports specific activities] 'cause they feel like they're involved and, that they get a chance to have their say. Just gives them a feeling like they have some control over what's going on.

Participant recognition of patients' role in generating and modifying care activities (such

as exercises) supports *collaboration* and directing their plan of care as *partners*. This

receives additional support in the following passages:

> L272 If you're kind of at the point where you're struggling to get ah like, a good rehab plan or new exercises to get them back faster. If they have some ideas um, or just some suggestions, I think that's very helpful. Cause I mean I don't know everything, so taking information from them is always helpful.

> K156 And also you know, I take their input a lot because I'm not an expert on every single sport. Like, when I get to sport specific activities, you know I'd rather talk to them or talk to their coach and 'ok, what's a good drill to incorporate, you know balance into shooting, or cutting into shooting?'….I think allowing them to be part of their rehab and allowing them to, kind let them think they're helping themselves progress.

> L312 Uh it's just with ah, like if they're going through rehab and they're kind of giving you ideas for new exercises. Like if you've been, say you're stuck on new ways to push them, if they have ideas that might help. I use that in the final return to play for sports specific stuff because I, I've only ever played one sport, so a lot of the sports I work with I have no, like playing experience. So I kind of lean on the athletes like alright, what's some

sports specific stuff we can try. So that's when their input is most valuable to me.

J   *With things you may not be as comfortable with or, as personably knowledgeable about…*

L   Exactly

L328   The closer connection, I'll kind of let them dictate what they want to do. Even the ones I don't have a close relationship with I'll ask like, I'm always open to asking them like what uh, what sports specific stuff do you think will help? Cause like I said I, I mean I wouldn't be able to tell you, like I've got a couple baseball guys, I wouldn't be able to tell you what it's like to catch a ball the whole game, or try to pitch, so I'm always willing to hear what they think might need to be, you know what will help them return to sport. Even with the volleyball team that I work with here and in the past, I have no clue how that stuff impacts, or what it's like to go through a practice. I lean pretty heavily on them as far as any sports specific stuff.

Collaborating was present in various aspects of care: therapeutic exercises,

selecting treatment times, treatment modalities/therapies, and goal setting. Here, patient-

identified goals guide the plan of care, and then participant and patient work jointly to

solidify these goals:

A81   For me as well um, I also try to, kind of develop and understand what their goals are. Cause to me it's all about their goals. So, for example, for break here, I have one patient, with a femoral stress reaction right now. And so it's like ok, what's your goals? So you're going to be studying abroad during your January term, and you need to be able to walk. So it's like, hey lets focus on, that's our goal for right now, like don't worry about your sport, but um. Your sports gonna be, we'll worry about that in February, but right now let's take steps on actually being able to walk around and having a good study abroad experience, as opposed to. So kinda breaking it down to them as an individual and kinda manageable, achievable goals within that.

L567   I'll let them kind of set their goals and then I'll look at them and see if that's something that looks like that they can be achieved. Um, and then I just kind of explain to them like you know this might be a little aggressive for you to try to achieve right now, we could get it but it would be tough….Trying to be there, you know kind of slow them down a little bit if I think they, they're trying to set something, you know set the goal too high, or if they're setting a goal too low. I'll try to be like, where we're at in this you can do better, you can do more.

Collaborating also captures patient contributions to selecting treatment times,

therapeutic exercises, and treatment modalities/therapies. However, as in the *property*

solicitor, when *collaborating*, participants retain power in various ways by selectively

accepting contributions for specific aspects of care.

L347   Yeah, I would say (therapeutic exercise is an area that patients get more control), cause, when we're doing the exercises, I like to give them more of the control of you know, what they feel comfortable doing. Just 'cause that way they feel like they're contributing and they kind of have, they're more comfortable that way. In the evaluation stuff and, when I'm evaluating an injury or anything like that, that I tend to not give them as much control or as much say, but that's just because I need to figure out like what's going on.

O316   …a lot of it is feedback about how they're feeling. But then some of it is a ah, it's kind of a, I want to try something different. Um, so again, I'll come back to cupping, it's not a very comfortable treatment. So like the day after I'll get a lot of how bad you know, that particular treatment felt, um because they don't want to do it again. But then if you wait about, again about three days, three or four days, that's when they start really getting the effects of it. And then they'll start to like it a little more after that. So ah, again a lot of times it is how they're feeling but sometimes it's just they want to change it up. Um, certain other things ah you know doing ultrasound again they don't feel that a lot, so wanting to give me feedback you know 'we've been doing this you know periodically for this long, I don't think it's helping. I feel the same…this, you know, can we try something different?' A lot of things do kind of end with can we try something different.

L359   Yeah, when they're coming in for treatments I let them kind of have a little bit more control. Like ok, what's your class schedule, what times work good for you. Ah, at least during the initial phase um, of that. And if they're you know, consistently coming in when they say they're going to come in, they're always good about it, then I kind of continue it. But, on the other spectrum of it, if they're ones that say 'oh yeah, I'll', they'll tell me I'm coming it at 11 o'clock to do treatment and they don't come in. I'll give them a couple of more chances at that but if they keep doing it then that's when I take that control away and tell them that they have to be here at such and such time.

A strong presence of patient-driven attempts to collaborate arose in second round data. Despite acknowledging the value, not all attempts at *collaboration* are perceived as helpful. Participant concerns arise from patients accessing potentially untrustworthy information, their limited understanding of diagnoses, treatment plans, and variation in care timelines. Moreover, at times patients do not realize other care providers (i.e. physician) are the ones with authority to change the plan of care.

L276   If you get some of those kids that, after their initial injury, they, instead of right away coming in they decide they want to look it up on, like Web MD or something like that. And then they're trying to tell you what's wrong with them, then that's a little not helpful when they're trying to collaborate. But that's one where if they're doing that you can tell them well, Web MD is good but, it's not an end all. So let me actually look at you and try to figure this out.

J   *And so your way of managing that is explaining to them that this is not necessarily a reputable source.*

L290   Exactly. Yup. A lot of times they'll laugh about it, or they'll kind of chuckle it off. And then like, alright, I'll, let's take a look at you. So luckily they don't get too defensive about the fact that I kind of, you know not, call them out's the wrong word but kind of say like well we're not gonna trust what Google or Web MD says you have.

L297   There have been a few cases where they've looked it up and been pretty close to what's actually wrong with them. Um, the biggest thing that I had with them looking up, with my athletes looking up injuries on the internet is the recovery times. So that's, that's the biggest trouble I had with that. But usually they're, usually they were pretty spot on. But um I mean every once in a while I kind of get the one where they, we had an athlete that kind of messed their hamstring up so they looked online to see the recovery time was and was like 'well I should be back by now.' Well, no, everything's different, it takes time.

O368   A lot of times right when people get hurt, you know it's 'I just need e-stim and I'll be better.' And that, that's one of those things it's not very helpful. I mean you can tell me that until you're blue in the face, we still have to evaluate and e-stim doesn't really treat anything so you're going to have to, you know do other stuff along with that. You know, you get that a lot, 'I just need this one thing every day for the rest of my life and I'll be fine.' I mean, that's not what they say but that's what I hear whenever they tell me that.   Whenever they are kind of asking for something

specifically, for you know even though you know they don't know how it works.

K387   Kids come in all the time 'oh I need that [instrument assisted treatment]. I need you to rub this.' I'm like 'yea I'm hearing you, but probably not what you need. I need to look at it. Yea, you know, there's a line where you know, I'm always going to listen to what you have to say, that does not necessarily mean I'm going to take your advice or listen to your advice.

K399   I really hate when you know, someone comes in, and then someone else comes and, like "oh yea, I had that too. Well she (athletic trainer) did this, this, and this." And you know maybe I did that, that, and that, on day 10 and it's day 2 and, 'well yea, I want that now and she's playing!' Now I'm just like oh geez.

J   *Right, they want something that they see as opposed to understanding why it's being done.*

K408   Yea, whenever they see you doing something different with somebody 'oh I want that too!'

O343   …coming back from concussions. So that is ah, that is a part where they [patients] always want to try to talk you into a little more, how good they feel, and how they want to do more activity, be more active, how they feel great and they can do more. And that is a pretty unhelpful conversation, especially with me, whenever they're you know, what we're doing concussion wise, where I'm at is all based on doctor's orders. So they can say everything they want to say, it's not going to change because it's not even me creating it. It's somebody above me telling me what to do. So it's, it's not helpful in that sense…And so that, that is probably the biggest time where patient collaboration is not the most helpful. Like stuff where they've already been put on a treatment by a 'higher authority than me' and I'm just following the rules, and then they're just trying to push all the boundaries as much as they can.

In summary, second round data clarified which aspects of care were appropriate for *collaborating* (therapeutic exercises, treatment times, treatment modalities/therapies, and goal setting) and when *collaboration* was not viable (limits to patient understanding of injury, plan of care, and variation in injury response, and when participants do not have authority to change the plan of care).

Round one analysis revealed that how and when patient input was sought and integrated manifests along three dimensions of *partner* (rehabilitation, severity of injury, and relationship). Two of the three dimensions (rehabilitation, severity of injury) gained additional support in second round analysis (relationship did not).

Rehabilitation. The dimension rehabilitation, specifically the length of the rehabilitation process (short----long), influences the **care role** *partner*. Specifically, length of rehabilitation effects seeking and trusting patient input and provision of care. As seen below, participants are more apt to trust patient input with long-term care, whereas during short-term care, patients may be less likely to divulge how they are really feeling.

> K435   I think it's [patient input] I think it's really different because like it, in long term care they know I'm gonna be like this a while. There's no sense in saying, 'nah I feel great when I don't.' In short-term care, "yeah I feel fabulous", translates to my ankle is throbbing, but I want to play tomorrow. So I think um, you really have to get your point across that you have to honest with me so I can help you get to that point. Because if you, you know, after we try to run you walk out of here and say you're fabulous, I'm probably going to slap an ice pack on you and say ok bye, when maybe you're really in a lot of pain and it's gonna start swelling, and I could have done something else. And I, you know, then I plan to do something else the next day because you said that was fine. Instead of you know, backing off, maybe having you come back if you had an early practice, maybe having you come back in after you have a class or something and do some more treatment on it. Like I need to know so I can do everything I can. 'Cause you know, I can see it but I can't feel what you're feeling.
>
> J   *So you accept patient input in regards to a short-term plan, however.*
>
> K450   I take it with a grain of salt…. And that's where knowing your patients really comes in.
>
> J   *You know if they're telling the truth.*
>
> K458   This persons gonna push the envelope. Or yeah, I know this person wants to play but they're gonna be honest with me.

As evidenced here, round two analysis adds further understanding to seeking patient input in relation to the length of the rehabilitation process, and shows that long-term rehabilitation promotes participant trust in patient input as a *partner*.

      Severity of injury. The second dimension of *partner*, severity of injury (simple-----complex) also independently influences participant's experience as *partners* with patients. Severity of injury impacts participant determination of when and how much patient input is solicited, as seen here:

> M504 …two scenarios, one being like they've just come in, you've just met them or whatever. Um, then it's, it's sort of, to me has to be somewhat, not immediate, but like in that first meeting you have to figure out like, what are their goals as far as like this injury or this you know the race this weekend. Like what, what are we working with for like timeline but also just sort of like general expectations. Um, and then I'm thinking also, like longer-term, like at what point do you let them start, I'm thinking of again like of the ribs and at what point do you let them start making exercise decisions on their own type of thing. Like at what point. And I think it's when, I think part of it depends on, again back to buy-in. Like if you know that they bought in and they trust that your exercise prescription is what, like that, that's the key to return right, versus if they haven't, and it's very obvious when they haven't because they just keep trying to push and then their ribs still hurt, so it's like pretty obvious.

> M516 Um, so those I guess are the two sort of scenarios I'm thinking of, and they are different like, their [patients] input and their goals for something where there's ah, like an injury where you can sort of work through it I think is like an immediate question. Like what's the end goal here are we trying to [participate] this weekend, are we trying to [participate] in three weeks, how do we modify to get to that point? There is like, something where there's a very definitive, either like you're going to get worse if you keep doing it or it's unsafe to play then it's like, there has to be less patient input there…. But, yeah I think it's really, really um situationally dependent.

> M531 And I think working with them so that, again it's all situational dependent, but I'm thinking of again the back cases where like they're gonna have flare-ups and that's okay, and in the long term we know we're not doing anymore, you know, drastic damage to them, then okay so maybe you race this weekend and then we take a couple weeks off in preparation for whatever the race is in three weeks. Like that sort of patient input with regards to like their goals but also knowing that it's safe for them to do so,

right. Whereas somebody who, if they race this weekend they're probably going to break a rib and be out for 6 to 8 weeks or whatever, then that's, that's where like yeah, you want to race this weekend but, you don't really.

While participants often seeking patient input daily regardless of injury complexity, severity of injury influences when patient input is sought as a *partner* in relation to simple or complex injuries.

> O264 Whenever stuff is more chronic in nature the timing of when I ask for, as far as the follow-up, is when I ask if you're getting better, if stuff has happened chronically over time I usually, that's usually like a weeklong of treatment before I ask them if they're having any help if it's real chronic. Whereas if it's something more acute like an ankle sprain, I'm probably asking them every two days how they're progressing. So ah, especially after initial acute injury, I'm asking them more, whereas a chronic injury I'm probably letting the treatment play out a little longer before I'm doing that follow up. But again I am still always asking, talking to them you know the days of treatment of how things are feeling at that time. But as far as that follow-up it's for acute injuries it's you know two days almost, and for chronic it's really about like once a week I'm trying to get input on where they're going or where they've gotten to and if it's helping or if we need to change things up, stuff like that.

Second round data clarified the importance of the dimension severity of injury: participants limit patient involvement for complex (severe or life threatening) injuries, whereas with less severe (simple) injury, patient input is sought and integrated on a more frequent basis.

Educator

Round two analysis supports the *concept* of *educator*, the third and final *concept* of **care role**. *Educator* represents attention to and delivery of patient education across all aspects of injury and the care process. Here, participant experience assuming the **care role** *educator* begins when establishing patient relationships, and helps normalize patient education throughout the care process.

M842   Having that initial sort of patient ed. session, for lack of a better word, makes it so that door is open for questions, you know. If they come back and something changes or they don't understand something or, a lot of times it's like, they'll meet with the Doc and then they'll come out and be like 'what?' um, but then they know that like you'll explain it to them, right? Because you've had those conversations before, so you've sort of opened a door for that they know that they don't have to just like blindly accept information.

Delivery of patient education as an *educator* depends on assessment of the appropriate

amount of education to offer different patients, as seen in the following passages:

A294   For me it's patient education and then developing, ok, here is the plan and this is, kind of the quick road map. And sometimes that's, I give the full picture of a road map, of kind of here's the final step and here's all the little steps in between. Sometimes I'll just be like here's the final step, here's what we're gonna work on this week, and then we'll, we'll take the next step next week and kind of, kind of walk through it. . Um, and a lot of that depends on how much time you have with that patient of course, but. …. So, for me it's buy in, it's giving them the full plan and, um where we're going um.

F682   Well I definitely don't want to overload them [with patient education] too soon. Um, cause then I think important details get lost in everything and they won't understand if I try to go start to finish with them the day after they've been injured. Um, so just trying to break things down one step at a time.

L168   Initial injury um, I'm very involved. I'm out with them constantly, always talking with them, explaining what the injury is, what their plans gonna look like as far as rehab and recovery. And then um, I really don't get into the return to play, like the nuts and bolts of it until we're a little bit closer. But I'll give them a general, a general idea like you sprained your ankle you might be out for a couple of weeks but it's, it's a fluid situation and it could change. Um, and then just throughout the rehab process. And I'm involved to what their level of ah, of comfort is, and then when we get closer to them trying to play, I kind of ramp up my involvement a little bit and make sure they, they're, emotionally, mentally, and physically ready to get out there.

A607   You start larger and kind of here's the big road map, and here's a few specific things that we're gonna work on. But as, as you develop through a rehab it gets a lot more specific of, we're not gonna have you know large gains in range of motion or we're not gonna you know, once we get the swelling gone…But um, yea it's working through so it's getting, kind of

from larger goals down to little, um smaller goals that are more specific and general of, very, a lot more sport specific as well. And kind of tailoring that into, you know the education side comes within that of, ok, here's, here's the big picture stuff, and here's what we wanna work on. And then after that it's, we wanna work on these finer details to kind of polish things up if you will. So they kind of understand that and progress through that. So, I do think it's kind of, you paint a big picture at first, and then it has to get smaller as you go.

Length of care also impacts participants' role as an *educator*. Over time, education becomes less formal and detailed in response to patients' accumulated understanding of their injury and the care process.

> O480 …it really is, a lot for me kind of ah, you know, it kind of builds on itself. The more you see people the more education I'm giving to them as far as what we're doing. Whereas, you know acutely you just kind of, you're doing it, hopefully this will make you feel better, and that's kind of all they want to know and kind of all I'm really giving to them. Whereas the more we go, the more I try to explain to them why we're doing stuff, what I'm hoping to see from not, you know, down the road.

> M838 Not that it's always a formal conversation (patient education), but that it's less like you're taking time out to discuss what's happening, it's more like they'll come in and be like 'hey, so today you know I can feel, you know, numbness on the bottom of my foot. Like what's that?' And I'm like, remember when we talked about the nerves and all that? And then sort of like circling back.

> A458 And I still think there's an aspect of patient education that needs to occur, but you don't have to go as in detail. It's hey, we're going to do this exercise for this muscle group, and they'll buy in. And, because normally at that point you've also developed why you're building that muscle group into your rehab. So if you're an ACL, and you're working on the abductors of the hip like, at that point you've already established why you're doing that. With someone who's newer it's hey, we want to work on this because this will help, you know, stabilize the hip as well as be a little bit more, keep your knees and not allow them to go into valgus. But, so it's kind of explaining that, and you kind of, it's hey we're gonna do this muscle and they'll remember why and they'll buy in of ok, this was already explained to me, I don't need an explanation again. I can just move on.

Adapting patient education to meet perceived wants and abilities of their patient

audience (ie. maturity level, year in school, personality, interest) also supports variation

within the **care role** _educator_.

> F688   Depending on the athlete, um I will, educate them sooner or later and some of them just don't care about the why. So I'm not going to push all of this on them if they're like 'well I just want to play again, what do I have to do? I'll do whatever you ask.' Um, and some of them I wait until they ask. Um, then go from there. Try to tailor it to their personality I guess, and even like maturity level or, I'm not going to tell the same things to a freshman that I would a junior, right off the bat. I don't think.

> K517   So for me I like, I like to do that a lot, pull out an atlas. And some of them are like 'yeah, ok great, thanks.' And that's the end of it. But then some of them like want more. Some of them will want more. And I can gauge that like when they're 'ok, so what exercise, like this exercise is doing what?' For this, 'you know, I'm doing a quad set, how does this help my knee? Like, I don't get it.' You know, things like that. Um, some of them want to know every little thing, some of them are just like 'yeah I don't know what you're doing and I don't really care, just get me better.'

Rich variation characterizes the education participants provided to patients,

encompassing all aspects of the care process, as seen here:

> L525   Right after the initial injury I'll tell them like 'alright, this is what, you sprained your ankle.' I kind of give them the details, then I tell them, you know recovery time, just kind of explain the whole process, and then throw out the rehab program, and kind of educate them on why we're doing things, or why we're progressing you as slow or as fast as we are. Um, and then just kind of when we get closer to the return to play, you know educate them on what they can expect when they're, they're coming back and they might have days when it feels great. And they might have other days when it ah, it feels not so great. Kind of explain to them that they might have to keep getting their ankle taped or they might have to buy, or get a brace for it. So the education's a continuous, a continuous cycle of information for them. That way they don't feel like they're not getting any kind of information that might help them. Cause if they're not getting information, then they are more apt to go and find it on the internet, and then that just starts that downward cycle of them not, not trusting you, and not really believing in what you're doing.

> M821   Um, so just you know explaining what's happening, why it's happening, use models, let them ask questions, um things like that. And then go into

um, whatever you're going to do to fix it, treatment, there, whatever, and explain why those are what you're doing. So, okay so we're going to do soft tissue on your hips, we're going to mobilize the hips, and then do a lot of stretching for that because of X, Y, and Z muscles, and again go back to the models. If all of this stays loose and then your core stays really stable, you're going to have less back pain.

Round two data develops previous understanding of _educator_. Patient education encompasses all aspects of injury and the care process. Participants adjusted based on patient curiosity or confusion, what participants perceive is necessary, when (to match patient location in the care process), and how much (detail and depth).

Second round analysis expanded on the rich variation evident within the **care role** _educator_. The _properties body awareness_, _understanding injury_, and _purpose of treatment_, are further developed.

Body awareness. _Body awareness_ continues to characterize patients learning about their body function, tissue healing, and anatomy.

K524   I am very much an advocate for being a student of your body because this is the only body you're going to have. Sometimes it's really hard to see beyond 4 years, 5 years, however long you spend. But it's gotta get you through the next 60 or 70 too. So you should probably learn to listen to it, if not now, later.

F217   And then I also try to explain to them a little bit of the process, um, cause a lot of the girls that I have are um, like biology or pre health majors, so if I can kind of relate to them on that level, like where they're interested and like the healing.

M803   I start basic patient education as I'm doing an eval. I'll be like hey this is, you know, does it hurt here, this is your hamstring tendon, this is whatever….Like, I'm going through an eval with somebody, I'm going to start with just sort of basic anatomy as I'm going through, you know. Um, and then I always sort of, I gather my thoughts, like I think this is what's going on, and that's sort of happening, right, throughout the process. And then before I do any treatment or tell them about any treatment, I like breakdown the anatomy. We have a ton of models in our room…so I'll steal a model and say hey this is what's going on. And explain why, like again I'm thinking of the low backs, like I always highlight like where the

sciatic nerve comes out, like why are you having leg pain when it's a back problem, right? Like that's a common thing that they don't, they don't put together. Because it doesn't really make sense if you don't know the anatomy. Um, so just you know explaining what's happening, why it's happening, use models, let them ask questions, um things like that.

K513   … I try to do that with students just, cause I can say you know, you sprained your calcaneofibular ligament, and they're like 'say what? English please?' And I can point, it's right there. But if I can show them I find then that works out a lot better because I think a lot of college athletes are visual learners just by nature. So for me I like, I like to do that a lot, pull out an atlas.

Participants support *body awareness* to facilitate patients' ability to provide specific

feedback.

O487   Educating them on why those are important [pain, or going up and down stairs] you know, and like going up and down stairs a lot of people like 'well I never think about it so I don't know.' I'm like well this is why that's important. And so then when they come back next time they'll be able to answer that question for me hopefully because they'll be thinking about it whenever they go out through their normal lives.

Finally, *body awareness* provides the foundation for educating patients about their injury

and the care process.

M835   That's like the groundwork I think, is like making sure they know what's going on with their body and that they, helps with buy-in too right, that they like know why you're recommending what you're recommending.

Body awareness, teaching patients about their body function, tissue healing, and

anatomy, gained additional support in round two. What is new in second round data is an

element of patients learning how to "listen" to what their body is telling them and

focused education as a mechanism to facilitate patient understanding and feedback.

Understanding injury. The second *property* of <u>educator</u>, *understanding injury*

encompasses provision of information to aid patient understanding of their injury and

natural variation in injury response. Second round data provided additional support:

K339   you know everybody's body heals differently. Sometimes, no matter how much you elevate and ice and whatever, sometimes the swelling just takes a while. Sometimes it just does. So, that's always a good conversation to have. …

O453   I find that um, especially with acute stuff, um all the patient education I give is what they're going to feel, kind of this is going to hurt and hopefully it will reduce swelling, stuff like that. So it's pretty general. But whenever things become more chronic, and I start seeing people more often, I find it's way more helpful, not to mention they want to know more about where you're going, why you're doing certain things.

Following deconstruction of second round data, *understanding injury* becomes more robust, continuing to signify provision of information to aid patient understanding of their injury and natural variation in injury response.

    Purpose of treatment. The third *property* of <u>educator</u> embodies educating patients about aspects of the care process (treatments/modalities, exercises/exercise plan) to support understanding of the purpose and effect of treatments and exercises in the care process.

F220   Some of them, one girl asked me the other day, was asking me about Graston and wanted to know exactly like what all of it did and why we were doing it for her particular, on her hamstring. So, I like explained everything to her and she was kind of just looking at me and I was like "I'm sorry was that too much?" She goes like 'no this is really interesting, I really want to know like why we're doing this and how it's going to help.'

O458   [for example] with cupping is reinforcing that idea that you're not going to feel better when you leave here, and you're really not going to feel better tomorrow, but it's really that third day when everything starts to kind of re-heal and go through and everything starts to relax, that's really the day that you start to feel better. And explaining that and explaining how cupping works in general and what the theory behind it is, is more important for stuff that they're not going to see immediate results for.

K537   I guess when I would get into more of the conditioning process, you know explaining to them like, ok what are your, you play this sport, we have to train this system, we have to train this system back into shape for this sport. You know that's why you don't need to do, or you're not gonna

focus heavily on just doing sprints or whatever. Like, you're a cross country runner, I'm not going to have you sprint up and down the gym, you know. Um, or some stuff with modalities, like I think everyone is naturally curious about the magic modalities that we have. And I think when you educate people about that the less they come in ' well I need that, I need that'

A272   So, um, I use for example, um, three weeks ago I had a patient come in with um patellar tendinopathy. Um, and has had it for years…but I was like I've used a lot of eccentric training in the past as far as to rebuild the tendon and kind of, so single leg squats on a slant board, 4 seconds down 2 second hold. Double leg up, kind of. So it's like hey, lets change your workout around a little bit, we'll build these in and see how things go. So it's kind of explaining that, ok why in the world does that work? Why is slow controlled…why in the world am I going 4 seconds down, holding for a little bit and then up with two legs? It just doesn't make sense at all. But it's, hey we're overloading the tissue, we're getting the tissue to respond to this, we're you know it's the long, it's an overuse injury long term, so it's a log sitting in the woods just rotting as opposed to camp fire logs, we have to reverse the inflammation process. Like it's using those analogies so they can understand and say ok I have to overload this, I have to get something, to change something and break that cycle and system. Cause otherwise if I keep doing the same thing over and over again, and expecting a different result, that is the definition of insanity.

O471   I'm constantly explaining things as far as what, what things do and why we're doing them. [for example] It's really easy to get a person to do an exercise that you know is uncomfortable with whatever's hurting, because then they know that it's working what's hurting and they get that. However it's less easy to get them to do like cat and camels [stretch] because, it doesn't really hurt what they're doing…So explaining why those are important is also something that you know, everyone wants to know and something I really have to justify no matter how many times I've had somebody do it, you know you just have to re-justify why you're doing that.

Here, participants explain the plan of care to foster patient understanding of when they may be able to reach certain milestones.

K152   I think if you can help lay out a good chunk of the path, that, um, cause athletes want to know like 'ok, I can get back on the court shooting on this date, I can run on this day,' and talking obviously about a long term injury here. But I think that they want to know all about that, just because of their personality, who they are, but I think if you can unfurl a chunk of the road for them to work towards.

A267   For me it's education of explaining things. Um, of being able to back up and say kind of, the plan the road map and say hey, based on your injury, based on what we know through our evidence based practice now, um, you know this is kind of the course of treatment that you know, I have a background in or I've seen really great success with. So um, you know, lets go down this path if you will and kind of developing and explaining what's going on. I think, for me helps with buy in overall.

K168   Yup. I mean you're obviously not going to lay out the whole, you know, 9 months of an ACL rehab but, they've got a doctors appointment in 6 weeks, ok so, week 2, this is week 4, this is what your doctors potentially going to clear you to do so this is what we need to do to get you there.

Remaining loud and present in round two, *purpose of treatment*, embodies teaching patients about various aspects of care and supporting understanding of the purpose and effect of treatments and exercises.

In sum, **navigating** continues to represent how athletic trainers move into and through the care process with patients, reflecting who is contributing to care at that time. Care roles (director, partner, and educator) continue to represent the varying roles participants take on during care. *Partner* and *educator* received additional support; highlighting that decision-making is not always unilateral. Acknowledging and valuing patient input, identifying desires and values that are significant to patients, and utilizing patient input to inform care decisions, embodies the care role *partner*. Participants incite patients to be partners in decision-making processes by encouraging them to provide input. Two *properties* of *partner*, *solicitor* and *collaborator*, and two dimensions (rehabilitation and severity of injury) garnered more support in the second round. Soliciting patient feedback informs patient initiated changes to the plan of care. While participants maintain power over care decisions, changes are initiated based on patient input. Various ways patient input is sought was exposed in round two (daily, before or

after appointments, or at points throughout care process), what input is solicited, and how

input is integrated into the care plan. Participants *collaborate* with patients by jointly

identifying and integrating meaningful care decisions, and when patient requests catalyze

a change in the plan of care. Second round experiences clarified which aspects of care

were appropriate for *collaborating* (therapeutic exercises, treatment times, treatment

modalities/therapies, and goal setting) and when *collaboration* was not viable (limits to

patient understanding of injury, plan of care, and variation in injury response, and when

participants do not have authority to change the plan of care). **Navigating** how and when

patient input was sought and integrated manifests over three <u>dimensions</u> of *partner*

(<u>rehabilitation</u>, <u>severity of injury</u>, and <u>relationship</u>). Two <u>dimensions</u>, <u>rehabilitation</u> and

<u>severity of injury</u>, gained additional support. Length of <u>rehabilitation</u> (<u>short----long</u>)

remains influential to seeking and trusting patient input. <u>Long</u>-term care incites trust in

patient input, whereas during <u>short</u>-term care, patients may be less likely to divulge how

they are really feeling. <u>Severity of injury</u> also continues to independently influence

participant's experience as *partners*. Participants limit patient involvement for <u>complex</u>

(severe or life threatening) injuries, whereas with less severe (simple) injury, patient input

is sought and integrated on a more frequent basis. **Navigating** the third *care role*,

educator continues to capture delivery of patient education throughout the patient care

process while shedding additional light on awareness that education encompasses all

aspects of injury and the care process. Education is adjusted based on patient curiosity of

confusion, what participants perceive is necessary, when (to match patient location in

care process), and how much (detail and depth). Embodying the intent of information

provided to patients, *properties* of *educator*, garnered further support in the second round.

Body awareness was grounded in educating patients about anatomy and physiology, tissue healing, and body consciousness (patients learning to "listen" to what their body is telling them), which became a mechanism to facilitate patient understanding and feedback. *Understanding injury* (also a *property* of *educator*) aids patient understanding of their injury and natural variation in injury response, and educating patients about aspects of the care process (treatments, modalities, exercises/exercise plan) supports understanding the purpose and effect of treatments and exercises and embodies a final *property* of *educator*, *purpose of treatment*. **Navigating *care roles*** remains foundational for moving through the care process, however, participants must also **navigate *patient resistance*** encountered during care.

Patient resistance

Patient resistance remains present in second round interviews and the following passages highlight two new manifestations of *resistance*: *resistance* to buying in or to compliance.

> F298   I think, I think when they (buy-in and compliance) happen together, that's the best of both worlds. But I think you can have buy in, not necessarily compliance. You can have someone who understands what they're supposed to be doing and works really hard when they come in and want to get better and then kind of fall off the compliance wagon. But then at the same time I think on the other side you could have somebody who comes in every day but just goes through the motions.

> O544   Buy-in's a little different from compliance. Um, because and the reason I say that is because I have patients who believe in what ah, in what you're doing and the exercises or modalities and stuff like that, they just don't want to, I don't want to say they don't want to, but just aren't the type of person who's going to do it without you with them. You know they're not going to put in their own time and you know, I teach where I'm at too and it's the same type of person who doesn't, no matter how many times you tell them to, doesn't turn in their paper on time. You know it's not that they don't do it and that they think they're not learning anything, they just won't do that because they won't make that time. And I think that with

compliance that's a big issue is you know, I shouldn't say they won't make it, but you know they feel as though they don't have that time to do that and I think that is a big to do with compliance. Whereas buy-in a lot of people believe in what they're doing, they just don't think they have time to do it. That's why I consider them different, especially in my case because I'm not always there, if I was seeing them every day then I guess buy-in and compliance would be about the same, but since I'm not and I have to rely on them to do their own, you know I trust that they believe in what they're doing but you know even though they believe that this is going to help them feel better, some people aren't, and don't want to go the fastest way there and put in all the effort to get there.

Patient resistance also manifests as patient concern surrounding divulging injury/illness and the potential effect of playing time.

F423   I think some of the girls will not tell me about things right away, ah because they, they just, they're afraid I'm going to hold them out. And then the coach is going to think that they are just being a baby, and they're not practicing and they're not putting the time in and so then they're gonna have their spot taken away or they're never even gonna get off the bench.

Another aspect of *resistance*, reaching the limit at which participants are either unable or unwilling to manage patient care, also surfaces in the second round. Here, patients are given so many opportunities to display responsibility, effort or commitment before participants become less willing to work around undesirable behaviors.

L446   I mean it's throughout that whole process I'm trying to, I'm giving them [patients], I'm trying to get them to commit more. I'm giving them plenty of opportunities to correct whatever negative situation might be going on. But if it gets to a certain point where, I mean, even with all the feedback I'm giving them and trying to get them to buy in and come in and put the work in, and I tell them, I mean if it gets to a point where, you can come in and do your stuff but, anything extra it's going to be. I mean, we'll take it a case-by-case basis but the odds of you getting that. I won't tell them, you know, the blunt per say, like well, if you want anything extra then you might just have to wait until either we're open and or somebodies here for practice. So I mean I give them every opportunity to um, to kind of correct any negative mistakes before I start dishing out the consequences for them not ah, not buying in or not being as open or complaint with anything.

L251   Um, as far as them not wanting to come in that's, I give them as much rope as I can you know, allow them to take. Um, but it gets to a point where if they don't want to come in, if they don't want to take responsibility for their own well-being. I mean I've got other athletes that I've got to take care of. And it might sound you know, cold and heartless but if they don't want to come in and put the time in then I'm not gonna give them, give them the time. But throughout that whole process I'm constantly talking to them like 'hey, you gotta keeping coming in.' I keep asking them 'why aren't you coming in?'…And then, they get a couple warnings and then they get to be the point where alright, now we're…but we're gonna be to the point where alright, you're not going to come in, I'm not going to see you today, and then there will be consequences, yeah.

While participants don't want to "give up" on patients, they will meet and not exceed

patient effort and involvement, as seen in the following passages.

O417   …I'll kind of meet them [patients] as far as they meet me. But ah, I guess again with those un-compliant ones, again I do have the coaches and stuff, try to help me through all that. It's not like I'm going to give up on a patient, or something. But yea, I do kind of meet them where they'll meet me as far as what we can do and can't do.

K607   People [patients] who want to be there...I'm gonna devote my time to the people who I see, you know, want to be there and it's you know, it's just easier to do that.

J   *If they're putting in effort you're gonna be more likely to put in effort*

K614   Yea, if they're putting in effort, you know if you're doing everything you can do for an injury, and you're still in pain, I have no problem with you complaining. I mean you can complain all you want. But if you're coming in like every other day for treatment and you're skirting stuff and you start complaining about how everything's not working and start mouthing off to the coach and stuff like that, I've got no tolerance for that whatsoever. Because you're not doing everything you can do, and therefore I cant do everything I can do, so no right to complain there.

L464   I mean I've had a couple of athletes who are very, very noncompliant. The communication probably wasn't, wasn't there enough and it got to a point where I just got frustrated and just. Like when he was there, or when he came in I would do his rehab with him. And if he didn't come in, it really didn't faze me. Um, so going back I'd probably do it different, and just communicate with him more. I mean that, you'll have those wherever you go, where you just get to a point where an athlete pushes you far enough and you just give up on them….I mean it just got to a point where when he started out he was good about coming in whenever I had told him to. He was always doing his stuff, then he just, he, every once in

a while he started to skip out on some appointments. There were stretches when I wouldn't see him. So instead of when he came in instead of asking him 'where've you been?' I just kind of ignored it and just did his stuff then and kind of just progressed him as whenever he came in….Yeah and just, yeah, getting frustrated and not wanting to keep doing all the extra work when he wasn't willing to match my, my work.

Following round one data analysis, *patient resistance* represented the threshold at which participants were either unable or unwilling to manage patient care, or elicit patient commitment and motivation to participate in their care process. Participant limits remained present and gained additional support in round two data, appearing as meeting and not exceeding patient involvement. Second round data sheds additional light on **navigating** various kinds of *patient resistance* such as: lack of responsibility, effort or commitment, hesitation to divulge injury/illness, buy-in and compliance.

Navigating continues to represent moving through the care process and addressing barriers encountered during patient care. While the *care role* _director_ was not further elaborated on, **navigating *care roles*** of _partner_, and *soliciting* or *collaborating* captures who contributes to or directs the care process at any point, athletic trainer or patient. _Educator_ encompasses providing education to patients about *body awareness*, *understanding injury*, and *purpose of treatment*. **Navigating *patient resistance*** requires recognizing and responding to various kinds of *patient resistance* and capturing participant limits to managing care. In addition to **establishing** and **navigating**, second round data expands upon and clarifies **buy-in**.

Buy-in

The third **category, buy-in**, has a strong presence in second round data. **Buy-in** embodies patient investment in their athletic trainer, treatment tasks/modalities, and care, which was the understanding moving out of round one. Round two expanded

conceptualization of **buy-in** by highlighting patient attitudes and behaviors and how participants respond to bought-in patients. The rich variation in second round data generated creation of two new **buy-in** *sub-categories*, *beliefs* and *actions* that add depth of understanding to **buy-in**.

Beliefs

The ***beliefs sub-category*** captures patient trust and confidence in athletic trainer knowledge and ability, recommended treatments/modalities, and plan of care or system as a whole. For Maeve in particular, patient trust and confidence in her ability to manage injuries (specifically chronic injuries) undergirds patient commitment to working with her for the duration of their injury or sport career.

> M367 Um, I think the biggest thing, the kids that like I work with regularly, they've bought in. I'm thinking a lot of the long-term back patients, because that's my life in [my sport]. And because it is so important to get their buy in because they're, because I'm going to work with them for you know most of the time that they're there. They're going to have flare ups, if they have disc pathology and they [participate in this sport], that's a thing that's gonna happen.

> M508 Um, and then I'm thinking also, like longer-term….Like if you know that they bought in and they trust that your exercise prescription is what, like that that's the key to return right, versus if they haven't, and it's very obvious when they haven't because they just keep trying to push and then [they don't get better].

Patient ***beliefs*** can also engender participant trust and confidence in patient responsibility to complete requested tasks. This facilitates work with patients and influences participants' professional abilities to efficiently manage the care process.

> K211 [When patients are bought in] It's a lot easier for me. So much easier for me. Cause I don't have to like sit there and police them. Like ok, that was only 9, or put your phone away, or you know pay attention, we've only got a few more minutes before you have to be out at practice to you know, film or run the clock or whatever. Um, when I know that when I can hand them their sheet with the stuff that they're supposed to do that day, and I

can walk out and it would be done. That makes it a lot easier. So I'm not just sitting there baby sitting.

M373   They come in and they start doing their own thing, and then they know that I'm going to come over to them when I get there and then we're gonna talk and we're gonna discuss like how things are going, like where they're at, you know that day but then also like what's the plan for X amount of time right, three days, five days, a week, however long it's gonna be. Um, and that they sort of not only know the routine but know that like, know that I, they don't need to sit on a table and wait for me to come to tell them to foam roll. Right? Like they know to start with that and then they trust that I'm going to get to them and then there's going to be treatment and whatever, and there, and whatever it is. Um, and then that they know that then a discussion has to be had before they leave to talk about any modifications or when am I going to see you next or whatever it might be. Um, but I think that they trust that that is a system that works and then also that I know that if they're sitting in a corner from rolling they're not just on their phone, right? Like I already know that that's something that's been done, I can put that in the rehab note, they did this and did that or whatever and like I trust that they're doing it and they trust that I'm going to get to them and it's like a mutually, mutually beneficial situation I think.

In sum, *beliefs* denote patient trust and confidence in participant knowledge and ability to manage care, and participant trust in patient responsibility.

Actions

De-construction of round two data identified the ***sub-category actions*** as what patients do to show **buy-in**. Participant experiences of **buy-in** *actions* were multifaceted or tiered. Here, Maeve speaks to two levels of buy in; basic and deeper:

M328   I think to me it looks like they, I mean, basic things like they show up on time and they show when they say they're going to. Things like that are a very basic level of buy in. Um, and then deeper than that I think when it's obvious that they've been, you know doing their home exercise program because they're been getting better at things. They, and not only that, they're doing what you ask but they're asking for more, right. They're like, you know 'this exercise is easy, I'd like to do something harder, I feel like I can be more challenged with this.' But they're really, they're, I don't want to say pushing themselves, but they're sort of, they're like working with you to push themselves. Right, like they're asking you questions as well as you asking them questions. It's sort of a back and forth. I think that to me is like a kid is really, they get it, they're bought in, and they're

gonna, I think I told you this last time too but like my line is always 'help me help you.' And like they're really doing that. They're helping themselves but then they're also like how can I help myself, you know, like asking. Asking questions and um, and what's the word I'm looking for, collaborating, that's it. It's like, it's a two way street but they get that like, they get that I want to help them get better, but they also understand that they have to, it's a give and take.

J   *So they actually are trying to, and are, collaborating with you because they want, they want a bigger role in their care.*

M348   Right, right. Where they're saying things like, you know, 'I did this foam roll and stretch program that you gave me, I did it twice this weekend. Is there something else I can do? Or is there, you know, more or different or something, something I could be doing better to make this go well?' Yea, I think when they're, they're actively engaged in not only me trying to do more, but them trying to do more, then I feel like great success.

For Fiona, **buy-in** occurs when patients take ***action*** and become outspoken advocates for her professional capabilities.

F349   Well, one of my girls who's fully bought in, she's had Achilles pain almost her entire career here. But um, she knows when she comes in regularly for rehab and does it right that her pain goes away, or gets less. Um, and she tells her teammates that. So, she like, she's become like an advocate for me. She like sees these girls come in and they're doing their exercises half way, and she will be like 'listen, you're in, Fiona's not having you come in to be mean, she doesn't want to take time away from your life, like if you do what she asks and do it well, you're not going to have any problems anymore!' Um, so that's probably the most obvious characterization of buy in. She's like being my hype girl. But um, I think that there are other, other girls who have truly bought in that aren't as vocal as she is.

In round two, participants articulate diverse ways that patients display buy-in, resulting in the identification of four *concepts* of ***actions***: *accountability*, *communication*, *effort*, and *engagement*.

Accountability

Accountability embodies patient responsibility and willingness to follow care guidelines regardless of being reminded or asked:

F358   I mean they just, they show up when they're supposed to come in, even on days that they don't want to be there. And they'll tell me 'do I have to do this today?' and I'm like well 'yea, you haven't been in for 2 days or 3 days, or you know we need to stay on top of this' and, 'like ok, well, I don't like it but I understand.' Kind of thing. And then they do what I ask them to. Um, and I think another way I see it is through my student [ATS], um, when they're working with her they don't try to pull anything. (*Laughing*) Um, cause she's still learning and getting to know everybody and when I see them holding themselves accountable, um, that's a good indication.

O37   So like at home programs and people coming in and doing their own stuff that, you know if they're responsible and stuff you tell them, you know and doing it, you know whether you're there or not you can see whether they're committed to their type of ah, to whatever they're working towards, towards their rehab…it's more about their actions.

L397   I think, you notice it [buy-in] when um, they're coming in, they're always in a good mood when they're in the training room, they're willing to come in, I mean they might even come in when they're not supposed to just to, just to chat, or to see if there is anything else they can do. I would, I think the biggest key to them buying in is them willing to come in even when you tell them that they don't need to.

Communication

A second *concept* of **actions**, *communication*, speaks to various ways patients attend to sharing information and conveying investment in managing their care.

F80   [when participants have a personal connection with patients] they [patients] just seem more um, **invested** in what we're doing….

J   So you, you mention invested, they were invested. So that kind of means that they'll, what does that mean?

F96   Um hm, um, they show up on time, um, if they are going to be late they let me know ahead of time. Um, they tell me when they are going to be in and then they talk to me like after, like if they cant make it in the athletic training they make sure to grab me before practice and say 'here's how I'm feeling today, what should I, what do you think I should do?' And then even, then after practice if something's come up during the drills, they're sure to be like 'how long are you here for today? Ok I'm gonna shower and I'm gonna be right down.' Um, so, I think the communication part is the big difference.

Effort

Effort, the third *concept*, encompasses patient commitment to complete tasks and

exercises correctly, work hard physically and mentally, and stay motivated.

A373   …and I think a lot of it is the effort you get too is from buy in. It's not just sitting there going through the motions of an exercise. Um, it's I'm gonna go through all of these steps first of, before an exercise, of how to engage my core and draw the belly in, opposed to just 'yea, I can plop through the exercises no problem, I'm outta here, see ya later.'

K176   When they're the ones that are you know, 15 minutes early and I'm like 'ok, sit tight for a second, I gotta finish this.' Or they're the ones, 'can I do some more?'' They're the ones that put they're damn phones away because they actually want to do rehab and they're not texting while they're trying to do straight leg raises or whatever. I think you can tell when they're not just physically going through it, but they're mentally going through it as well. I think that's my biggest clue….When they change their attitude towards rehab, the same as a practice, that's my big cue.

J   *Can you explain that?*

K190   Um you know like at practice you're gonna go out and you practice like you're gonna do it in a game and you're gonna be focused. And then people come into rehab and they're, they're talking with everybody, they're texting, they're horsing around while they're doing it. I mean I'm not saying you cant ever talk to somebody, but when they're doing the exercises, they're focused on it, they're concentrating and, they're not letting other things get into their minds during that I would say. So they're not playing on the phone, they're not, you know, engaged in a conversation heavily while they're you know, doing their squats. Maybe during their break they'll talk, but…. They see it is a time to get better. Like they would on the court

F303   I had a, one of my athletes recently has gotten to that side of, like she's, I know when she's coming in every day but she rushes through her exercises to get them done, and then leaves. So I had to talk with her the other day….and said you know, if you just come in and rush through the exercises it's not doing you any good. You have this chronic knee pain and I'm having you do these exercises for a reason and if you're not doing them right you're not going to see any results. I know it takes a long time to feel better, especially with the chronic injury.

A406   There's I think a lot of clinical rehab exercises, where you don't have to be fully motivated, you'll still get benefits out of them, but um, but at the same time effort on each, each individual one does come from a motivated side of thinking of I want to get better I want to buy into the system and I want to improve so I'm going to come in and I'm going to give the effort

and be motivated to give the effort because I wanna be there. I wanna be back on the field, court, the, in play.

Engagement

Patient *engagement* was the fourth and final *concept* that arose in round two, further defining **buy-in** *actions*. Patient *engagement* captures patient efforts to take an active role in their care process by asking for feedback and expressing a willingness to collaborate on care decisions.

A358   Ah, for me buy in is when they're looking for the next step. They're constantly 'hey you know you gave this to me yesterday, and I did it, and today you said we're moving on to this'. And it's like ok, yeah, lets. It's when they're, they're always looking for that next step, that next thing, and they're asking you. Um, it's, um, I always tell patients now like, if I don't get back to you like keep bothering me because the squeaky wheel's gonna get the grease. It's, you know, if you're, if you're totally bought in you're gonna be the squeaky wheel of 'hey what can I do now, what can I do now, what's the next step?' Um and it's not the what can I do now to push the envelope, it's what exercises are next, where am I going, what's the next step of coming in, you know….to me that's that, some of it's a personality of them looking to improve themselves, but I think some of it is, you know when they come in, even your rehab patients of ok, we got this yesterday, where's our next step? Like how do I, how do I continue to go through the process.

A421   They're a lot more fun to work with (*laughing*). Yeah, um. But I think it's a lot more enjoyable cause you, you can keep them on that kind of, that plan, the road map of within things. And yes, you're gonna have to deviate, as you know the body responds to things differently, but um. As they buy in, as they're motivated to do stuff you can, it's more fun when someone's bugging me to look for exercises than for when I have to be like 'oh, here's your next one' and they have kind of that 'oh I have to do that now?!' Um, and it's, cause it just takes more time to just go back cause I think with people that buy in you don't have to explain things as much anymore. You can kind of say here's, here's, here's the next thing and, or here's the next course of treatment, whatever it is, and you don't have to explain things because they trust you. There's that element of trust. I think that's probably the biggest, they've bought in.

In addition to how patients feel and behave, **buy-in** comprises expectations participants have of patients to reach therapeutic outcomes, influencing how they regard patients. Here, participants respond to patient **buy-in** by matching their effort:

L115   I mean if they're active in their rehab with me, they're always asking questions, I mean I'll go out and I'll really engage with them. With the ones that just kind of like come in and do their stuff, there's the initial you know, I go over their rehab plan and then they know that if they have any questions they can always come talk to me.

L433   I mean if they've bought in then, I mean our relationships are a lot stronger. Um, just get along better and you're more willing to do extra things, is probably the wrong way to say it, you're just more comfortable around them. Whereas if you have somebody who hasn't fully bought in, or they're not fully engaged when they're in there, you may not be as willing to go out there, and you know chat with them and do extra things outside of the norm.

Buy-in also manifests as a social connection. When **buy-in** supports a participant-patent relationship, participants spend less time promoting trust and responsibility and have more time for casual conversation.

O583   I think it's when somebody's not bought in and not doing you know what I want them to do as far as treatment wise, I think that shows itself and a lot more of, I don't want to say me being harder on them, but a lot more of me kind of always talking to them and kind of being on them for stuff all the time. You know do this, do that. Whereas my people who are more compliant, um, instead of being kind of harder on them, I think because they're doing their exercises and because they're being compliant, um, the conversations I have with them are more you know, social in nature than the ones who are non compliant….I think whenever…I already have the buy-in, and they're [patient] trusting me you know, I think it's, again more of a social dynamic between me and them. Whereas if they're not bought in, it's more of a continually you know, why you need to do this, always talking about the athletic training part of it and less of, you know, did you see the football game and stuff like that. [My athletes] would say the ones who are bought in are the ones that I "like better", but I think that if ah, if you really looked at it, the people who are doing stuff while I'm in there, I'm more asking them about stuff, instead of talking about their exercises to people who are not kind of doing what they're supposed to be doing.

J   *So then it sounds like they, those patients who have bought in, in addition to the trust and the belief, they're responsible.*

O615   Yeah. Yes, that's a good way of putting it. They're responsible, and I trust them so, you know they get talked to just a little differently than somebody who's not as responsible I guess in my opinion.

L407   If they're [patient] coming in they want to do extra, um it shows they believe in what they're doing. Uh, if they wanna come in just to chat for a little bit, that shows that you're getting them to buy in too, because if they don't want to come in, you know if they don't feel like they want to come in and chat or do any of the extra stuff then, I mean how can you really see if they've fully bought in. Cause if they're willing to come in and talk for a little bit, just out of their own free time then, that shows that you have a good relationship with them and that, that they're willing to do whatever you say.

However, **buy-in** can have negative impacts when patient are over-eager to please their care provider, push too hard, and fail to guidance when needed.

F628   I think that was a case where like things swinging too far the other way [patient with low back pathology continued performing exercises despite being in so much pain they were crying. They did not provide feedback that the exercises were painful]. So like this was the same girl that I had to get after 3 times in one week that she was late and that she wasn't following directions and the coaches got on her. So then she became this like, hyper aware, 'I'm going to tell Fiona about everything, um I'm going to be in here all the time. Um, doing exactly what she asks me to do.' So I think she was just trying to be compliant and do what she was supposed to. Um, yeah. I felt horrible!

In summary, after round one, **buy-in** captured invested patient attitudes and actions towards athletic trainer participants, treatment and treatment tasks, and their care process, as well as patient willingness and perseverance to follow through on care and inclusion in care decisions. Variation in participant experiences evident in second round data identified two *sub-categories*, *beliefs* and *actions*. Patient *beliefs* that promote **buy-in** reflect patient trust and confidence in participant knowledge and ability, recommended treatments/modalities, and plan of care. These in turn, generate participant trust in patient responsibility to complete tasks, making it easier to attend to professional responsibilities and efficiently manage the care process. Patient *actions* also reflect buy-in, and four

concepts of ***actions***: *accountability*, *communication*, *effort*, and *engagement*, add further richness to the **buy-in *category***. Patients show *accountability* through responsibility and willingness to follow participant directives. Patients attend to sharing information and convey interest in managing their care via consistent *communication*. Concentrating on completing tasks and exercises correctly, hard work physically and mentally, and staying motivated show *effort*, and taking an active role in care by asking for feedback and expressing willingness to collaborate on care decisions displays *engagement*. Participant experiences in the second round highlight the direct effect of **buy-in** on athletic trainer and patient interaction and therapeutic outcomes, including meeting patient investment with matching effort. **Buy-in** allows participants' to spend less time promoting patient trust and responsibility, enabling more time for casual conversation. However, **buy-in** can have negative impacts when patients are over-eager to please, push to hard, and fail to seek guidance when needed. **Contextual factors** remains the fourth **category** and is continually influential to **establishing**, **navigating**, and **buy-in**.

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Contextual Factors

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   Contextual factors, the fourth category capturing the underlying experience and process of how athletic trainers utilize the working alliance in patient care, represent employment setting and person variables. The three ***sub-categories*** identified in round one remains present in round two: ***institutional variables***, ***patient variables***, and ***athletic trainer variables***. Second round data analysis provided additional support for three *concepts* of ***institutional variables***; *patient load*, *proximity to patients*, and *institutional emphasis*.

   Patient load

Patient load has a strong round two presence and continues to represent the number of patients participants manage and corresponding impacts on the provision of patient care. Large *patient loads* hinders connection, trust and the provision of comprehensive professional care to patients, as shown here:

L38   My last job for example…we only had 2 people on staff for 17 varsity sports. So, that was ah the biggest, I noticed that since I was stretched so thin with so many different, different teams, the uh, the relationships and the patient relationships and things like that where, the ones that were coming in every day, I mean we had good relationships. But if they [patients] were to come in maybe 2 or 3 times a week for random things, um, I might not have been as open or you know as caring. But just because you're spread so thin and you have so many other athletes to worry about, they kind of get lost in the fray a little bit. Whereas here now at my current job, I'm responsible for 4 sports. So it's easier to you know build those relationships with those teams, so you're only working with you know a certain number of athletes at a time, so that helps. Just to kind of build those relationships and just kind of, build that trust.

K562   We were basically running a triage unit because there was just too many people [patients], not enough of us [athletic trainers] to really do anything substantial….You know our mornings were spent trying to catch up on the paperwork, or like people were coming in in the mornings for treatment because they weren't getting them at you know 2:30 when practice was starting. … Um when we are at a normal capacity it is much easier to, I mean obviously we're still completely outnumbered, and if you do the whole NATA calculations, we're still under staffed but it is much more manageable and a lot easier to do our jobs.

A514   I think there's a reality aspect of, kind of too, to athletic training in that sense of, a lot of times we have our patient load is a lot higher than what we can, you know feasibly do all that time.

Patient load also challenges fulfilling the care role *partner*, as Orlando describes here:

O428   I guess that could be a little bit of a barrier too, all the other people I have to manage as far as getting all their feedback. Because you know sometimes they only have so much time to be in the training room and that time is maybe my busiest time and I might have 10 people trying to give me feedback to everything and you know trying to write that down. I mean I've gotten fast but, I don't know if I'm that fast. And trying to remember everything is ah, can be another barrier to getting all that because you know sometimes I've had people come in who aren't as

wanting to talk over people, who will sit in a corner and want to talk to me but there's so much going on that eventually time runs out and they just leave. I've had that before, and I guess you can consider that another barrier to getting that input and developing that relationship as well.

In summary, a deeper understanding of how *patient load* impact provision of care (inhibiting connection with patients and participants seeking patient input, and triaging injuries) surfaces in round two data and becomes part of the understanding of *patient load*.

Proximity to patients

Proximity to patients is another place aspect of **institutional variables**, remains as an obstacle to effective patient care. *Proximity to patients* captures patient access to their athletic trainer, and the location of the brick and mortar structure where participants attend to patient care relative to practice/competition facilities. Here, sport responsibilities and location of athletic facilities creates challenges for participants to effectively track patient needs and manage care, resulting in an increased need for participant and coach communication to manage patient care:

> A786 The assigned sports I have now are cross-country, track and field, and hockey. And the downside is there's someone in the athletic training room right now at school, but I'm, um, I'm out at hockey practice every afternoon and that's off campus, so I'm never around for my track and field practices. Which is a terrible situation so it's, I have to rely on coaches to say to me "hey, I told so and so to come and see you, did they come and see you?" And it's 'no, I never saw them.' And then following up of. So whenever someone comes in it's, hey coach, so and so stopped by and this is what's going on. And they're like oh that's what I thought, so there's an extra communication piece that I have to kind of negotiate and so that we're all on the same pages and we're crossing our T's and dotting our I's if you will, so that I can balance everyone.

Proximity to patients also impacts how participants adapt their approach to patient care. Distance necessitates participant development of implied trust in patient responsibility, and encourages streamlining the creation of exercise plans to improve time management.

O159   Like they do, I wouldn't say almost, they do. It's a very, they kind of have to if they want stuff to happen. So they know I'm not going to be there for everything so they know they have to keep them going on some of that stuff…I think ah, definitely because of two facilities I have to have some semblance of trust in my athletes to do stuff when I'm not around. And ah, that is definitely, I mean before I got here I used to think I had to watch everyone do everything. And now I mean that's just not possible. So now it really has me more onto trusting that they're doing it, getting home programs developed [for patients].

O192   One of the things that my employment setting really changed about me as an athletic trainer is I have a, I used to write everyone's exercises out in like pen and everyone's were a little different. Um, now you know I kind of have a, I have a book that I made of exercises and that book is in each training room and then now instead of putting everyone's exercises on there, I refer them to the book and tell them they have to, you know like there's a knee section, you know you have to pick seven exercises from here and then I'll point out like three that I make them do every day. And ah, so it's a lot different than before, whereas everyone was kind of on something different, now everyone does something similar, which helps because then they can help each other do the exercises if they don't know how. Whereas before if I wasn't around and they were doing stuff wrong, then they were just doing it wrong without anybody there to correct them. So it's definitely that, I mean I've become a lot more cookbook-ish on how I do stuff, but it was one of those things I kind of had to do so that people could do it when I wasn't around.

Second round data analysis clarifies how physical location poses challenges to patients and athletic trainer care providers accessing one another, and suggests possible ways to manage these challenges. These include added attention to coach and participant communication regarding patient needs and injuries, and developing broadly applicable rehabilitation protocols to improve efficiency.

Institutional emphasis

Institutional emphasis, the third supported *concept* of **institutional variables**

continues to represent institution-specific emphasis on academics versus athletics, sport

success versus sport participation and the impact these have on participants' management

of patient care.

F771   Well I mean at the college level I think a lot of athletic trainers can feel a lot of pressure to get athletes back quickly, by any means necessary. Um, no matter if that's what's in the best interest for the athlete or not. Um, so I try to make it clear from the beginning too that I care about their health and that's my first priority.

M639   I think in a general standpoint we're pretty lucky in that our coaches are um, pretty understanding and pretty like, across the board not just rowing, but like all of our coaches in general are pretty understanding of the fact that like these kids are not probably going to be professional athletes. They're you know, they're at [this institution] because they're going to go work on Wall Street, or save the world, or whatever they're going to do (*laughing*) and so they um, they are pretty, they make decisions as such, right. So like I am never, in my time at [this institution] been like pressured to send somebody back when it was unsafe to do so. Like, and I think, I don't think I'm the only athletic trainer who would say that on staff.

M726   It's a different world in, I don't know if it's true of all [schools in this conference], but definitely of [this institution] where like yes, everybody wants to win but the attitude about it is just so different. And [this institution] does like, I mean they don't do well on the national spectrum because we don't offer scholarships, so we're always up against, like once you leave [this conference] you're toast. But, in most sports, not all but most….Um, but um, but within [this conference] we win more than any other team, so it's definitely, or any other school, but I think it's a perfect example of like you can have this different attitude about winning and still do it. And I wish that could somehow be permeated across [this division of] athletics but, that's just me.

Present in round one, *institutional emphasis* denotes an emphasis on academics

versus athletics, sport success versus sport participation. While this remains present in

second round interviews, here the impact and undue pressure *institutional emphasis* has

on participants to return patients to competition emerges and becomes part of the understanding of this *concept*.

In summary, **institutional variables** continue to clarify the environmental and place factors influential to athletic trainer-patient relationship and the care process. *Patient load* continues to represent the number of patients participants manage and corresponding impacts on creating connection, seeking patient input, and providing comprehensive care. *Proximity to patients* remain as an obstacle to effective care, capturing patient access to participants, and the location of the brick and mortar structure where participants attend to patient care relative to practice/competition facilities. Sport responsibilities and location of facilities creates challenges to effectively track patient needs and manage care, resulting in broadly applicable rehabilitation protocols and an increased need for participant and coach communication to manage care. Last, *institutional emphasis* on athletics versus academics, sport success versus sport participation impacts participants' management of care by generating or limiting pressure to return patients to competition prematurely. These *concepts* round out place variables that influence relationship development and patient care.

Patient variables

Whereas institutional variables account for unique aspects of the work environment, the **sub-category patient variables** encompasses features unique to the collegiate athlete population group as well as individual patients. Patient personality and regional location arose in second round data as factors contributing to distinctive differences in patients. These factors help participants define how patients will approach care and respond to establishing a connection.

L127   I think it's just the personality of some of the athletes I've been working with. They're, some of them are very independent and like doing their own thing. And some other ones like to, like to have somebody out there with them to talk to and to just, you know be around.

A39   Students and athletes [in the region where I work now] are different from where I came from [in a different region] and at the last place I worked. They aren't as open initially, and not as willing or apt to share about themselves. Whereas kids from where I grew up, they are much more open and willing to talk and to share.

Additionally, perception of patient need for explicit direction and instructions influences how participants lay out and deliver care directives to patients.

F559   So I don't know if this is a thing [at my institution], or if this is just how college students are now, but they, like cant figure out what to do if it's not explicitly laid out for them. Um, and I see it in making good life decisions outside of school. And um like I tell them, you know, just please rest this weekend, blah, blah, blah. Well then I don't specifically say don't go to a party. So. 'I'm in tennis shoes, I was in tennis shoes all weekend! I don't understand why my ankle's swollen.' "Well, you were up at a party all Saturday night walking around on it." 'But I was in tennis shoes!' Um and then on the court, if the coaches don't go through every possible option and a play. Like they've written up this play and they're supposed to keep moving through it, if they don't know, 'well if she's not open and she's not open, I don't know what to do anymore. Is this ok? Can I do this?' They have like never ending questions. 'Like what if this happens? Well what if this happens?' So then when they come into rehab it's the same kind of thing like, um, if it's not all laid out specifically um, then they seem a little lost.

Patient variables continues to be understood as features unique to the collegiate athlete population group and each distinctive patient that influence how participants understand and interact with their patients as they establish relationships and navigate through patient care. Patient personality and regional location arose in the second round as factors that help participants define how patients will approach care and respond to establishing a connection. Two *concepts*, *sport valuation* and *additional relationships*

remained present in the second round and added additional insight into specific

understanding of *patient variables*.

<u>*Sport valuation*</u>

<u>*Sport valuation*</u> denotes participant perception and patient attitudes towards sport

and characterizes the personal significance and importance patients place on sport

participation versus other commitments and activities. Here, participant perception of

differences in <u>*sport valuation*</u> influences their opinion of patient motivation to attend to

their injury/illness, as well as their approach to delivery of care:

> A639   Yea, division 1 it's about the sport, um, division 3…it's a lot more about everything else than it is about the sport. [Changing divisions has] been a little bit of a shock for me.

> A663   I transitioned from [upper division to a lower division] and, it's a huge impact. I think some of it is the patients, um, the [higher division] had student athletes who wanted to get better a lot more. Like they were, I'm here to get an education but I also want to excel at my sport. That's why I came to [that division]. I'm you know, I'm about, I want both and. The [lower level], I mean I have student athletes who are involved in you know, the Christmas you know katada program, the journal club, they're on the you know, this class and then oh by the way I do my sport but, I mean kids are skipping practice to go to other things and you're like 'what, that doesn't happen?! You don't skip practice!' Um, and it's just the, kind of the environment within [this lower division], it's about participation. And every [school in this division] is different, I understand that.

> A676   …so the patient care there has changed a lot in the sense of you have to take in a lot more of the outside um, kind of what their [patient] other goals are as well. And fit that in of. A lot of my kids, now they don't have time to come in and do stuff and you have to really give them an abridged version of, hey you cant come in, alright well, can you do this at night you know in the weight room? Things like that, or before you go to bed I want you to do these exercises, and um kind of, you have to get that balance a lot more of um I'm treating patients via text messages, not treating, but designing rehabs and kind of monitoring that via text messages more than one on one….Yea and its, its added a dynamic I wasn't expecting. Because I would prefer, and we've kind of talked about the one on one, lets spend time and, and like I got that at the [upper] division because they

would be there all throughout the day, and it would kind of be a lot more one on one. Where now it's kind of, they all shuffle in at 330 and practice is at 4 and you have to, you know fit 2 rehabs in during that time because this is the only time I have today cause I have a meeting for whatever club tonight….Uh yea, so it's. It's been a lot different to, in that aspect of it's not as personal, it's a lot more um, just get things done and kind of hit the big parts and move on because you cant work at, you cant spend the time to work on the fine details.

After round one, *sport valuation* was understood as participant perception of patient attitudes towards sport. Round two added depth to this understanding, exposing the role of participants' assessment of patient motivation and the resulting adjustments to approaches to delivery of care.

Additional relationships

The *concept* of *additional relationships* continues to capture the interaction and influence of other patients, teammates, friends, parents, or physicians (new within second round) on patients and the care process. Round two also provided additional support for participants purposeful encouragement of *additional relationships* to promote patients overall care trajectory, as shown here:

F214   It helps sometimes if I have an example to show them. Um, another teammate that they respect, um, who has not necessarily been through the same injury, but an injury and followed through with what they needed to do when it was successful and they haven't been back in the athletic training room.

K288   [when patients aren't bought in] A lot of times I feel like it's because they're feeling isolated from the team. So I try to like get their rehab done while other teammates are in there, so they have that presence around them. And you know, I'll discreetly talk to their teammates like hey you know, check on this person, you know he's a little down, he's not gonna play the rest of the year, he's gonna miss a big game, like when he's in here talk to him, encourage him while he's doing his rehab.

K306   For some reason it's a lot easier with girls, just because it seems like when someone is…I think it's less a problem with my women's teams, because it seems like whenever someone suffers one of those catastrophic, like

major time loss injuries, like there's always a roommate or best friend that's you know always in the training room with them while they're doing rehab and supporting them and helping them. But then just I think that it's the guys nature that they don't want to need any help. So some aren't gonna follow them around, kind of be that buddy. So I think its, I've noticed that difference.

In contrast, second round data also identified situations where *additional relationships* were unhelpful. Here, a previous patient becomes an outspoken and unqualified care provider, thereby complicating patient comprehension

> F745   And there's one girl in particular on my team, who's, unofficially made herself the team nurse, and will tell the other girls like what's going on with them. So then they'll come in and say 'oh, well she said I have this and I should do this and I should ask you for this'. I said, "No. Is she a certified athletic trainer?" 'Well no.' Ok, well then have a seat on the table and we're gonna take a look at this and figure out what's going on.

Parents also emerged as an *additional relationship* with potentially negative impacts on care. Below, parent desire to influence their child's healthcare and the care process impedes relationship development and participant management of patient care. Specifically, parental pressure to consult outside caregivers negatively impacts patient buy-in and trust in both the participant and the institutions care system.

> F699   Um, and sometimes, not very often, but sometimes I'll have parents input, you know contact me and ask what exactly is going on. I had that conversation with one of my athlete's parents this weekend, um, she had a stress reaction in her foot and right now the doctors like well, it's [a stress reaction, so not serious], and um we're going to allow her to continue to play. And, she's a freshman, so I explained all of this to her. And I saw her parents after the game and I asked you know is she keeping you updated on what's going on and why we're doing what we're doing. And they're like 'oh yea, don't worry about it, um if we don't understand something we will ask her and she's gonna come to you so that she understands what's going on.' Um, which I thought was interesting, um that the, I think that's great that the parents are making the athlete go through it. Rather than them just calling me 'why are you doing this and why are you doing this?' And you know then I can say well, have you talked to, you know your daughter?

M97   I was just thinking about a couple of cases I've had recently that were, and this never happened at my old job because the kids, it's a different clientele [at my current institution]. But recently I've just had a couple of cases where the kids think that, and by kids I mean kids and parents and that's 90% of the problem, but kids think that if they know someone, if they know a doctor outside of [this institution], then they must be better than the doctor that we have [at this institution]. And so therefore they must know more and they must be better and whatever, because they know them on like, they're friends of friends or whatever. Um, and I think once that happens it's so hard to get them [patients] to reign back in. To be like our doctor makes the final decision because our doctor's overseeing the care of the student athletes at X. So great, you want to go see somebody else for surgery, fine like that's your prerogative, I don't have any control over that. But the bottom line is that our doctor has the final say, and he's going to go with what we think because we know each other, right? Once they sort of go outside of the bubble it's so hard to reign back in. And, that just like recent experiences I've had that are, it's tricky. Cause then you don't have the buy in.

M115   So, there were 2 cases recently...And so they [parents] wanted to fly [athlete] home to see the doctor that they're friends with. And so they did for a very routine injury that I probably wouldn't have even had him see a physician for. But there was this scene being made, right? Um so then [patient] comes back and just falls off the radar. Doesn't come in for rehab and doesn't do anything and then is like 'can I get cleared?' And I'm like where ya been? Um, so that was one case and it was just, clearly a situation of the parents wanting to have [patient] see people they knew. And then another was [patient] kind of had a weird case where [they] had [a knee injury], like as a child. Um and then since then had had like a series of knee problems, like before coming to [this institution]. And then ended up seeing our docs and they said actually you have a meniscus tear … Um, and our doc was ready to do surgery which was fine, but [the patients] dad was friends with another doc…and so wanted him to do it. So, again like not, not necessarily like a case of looking for a second opinion, parents just like already knew people and wanted [the patient] to see them.

J   *So then it's the parents that are kind of driving that ship as opposed to the kids.*

M134   Right, precisely. So then it's hard because getting them back on. The other problem is that like neither of these particular parents have any medical training or know anything. And so then they don't ask the questions like ok so who's going to do the rehab? And like what's the follow up care going to look like? And sort of like those things that we would think to ask, they don't think to ask. And so then you just have this like, out of the bubble medical information coming in with no plan for [patient] follow up or anything like that. Um, and so then reining them

[patients], again back into the bubble to then get the buy in I think is harder.

Round two also expanded *additional relationships* to include physician influence,

encompassing patient desire to seek a second opinion from a physician.

A318   And sometimes as you know, if they [patients] aren't gonna buy in to your plan at all, some patients, which I've experienced a little, but more in the Midwest, is the doctor influence is a lot larger than what I was used to at my previous clinic. So, sometimes kids will be like, 'all right, well, I like where we're going, but I still want to see a doctor'. And I'm like "well, a doctor's not going to change anything." So there are times where I'll actually be like "alright, lets see the doctor."…We kind of, we skip that step a lot. Which I mean it's a nice step to have. But um, at the same time it has been a unique aspect of sometimes just having the doctor look at them and say 'yea you're on the right track with where things are', um, you know, that will really change for that patient, that changes a lot of things. And um, for those individuals that have to hear it from a doctor.

After round one *additional relationships* encompassed the interaction and

influence of other injured patients, teammates, and/or athletes, on patients and the care

process. Round two provided additional support for these factors, clarified the influence

of social support networks, and introduced the often-challenging influence of physician

and parental involvement on the care process.

In summary, **patient variables** continue to capture features unique to the collegiate

athlete population group and each patient. These variables help define how participants

understand and interact with their patients as they establish relationships and navigate

through patient care. **Patient variables** are further elucidated by *concepts sport valuation*

and *additional relationships*. Round two highlighted how *sport valuation* encourages

sensitivity to patient situations and how *additional relationships* and effective care

depend on participants managing and integrating these relationships throughout the care

process. The final **contextual factor** linked to creating patient relationships and carrying

out the care process is ***athletic trainer variables***.

Athletic trainer variables

Whereas patient variables capture unique elements of patients' personal context

and character, ***athletic trainer variables*** comprise participants' personal and professional

experiences, and the effect these factors have on their lives and practice. In round two,

participants speak to specific experiences that shape their professional practice. Clearly,

a multitude of experiential factors influence approaches to practice, some obvious, others

discernable upon reflection.

> M1013 I was trying to think of like specific things that have really changed and
> shaped how you practice, but I don't think there's, I think it's a more fluid
> process than that. I mean I'm sure there, I'm sure if I thought really hard
> for a long time I could come up with specific, like cases or specific people
> that have like changed how you practice. But I really think it's more of a
> gradual, like you learn a little bit as you go every time and you don't even
> know it's happening, right. You just all of a sudden realize that you're
> practicing differently than you were three years ago and you're not even
> really sure how.

Participant experiences that arose during second round interviews continued to

support two _concepts_ of ***athletic trainer variables***; _personal influencers_ and _professional_

influencers.

Personal influencers

Personal influencers continue to represent distinct personal experiences

(familiarity with a patient role, experience with injury or illness, and/or previous work

with an athletic trainer due to injury) and their effect on care. Gaining additional support

in round two, these influences highlight how distinct personal experiences impact

establishing connection and trust.

F819   I think from you know, how I was treated through my injury, um. When we first found out that I got hurt, my parents didn't tell me right away, and that really upset me that they knew what was wrong. And I know now, I mean I know they were trying to get everything lined up and wanted to make sure that everything was ok before they dropped this bomb on me that I was going to have to have surgery and miss sports for a year. Um, but I think that's really played a big role in my focus on trying to be up front with athletes from the beginning, not only with my athletes but with my coaches to, about how long they're going to be out for, and what it's all going to entail. And it's gonna suck, it's not all going to be fun times. Ah, but then you know it's not all going to be bad either. You know there's going to be good days and bad, and I think that experience personally, has led to me trying to make them aware of what's going on right away and then making them aware of all of the options too, um, with their care. Not making them feel like this is the only way.

F850   I think another part for me is making sure they're being treated as a whole person, um not just an athlete. Cause you know I wish that I had the resources they have when I was going through my injury, um so I try to make sure they're aware of the counseling center…or like if the treatment isn't working here's what we're going to try next. You can go talk to the nutritionist or we have a chiropractor that comes in. Making sure they're aware of all of the opportunities and options that are available to them.

K695   Um, and people like that, that have gone above and beyond, I think have really shaped me into who I am. And some of them are the reason I'm still here today. Just because of that. But also, you know being away from home for the first time for a lot of kids is really hard, and I think that they need somebody that can kind of step in for their mom sometimes. And I needed that too when I first came, when I first went to college. So I'm really conscious of that, and I know that…having a mother that's constantly worrying when you know your kids not there, that they want to know that their kid is safe too. So I think stepping in and being that role, you know…because I would rather be there, be with them [patient], to know that they're safe, rather than sitting at home waiting for their roommate to text me, and say 'yea, everything's ok.'

As illustrated above, the significance of personal experiences (familiarity with a patient role, experience with injury or illness, and/or previous work with an athletic trainer due to injury) on participants work with patients is elevated in second round analysis, and is now integrated into the understanding of *personal influencers*.

Personality. *Personality*, a <u>concept</u> of <u>personal influencers</u>, details the impact of participants' personality and interpersonal characteristics on patient interaction and the care process. Round two exposed personality as a driving force behind participants approach to relationship development and provision of care, as shown here:

> A222 I've found especially in [the] Midwest, I have to really, for females, I have to really tone myself down, even though I don't think of my, in this area, that can be hard, I'm not outgoing, but for them I'm too dominant as a male. And some of the females have really struggled with that. So I have to really kind of tone that down first before we can really get deeper and try to define things. So within that I've had some situations where it's like hey like, it's just not working well. And even [at my previous job] I had some females, it's like, alright, it's not working well, like can we shuffle things around to where maybe I exchange patients with my you know, one of my co-workers where you can get the care you need, and still you know, cause they'll just shut down personality wise, and it's not personal it's just how things are and so it's, at the end of the day it's about them getting the care they need and about that student athlete or patient getting better. So, in that it's, kind of getting your pride out of the way and saying aright, I'm not here to make myself feel good, it's, I'm here to help others get better. And so, how can we make that happen…And if the patient's gonna shut down completely and not really, you're not getting anywhere, then it's, in my opinion, time to, I don't want to say shuffle the deck, but make changes. You have to make those changes of maybe it's a different personality. Maybe cause, if the patient's going to shut down and not buy into the system then you're not going to get anywhere.

In round one, *personality* detailed how participants approached patient interaction, addressed patient resistance or facilitated patient awareness. While these did not receive additional support in the second round, the influence of participant personality on developing relationships arose. Personality continues to capture the impact of participant personality and interpersonal characteristics on patient interaction and the care process. In addition to *personal influencers*, *professional influencers* garnered additional support in round two data.

Professional influencers

Professional influencers encompasses educational and clinical learning experiences within participants' Athletic Training Program (ATP) as well as prior professional job experiences garnered additional support in round two. Deconstruction of second round data supported creation of two properties, student and employee, reflecting participant' academic and professional experiences respectively.

Student. Student embodies participant experiences within their ATP and with clinical preceptors (CP's) as an athletic training student (ATS). Experience with CP's continues to have a significant presence in second round data, informing how participants approach patient care and value patient relationships.

> M915 I think, well like when you're a student you don't have a, you don't have like a mode with which you operate, right? Like you're just soaking it in and trying not to screw it up. And so like you're, you're sort of, you're a sponge for better or for worse like, you're taking in probably good things and bad things. But then I think, like all you can hope for is that you take like the good things from all your preceptors, right. And I know that the best preceptors that I had were ones that were, personable isn't the word that I want to use but, personable like with the athletes as opposed to, like I had one who was like just cut and dry and like there was no talk of life outside of sport. And like the kids didn't respond to that, and I didn't respond to that, so like, I knew that wasn't the way to go. Because the athletes would tell me as the athletic training student that like, that they just didn't have a great relationship, right. And so, I think we're ultimately just formed by all of our experiences but you'd hope to take like the best from all of the people you work with.

> F840 …one of my former preceptors was like 'you're here to do a job, they don't need to, you're here to, you don't need to do anything with them beyond health, just take care of them and go home.' Um, I don't think that's the best way to facilitate buy in or gain their trust, um or create those relationships. They need to know that you're emotionally invested in what they're doing…um, that you do care on some level.

> O673 Where I went to undergrad at, the head athletic trainer there was very, strict. It was very much a ah, you know come in, do your treatment, get out type of [person]. And ah, while I didn't dislike that really, when I got to ah, when I rotated to a different kind of preceptor who was more, um talkative, more social. [They] had better compliance in my mind and also

people [athletes] were more comfortable coming to talk to [them]. And that was big for shaping how I wanted to, whereas my first, the stricter athletic trainer, you know everyone, the athletes were all scared to talk to [them]. And I felt like that was bad because you know that means that they were hiding maybe something that was maybe a little more, uh, maybe worse than they thought it was and they were trying to hide it because they didn't want to go talk to [the head athletic trainer]. Whereas the more social athletic trainer who I learned from, um you know they [patients] weren't afraid to tell [them] anything. And they weren't afraid to say anything and then, yea [they had] to I guess, take a little bit more time to kind of discuss whether that's a huge issue or small one, but at least [they] knew about everything that was going on. And I thought that was important. You know, the knowing at least if somebody's having these problems, even if they're small. As opposed to people being scared of coming in to talk to you which I think would be a huge barrier in patient care. And that definitely shaped how I was.

O739   I do think that [establishing relationships with patients] is learned through the [CP] connection. I think, you know, what kind athletic trainer you want to be, how social you are, how you want to do that is learned through your CP's. Which I really appreciated the fact that I had like 13 [CP's] when I was an ATS, because we did a lot of rotating. But I appreciated that actually because it gave me a lot of different views and helped develop kind of the style I wanted to develop. You know I talked about the head athletic trainer, and then I talked about you know, one of my primary [CP's] who I really base myself off of, but it's really a combination of everyone. As far as ah, how I developed who I am [professionally].

L715   Like I said I think it started my senior year when I was [an ATS], I had 2 ACIs that ah, you know basically allowed me to act like a certified, and take individual athletes through rehab and things like that. So I think that's where that seed got planted where, you know, building those patient relationships to improve, increase patient outcomes. It was where it started, and you realize, you know that having a good relationship just increases everything. And then just as I've worked throughout the year and we just keep, I mean it just keeps growing. The fact that having good relationships improves outcomes. And it keeps growing from there.

K511   I always, I had an athletic trainer in college who very much made you a student of your body. So when you got hurt he sat at your table and showed you pictures in an atlas, which kinda redundant for an athletic training student, but, I saw him doing that a lot with other people. And I try to do that with students just, cause I can say you know, you sprained your calcaneofibular ligament, and they're like 'say what? English please?' And I can point, it's right there. But if I can show them I find

then that works out a lot better because I think a lot of college athletes are visual learners just by nature. So for me I like, I like to do that a lot, pull out an atlas.

Participants recognize the value of the athletic trainer-patient relationship and the importance of passing this knowledge onto ATS's. However, ATS's must be responsible enough to take an active role in their education and be open to realizing the value of the participant-patient relationship.

> L749   I've actually had the opportunity to work with a couple of athletic training students here and I stress that while you're taking an athlete through rehab you need to get to know 'em, you need to you know, build those relationships because that's huge. So yea I think that should be something that's put in athletic training programs….So I don't know if that's actually being taught in athletic training programs or not, so. Um, I think it should be because I think that's a huge part of what we do, and I think that's what the profession should do. Will it do, who knows?...It's a big part of what we do is building these relationships.

> L732   I mean I can go back to, our undergrad programs were run where, if you're getting some seniors that don't take initiative or don't, you know buy in or give everything they can to their education they might not ever experience that [having good relationships improves outcomes]. They [senior ATSs] could just go through the motions almost and not really, not really notice it and appreciate it when it happens.

The influence of participants' experiences as a *student* and their interactions with CPs cannot be overstated, however round two data analysis also added support to prior experiences as an *employee* shaping professional practice.

Employee. Employee, the second *property* of *professional influencers*, encompasses on-the-job experiential learning. Direct learning from patient care and professional practice experiences informs adjustment in participants' approaches to care to better meet patient needs.

> M927   And then once you become a professional, I think the big difference is like once you become a professional then you're learning more from, I mean you're probably learning some from the student athletes when you're a

student but mostly you're I think looking to other athletic trainers to like get, to get it right, you're a student, you're trying to get it right…Um, and then once you start um, like practicing on your own I think you, I anyway felt like that's where I started like learning from the student athletes, right. And often times you learn from things where either like there was a bad situation or like things could've gone better, like obviously those are the cases you remember the most. Um, but I think that to me is a big difference from like student and professional, is like I started learning from student athletes. Like these are the things that work, these are the things that don't work, they respond better if they know what's going on. Like, I don't think my first year when I was working in a high school, I don't think I ever told anyone anything beyond basic anatomy. Like, because I was just young. And now I do a ton of that, like we just talked about patient ed stuff takes longer than the eval does.

L676   When you're working with those athletes that really buy in and they give you their complete trust, and then you see them succeed, um, that's what drives me, that's what keeps me doing what I do. Um, just seeing their reward for putting all that hard work in. That, cause that's the ultimate goal for me is I enjoy watching them be successful, just seeing their hard work pay off. So those are the biggest things that kind of drive how I work with ah, with my athletes. Just cause I want to see them, see them succeed. Cause when you're close to them and you feel good for their achievements, and watching them succeed is something, I mean I cant even describe it, how, it makes you feel good.

Subsequent to round one data analysis, *professional influencers* comprised learning from classroom and clinical experiences within ATP's or other academic programs, experience with differing levels of competition (i.e., high school, collegiate, professional), and accumulation of clinical experiences. However, richness of participant experiences from round two generated creation of two *properties*, giving additional depth to *professional influencers*. *Student* captures participant experiences as ATSs within their ATP and with CP's, whereas e*mployee* embodies on-the-job experiential learning.

To summarize, second round analysis deepened and strengthened understanding of **athletic trainer variables**. **Athletic trainer variables** are **contextual factors** that capture personal and professional experiences and opportunities and the effect these have

on professional practice. _Personal influencers_ influences participants approach to patient care and valuation of establishing a connection and trust. For example, although participant _personality_ can be a barrier to fostering a connection, recognizing and managing its impact in an effective manner supports patient outcomes. Embodying educational and clinical learning experiences, as well as prior professional job experience, _professional influencers_, receives additional support in round two and supports creation of two _properties_, _student_ and _employee_. Remaining loud in round two, clinical learning experiences as a _student_ informs subsequent approaches to patient care, and influences valuation of caring, connection, and investment in patients to facilitate care. On-the-job experiential learning as an _employee_ informs adjustment in participants' approach to care to better meet patient needs. These varied **contextual factors** continue to influence **establishing** and **navigating** a working alliance and achieving **buy-in** with patients.

<div align="center">**Emerging Processes**</div>

Process was heavily present in second round interviews and data analysis. Open and axial coding procedures during analysis of second round data allowed process statements to be uncovered in relation to collegiate athletic trainer experiences of a working alliance. Refer to figure 3 for the conceptual map of participants' experience and major processes evident from round two data analysis. Processes remained present within **establishing** and **navigating**, gaining additional support, as well as between **categories**, linking **establishing**, **navigating**, **buy-in**, and **contextual factors**. What follows is a description of the processes that arose during analysis of second round interviews.

Numerous process statements were present within **establishing**. *Athletic trainer*

commitment to support care and generate positive outcomes leads to *expectations of*

patients. Athletic trainers encourage patients to seek answers, provide explicit

instructions, check on patient progress, and seek ways to support accountability, and then

hold firm *expectations of patients*.

F580   I try really hard to force them to take responsibility and accountability. Um, and if I don't have to straight up give them the answer, I wont. I'll say, oh that's a really good question, what do you think? Like how are you going to find the answer to that?

F590   You know with my athletes it might be as simple as no, I'm not going to go pick up your prescription for you, here's the directions to the pharmacy, here's the sheet to give them cause it's athletic related so you don't have to pay, but you need to be responsible enough to not loose this sheet on the way to the pharmacy, find the pharmacy, and go pick up your medicine.

F594   Um, one of my girls, we were at a tournament., and she knew we had 2 games in a row and her knee always hurts more playing 2 games in a row. Um but not only does she not recover well, or you know think about what food she needed to eat and get her legs up, um, she went and explored. Um but she forgot to take her medicine, um one dose each day, and I was like "listen, I'm sorry that your knee hurts, what, I mean what do you want me to do at this point? We just kind of gotta get through it." Um so then this week I've been, I've asked "are you taking your medicine?" 'Yes, yes, I'm on it, I promise, I wont ever forget again.' So I think part of then too, but letting them make those mistakes and dealing with the consequences and saying "well, sorry, I cant, I cant help you out of this one."

M408   …my sort of clinical philosophy of like I'm going to help you help yourself get better. Like that's how I operate, and so if you're not doing that part of it then you're not going to get better. But, that's more or less the bed you've made. Um, and obviously I don't then drop them off the face of the earth, you circle back you try to pick them up and you try to make it better. Um, but I think that from like initial assumption that I make is that they are going to help themselves get better. And I think most of them do. And then you find out the ones that aren't going to, and you make another strategy.

K266   Um, like sometimes if its not clicking after, you know, I understand there's a lot of anger and resentment [after injury], and like no doubt I completely sympathize with that, but if its not clicking after a couple weeks like

sometimes I'll sit down, like with them [patients], and be like what can I do with them. And you know is there something that I can do to help, you know get you on board with this, make this a little easier for you. Because, you know, obviously you know, it's not fun for me when I've gotta pull teeth to get you to do this. I know it's not fun for you to be in here, it's not fun for anybody to be in here. Um, like what can we do to get this machine a little more oiled? And sometimes they need different stuff. Like sometimes they need someone to help hold them accountable, and you know, if they voice that and say you know that's what I need, um, and I'm more than happy to do that. And some people are just like that, they need somebody to make sure, help count out that 10. And if they let me know that, that's fine. But when they're not talking to me about it or they're not communicating to me about it, then it comes off as you know, I don't care. So, I try to have that conversation with them [first] before I, you know, break out any other tools.

Participants begin with commitment to patient care by adapting to promote outcomes and patient responsibility, which then generates firm expectations of patients to be accountable to their care.

Attending to *role induction* as part of **care contracting** can facilitate or inhibit **establishing** *connection*. Knowledge of participants' professional capabilities initiates *connection* and encourages patients to seek care, whereas inability to attend to *role induction* can inhibit **connection** and seeking care from participants.

M145 So one [patient], we didn't have, like back to the personal versus professional relationship, we didn't even really have a professional relationship. Like I had met [the patient] at physicals and then [the patient] hadn't been hurt so I hadn't seen [the patient]. And again, part of that is a result of my weird position where they're [at practice 2 miles away and I'm not at practice]. So I don't know until they have a problem. So [the patient] ended up going home [for surgery and physical therapy care]….And I was like, whatever, let me know when you want to [participate] and I'll have the doc see you…. Let me know if you need anything from me. Cause it was very clear right from the get go with [this patient] that like, nothing that like I could say or do or offer for information was ever going to be good enough.

M159 Um, and then the other kid, we had a little more, I wouldn't call it necessarily like ah, I didn't know [the patient] super well but we had worked together, [the patient] had been injured before with sort of like

minor things um so [the patient] knew like what we do here, like that we can do rehab all of that stuff. And so, [the patient] ended up just doing the surgery outside and doing the rehab with us….So that scenario ended up working out. But, again I think that part of that is because we already had that relationship built so like [they] knew that that's what I was there for, that that's my job. Um the other kid, I don't know, and I have no idea what [their] experiences with athletic trainers have been in the past, maybe [they] had never worked with one, maybe [they] had had a bad experience. I have no idea. Um, but we didn't have that underlying relationship so it wasn't like 'oh I'm hurt so I go see [Maeve].'

Furthermore, attending to *role induction* can also generate patient **trust** in their care provider.

F183   I could make sure just to take time then to introduce myself and educate them [patients] more of my job. I think we're getting better, there's more athletic trainers in high schools, but I think sometimes even if there is an athletic trainer they're not there all the time so they don't, still don't quite understand what my job is and um, so I think just some better education on my part. Um, could help [create comfort].

Without a **connection**, participants are readily able to move to other professional obligations, such as working with other patients, responding with *boundarying* to protect their professional time and obligations.

A19   When I don't have a personal connection with a patient and they aren't doing what they are supposed to be doing, I don't have as hard of a time moving on from them and focusing efforts on patients who I do have a personal connection with.

Process beginning with **connection** and resulting in **establishing *trust*** continued to emerge in round two. In the presence of a **connection**, participant-patient interactions become less formal and more personal, further establishing **trust**.

M14   The biggest thing that comes to mind right away is like when you already have a relationship built with someone it's, the tone of conversation changes and becomes more casual…Like when you just meet someone for the first time, somebody comes through the door and you haven't worked with them at all and you're like, the first thing I try to do is like establish a relationship of somewhat professionalism. Whereas when you already have, they already trust you as a professional you already trust that they're

going to do what you ask them to do, you already have that relationship built, then it's almost like, that wall is broken down and the conversation becomes more casual. Like, you'll be doing treatment and being like 'how was your day? What did you do in class today?' Like, that sort of, more personal conversation. As opposed to the first thing being immediately like some sort of professional rapport. Because that's already been built….it's just the delivery. And like the whole tone of conversation I think is different.

Moreover, a personal *connection* encourages participants going above and beyond professional responsibilities, thus proving *commitment*, which helps **establish**

trust.

L10   If I have a good relationship with an athlete, um, there may be days like say if they were, they were off from practice and I wasn't even scheduled to come in and they sent a text or called me and say hey I need, I need a little, I need something looked at or I need treatment. I might be more willing to go in on an off day for 10-15 minutes and kind of work with them a little bit. Whereas opposed I wouldn't say that if I didn't have a good relationship with an athlete I wouldn't do it, but it'd be, I'd try to make it so that I had multiple people coming in instead of coming in for just that one person. But if it was for something that was deemed an emergency, not an emergency but you know something that was very pertinent, I would still go in. But I'd be more likely to go in and give them a little bit of extra time, or my free time, if I have a good relationship with them.

L25   If I feel closer with them you know I'll be willing to you know go in and help them, even if I just work with them a lot, it's one where if it's a kid that you know is always in the training room and he's always getting rehab or treatment done and you're more, I'm always more willing to go in and help them, where if it's some kid that doesn't even play and doesn't even come in to the training room for anything text me on a random day saying 'hey I need some kind of treatment', then you're like well, you can ice, you're fine to ice and we can do whatever treatments you need when I'm in for before practice.

A9   I spend more time with patients when I have a personal connection with them. I am also more willing to do things for them and do things for them when they ask. Put in the extra effort. More willing to go above and beyond with those patients I have a personal connection with versus those I don't. It's just easier to do extra for those who I have a connection with….it's easier to put more time in, I am willing to. And it's not that I

don't put time into those patients who I don't have a personal connection with, it just isn't as much time.

Sharing of self while **establishing** *connection* helps prove <u>credibility</u>. This adds further support to the link between *connection* and *trust*. Sharing personal experiences about sport participation creates a shared reality and conveys knowledge of sport, thereby **establishing** patient *trust* in participants' professional ability.

A834   Last week I had a, ah track [athlete] come in….But um, [they] came in and was like 'I didn't really want to like come in and see you because, I felt like you were going to hold me out from running.' And it's like whoa, hang on. Um. So, I actually ran cross country in college so having that experience, I play that card all the time. And even though it might not mean anything at all in regards to what I'm going to do professionally as an athletic trainer, but having them understand, hey, like….But, having, letting them know you understand the whole 'I need to run every day cause if I don't run every day I'm not going to be successful'. Which there's a lot of truth to that as runners. You have to put in the time and the mileage. So, it's…letting them know hey, this is my personal experience. I know you have to be out there and I'm not here to hold you out, it's I'm here to keep you going. And we're going to do everything we can to get you out there and to get you going. But having them understand that you, you know their sport is huge. Of trying to understand that and having that personal experience.

Establishing coach and patient *trust* arose as a circular process within the second round. Generating coach *trust* in participants was critically important and influential to **establishing** patient *trust* in the participants.

A753   Um I think getting the coach to buy in and being on the same page as the coach is a huge aspect cause it's, I don't want to say it's a husband wife relationship, but it is kind of a parent relationship to that student athlete in the collegiate setting. Especially of, if coach is saying one thing and you're saying another, and you're not on the same page that, the student athletes only going to buy into the person they trust. A lot of the times they say we're recruited by the coach, so they're not going to buy into your system if, you know coach wants them to do something else.

Last, a comfortable *environment* and the presence of a *connection* generate

patient comfort to share concerns (medical or otherwise) and *trust* what they share will

remain confidential.

> O691 …you know I do try to be a little more social in my training room. A lot
> less, like I said, I don't really like to tell people you know do this or get
> out. So I don't do that, I usually you know try to incorporate the social
> part in there and that way they're [patients] not afraid of telling me
> anything. I also think it's helped out a lot…you know even some things
> that some people may be embarrassed to talk about or to ask about, I don't
> really have that problem….And I think that's another thing the social
> aspect has really helped with, is that you know, there's no shame, which
> can be a bad thing , but you know it can be a good thing as well, because
> you know they're not afraid to tell you things that might be embarrassing
> knowing that you know it's going to stay between you and them and stuff
> like that.

Within **establishing**, *athletic trainer commitment* to support care by adapting in

various ways to promote outcomes leads to firm *expectations of patient* accountability to

their care. *Role induction* can initiate *connection* and lack of attention to *role induction*

can inhibits *connection* and seeking care from participants. Furthermore, attending to

role induction can generate patient *trust* in their care provider. Without a *connection*,

participants are more able to move on to other professional obligations such as working

with other patients, displaying *boundarying*. In the presence of a *connection*, participant-

patient interactions become less formal and more personal, further establishing **trust**.

Moreover, a personal *connection* generates participant willingness to go above and

beyond normal job responsibilities, proving *commitment*, and **establishing** *trust*.

Creating a shared reality between participant and patient by *sharing of self* proves

credibility by conveying understanding of patient experiences, further generating patient

trust. **Establishing** trust is also a circular process. **Establishing** coach *trust* in

participants was critically important and influential to generating patient *trust* in

participants. Additionally, **establishing** an *environment* conducive to a connection

facilitates patient comfort to share information and trust that it is protected.

Process was also present within the **category navigating**. Second round data

continues to support a link between *educator* and *partner*. Providing patients information

about aspects of their care while in the *educator* role enables them to be *partners* and

offer input when solicited.

> F652   I think some of it [timing of patient input] depends on the athlete, and their
> um, level of maturity and understanding of what we're trying to do. Um
> and then at the same time and how comfortable I feel that I, cause like I
> said I like to go through the exercises and teach them. Which, teach them
> why I'm giving them these exercises and make sure they understand that.
> Um, before I let them choose which ones to complete. Um, and I've
> talked to my athletes about that, especially when I'm sending them home
> with a rehab plan, and over fall break. And some of them have asked you
> know, why cant I do these together or why cant I do two of these on the
> same day. So just making sure that they're educated on [what I'm asking
> them to do].

Participants also take on the **care role** *educator* to encourage patient control over

their care by *collaborating*. Offering patients information about the injury process

generates understanding and ability to *collaborate* on care decisions, exerting some

control over their care.

> M861   Well I think, and again coming back to ribs because that's what I always
> think of for long-term problems. I think once they [patients] understand,
> and can grasp and they get past the denial and then they accept that like if
> I continue to [participate] I'm going to get a rib stress fracture….Once they
> understand, and we go have like have a whole spiel with the anatomy and
> how bones heal, and …Once they like get that and can fully grasp it,
> which is not always immediate and that's fine I don't blame them, like
> once they get there and can really wrap their head around all of that, then
> they can make decisions about what level of exercise is appropriate
> without necessarily having to have me tell them every day. Then I can
> give broad guidelines like today, or this week we're going to increase
> volume of biking. And I don't have to be like today you're going to bike
> 20 minutes and then tomorrow you're going to bike 25 minutes because
> they get it and they grasp it and they know that if it's painful while they're

doing it or later than that was too much and then they can make decisions on their own and then I think they feel less like I am the czar of rehab, you know. And more in control of their own decisions. And then it's almost like I make guidelines as opposed to like daily prescriptions.

J   *They're (patients) making those decisions for themself now because of understanding as opposed to you making it for them.*

M   Right, exactly.

Also emerging in round two, participants take on different care roles when **navigating** various kinds of ***patient resistance***. When patients display a lack of responsibility, participants counter by unilaterally determining and directing appointment times as a <u>*director*</u> to progress care.

L359   Yea when they're coming in for treatments I let them kind of have a little bit more control. Like ok what's your class schedule, what times work good for you. Ah, at least during the initial phase um, of that. And if they're you know, consistently coming in when they say they're going to come in, they're always good about it, then I kind of continue it. But, on the other spectrum of it, if they're ones that say 'oh yea I'll', they'll tell me I'm coming it at 11 o'clock to do treatment and they don't come in. I'll give them a couple of more chances at that but if they keep doing it then that's when I take that control away and tell them that they have to be here at such and such time.

Participants also respond to ***patient resistance*** by providing patient education regarding *purpose of treatment* as an <u>*educator*</u>. Generating understanding of the effect and *purpose of treatments* encourages patients to overcome resistance to seeking and completing care.

M604   Um, I think the biggest, I guess like barrier but also just like, I guess the attitude is the barrier, but the attitude that like 'I'm so busy that I don't have time to take care of myself.' I think that's a common um, barrier. And I think the message that I try to portray is that like, if you don't have time to take care of yourself then you don't have time to participate in this sport. Like the two things are one and the same. Like, you can't expect your body to, you know, compete at this really high-level if you're not going to take care of it. Um, and that's, sometimes it's that blunt, like just saying that, and sometimes it's like more, over a longer term just trying to like portray that message, right? That like these are really important things, I know it takes five extra minutes out of your life to stretch after

you [practice], but you're not going to have back pain if you do. So, you know, sort of the underlying message is always like, yes there are time constraints, everybody's busy, but these are things that you have to do…And like working with them over time, the ones that are a little resistant. Because I do think, I mean everybody's busy, right? Everybody has time constraints, but um knowing them, and then reiterating that like your time, the time that you're spending to take care of yourself, is not time wasted or time lost or time whatever. It's things that you have to do if you want to be competing in this sport.

When met with a lack of buy-in, another kind of ***patient resistance***, participants responded by *soliciting* patient input as a *partner* and again turning to the **care role** *educator* to facilitate patient understanding of the effect and *purpose of treatment*.

A571   If I'm not getting that full buy in it's, stepping back, kind of debriefing, reassessing, and saying ok, like, what do you think about the plan? Is it working is it not working, um, what do you think will work better? And some of it, you know, you're not there to defend what your doing, and sometimes you have to and be like hey, this is why we're doing that. So it comes back to the patient education. 'Cause if they don't understand or they don't know why, then you know, why in the world am I going to do an exercise and be motivated to do it if I don't realize why it's going to help. Or why you think it's going to help me. Um, so, yea for me it's all about kind of taking that step back when you read that feedback and, debriefing it.

To summarize, links arose among the ***sub-categories*** and *properties* within **navigating**. Participants take on the ***care role*** *educator* to facilitate patient understanding about their care, which enables them to be *partners* and contribute when *solicited*. A new process in round two; offering patients information about the injury process as *educator* also generates understanding and supports their ability to *collaborate* on care decisions and exert some control over their care. When met with various kinds of ***patient resistance***, participants respond by taking on different ***care roles***. Encountering ***patient resistance*** in the form of lack of responsibility stimulates participants to take on the *director* role to progress care. Participants also respond to *resistance* by *soliciting* patient

input as a *partner* or by generating patient understanding of the effect and *purpose of treatments* within the *educator* role. **Establishing** and **navigating** were the only **categories** to exhibit processes within their ***sub-categories***, *concepts*, and *properties*. Numerous processes were present between the major categories: **establishing**, **navigating**, **buy-in**, and **contextual factors**.

New in round two, ***connection*** facilitates participants fulfilling the director role when **navigating** care. **Establishing** *caring* to uncover patient challenges helps participants gain a better understanding of patients, enabling them to respond in a manner supportive to the patient and the care process. Here, participants' display *caring* to uncover patient challenges, and then move into the care role *director* to progress the care process.

> A98   If they're [patient] frustrated, I think a lot of it is sometimes they just need someone to hear and understand that they're frustrated with things or that they're not happy….Um, and try to get that kind of information out of them so you can kind of discuss and say ok, lets break things down. You know, it's going slower then what you'd hoped. Yes, we were kind of trying to be aggressive with treating this but your bodies not you know, adapting to the aggressive so lets slow things down and these are the goals we're going to work on. So for me, I try to break it down into manageable steps. So ok, for the next 3 days this is your goal, or before I see you tomorrow these are the 3 things I want you to work on you know, of more range of motion, stretch, and you know walking heel to toe. Whatever it is within that. That's, like the 3 things, those are your 3 things to work on so you can focus on that and hopefully my goal with that is they're not caught up with the success they're not having and kind of focus on the goal and task at hand instead of the negative.

Attention to *caring* and *holistic appreciation*, appreciating and acknowledging patients' differences and roles besides that of patient, promotes taking on the *partner* role and *soliciting* patient input to inform changes to the plan of care that resonate with patients..

A151 …an opportunity for them to express kind of their frustrations, they're, I don't wanna say, vent is the best way I can describe it. Because I think sometimes as individuals we only see them for 2-3 hours every day, but they have to be able to deal with whatever they have going on for 24 hours. And then a student-athlete or athlete, patient that can be the worst thing for them cause they're not able to do what they can normally do, and so then the frustration of performing at a higher level and now not being able to perform at that level is you know, they live with that all day long of, does it bother them while they're sleeping, does it not, how do you kind of say hey, ok, you didn't get sleep last night ok, why is it? Do you have pain? Or you rolled over onto your shoulder and woke you up in the middle of the night for the 4th time. So, how can we kind of address that and talk about some different things so that at least they have someone to talk to and someone that hears them, understands it, and they can kind of get that off their mind off their shoulders and move on.

Connection enables participants to recognize and value patient experience; encouraging them to *collaborate* to jointly identify and integrate care decisions that are meaningful to the patient.

L328 The closer connection, I'll kind of let them dictate what they want to do. Even the ones I don't have a close relationship with I'll ask like, I'm always open to asking them like what uh, what sports specific stuff do you think will help? Cause like I said I, I mean I wouldn't be able to tell you, like I've got a couple baseball guys, I wouldn't be able to tell you what it's like to catch a ball the whole game, or try to pitch, so I'm always willing to hear what they think might need to be, you know what will help them return to sport. Even with the volleyball team that I work with here and in the past, I have no clue how that stuff impacts, or what it's like to go through a practice. I lean pretty heavily on them as far as any sports specific stuff.

Responsiveness, an aspect of *connection*, enables participants to be *partners* with patients. Listening in a manner that lets patients know what they are saying and feeling is understood allows participants to uncover patient wants and desires and seek patient input as a *partner*.

M246 Um, I would say active listening is probably the biggest thing (to learning about patient needs and desires). Um because everybody, especially on a team that's so big. Everybody's goals are a little bit different…And so like I think getting a little bit of their [patients] story, like within the team,

um. I'm thinking of like in the spring when we're, when they're racing every weekend and how things are managed a little bit different. Um, but you don't know, like you don't know how to use their [patients] goals to make treatment goals, to make rehab goals, to make you know ultimately return to play goals if you don't know what they are. So like, you have to ask.

In sum, the processes between **establishing** and **navigating** began with *caring*, which helps participants uncover patient challenges and then move into the care role *director* to progress care. *Caring* and *holistic appreciation* promotes taking on the *partner* role and *soliciting* patient input to inform changes to the plan of care. Recognizing and valuing patient experience, established with ***connection***, encourages participants to *collaborate* with patients and integrate meaningful care decisions. Finally, *responsiveness* to what patients are saying and feeling allows participants to uncover patient wants and desires, enabling them to *solicit* patient input as a care *partner*.

Processes also occur between **establishing** and **buy-in**. Fostering ***connection*** facilitates patient ***trust*** and results in **buy-in**. These passages speak to ***connection*** first, and then the rest (trust and buy-in) follows.

L379   Initially getting to know them and getting them comfortable working with me and, they see that you know, we're in this together that we're you know working for their ah, for them to get better. And that just helps them, help them buy in. So I would say that's how I facilitate it, just by staring those initial conversations and then getting them to trust and then it just kind of takes off from there.

O633   I think um, there are some patients who ah, maybe don't really, who appreciate the social aspect a little more, and they build the trust that way and not really, don't really care about whether they're feeling better, stuff like that. But they would rather you know, "come hang out" with somebody and do stuff, then be told to go somewhere and do these things because of this. So I think some of them, you know being more social with them would have helped.

Holistic appreciation of difficulties or challenges patients may be experiencing

outside of their patient or athlete role allows participants to attend to these challenges and

promote **buy-in**.

> A546　There's a lot of questions I'll start to ask of ' ok how do you feel like things are going? So kind of be brief and understand where they are as kind of an individual of, how do you think things are going, do you think things are going slow or are they not going slow and sometimes it's related to the treatment course of plan or treatment plan. Some of it's just totally unrelated of well hey, there's problems going on at home, or schools really bogged down right now and I'm [patient] busy with that, or you know there's a lot of other factors you know, we're having financial issues, I'm trying to find a way to pay for this. Or they are removed from the team and there's multiple roommate issues….So I think some of that is breaking it down, asking questions of how are things going, what's going on, um, you know.

One aspect of ***trust***, *credibility*, also promotes **buy-in**. Conveying professional

knowledge and ability by sharing successful patient outcomes establishes *credibility* and

encourages patient **buy-in** to the plan of care.

> A866　I also think um, you know being able to tie in your professional experience as well of you know, earlier I referenced eccentric training for tendinopathy. Of "hey, I've used this before with multiple, you know student athletes"…and you know, them [patients] knowing, ok it works for other people. Um even though there's, some of them care about the research um and you can cite the research and say "hey the research is pointing in this direction right now." But a lot of it is they [patients] want to know does it work, [patients think] 'I don't care what the research says.' It's "hey, this is what research says is going to work right now, and I've used it with other people and it works with other people, this is what I want to do." Um I think that helps buy in a lot of um. And obviously everyone's an individual and specific, you have to tailor it to that but. Um I think that's huge to tie things in and help them understand.

Coach ***trust*** in participants' establishes a precedent that patients seek out and

continue receiving care from their athletic trainers. Coach advocacy for the care

participants provide and showing support for their care decisions encourages patient ***trust***

and **buy-in** to the athletic trainer and plan of care.

K112   I think when they [coaches] can circle to the athletic trainers side and say 'hey, she knows what she's doing, she's not stupid, you need to listen to her, you need to respect her, what she says goes….I think when they step onto our side and back us, that helps tremendously. Because if the coach goes around and says, 'you know [Keeley] doesn't know what she's doing, I don't trust [Keeley], don't go see her.' What are the players gonna do? But if the coach goes and says you know 'if something's bugging you, you can go to [Keeley], she can take care of it, you can trust her, I want you to get better. If they tout you in a positive light, you're gonna have a lot more compliance with your rehabs and stuff.

M188   Um, I think um, I'm fairly lucky in that all of my four head coaches and then their staffs have pretty well bought in. Like they are, we have a really good relationship, and they really trust in both me and like the department in general. So like the resources that we have, our physicians, our dietitian, our chiropractor, like they [coaches] have great relationships with everybody and they really trust that we collectively will take care of the kids. And so I think part of it is when they come in as freshman, a lot of times like it's they'll say something hurts or whatever, my back hurts or whatever, and if they say it within earshot of the coaches, then they get directed to me immediately. Which I think really helps, I think that's huge because they know, then it becomes like that's what you do right. Like, something hurts you go see [the athletic trainer]. Like, this is the logical progression. So I think that's a big part of it from my end. Because I don't see them [athletes] all every day. So they, the people they [athletes] see every day are the coaches and if they [patients] know that me and them [coaches] are on the same page then it just sort of becomes the logical thing to do.

To summarize, aspects of establishing were influential to generating buy-in. A

connection facilitates patient *trust* and results in **buy-in**. Establishing *holistic*

appreciation of difficulties or challenges patients may be experiencing outside of their

patient or athlete role allows participants to attend to these challenges and promote **buy-**

in. Conveying professional knowledge and ability by sharing successful patient

outcomes establishes *credibility*, a property of *trust*, which encourages patient **buy-in** to

their care. Furthermore, coach trust in participants encourages them to advocate for the

care participants provide, inciting patient *trust* and **buy-in** to the athletic trainer and plan

of care.

Second round analysis also highlights links between **navigating** and **establishing**: in some instances participants take on the ***care role*** *director* to generate patient ***trust***.

> O637 um and there are some people where I think being a lot less friendly would have helped. A lot more you know either do this or get out, kind of would have helped. Which is bad to say, because that's definitely not the type of athletic trainer I am, but I do think that I have had patients who would have benefited from that type of treatment…I think it's about how people build trust. You know, and some people can't separate that whole you know that personal aspect from the other aspect of it. So you know where as I can talk to some people about you know the football, the NFL game, you know some people consider that as you know being too social and so they don't comply as much because they don't consider me really you know I guess, I don't know what the correct term is, but in a position of authority.

The *partner* role helps participants **establish** a ***connection*** with patients. As a *partner*, seeking and integrating patient ideas and feedback to inform or guide care decisions allows participants to display interest and value towards patients, aspects of a ***connection***.

> L72 Ah a lot of times it's just going out and just talking with them [patients] and like if they're out there doing rehab you're out there with them….I'll be out there just chatting with them [patients], just seeing how they feel, seeing what they want done. Like if they're frustrated with anything or if they want to try anything new. Um, I mean I take that input… I kind of take all the information that's available to me to, you know, build those relationships and provide the best treatment.

Thoughtfully fulfilling the ***care role*** *educator* can help create a ***connection*** and incite patient comfort sharing concerns or lack of understanding. Offering patient education while establishing an athletic trainer participant-patient relationship normalizes this practice and encourages patients to turn to participants with questions or concerns.

> M842 Having that initial sort of patient ed. session, for lack of a better word, makes it so that door is open for questions, you know. If they come back and something changes or they don't understand something or, a lot of times it's like, they'll meet with the Doc and then they'll come out and be like 'what?' um, but then they know that like you'll explain it to them,

> right? Because you've had those conversations before, so you've sort of opened a door for, that they know that they don't have to just like blindly accept information.

The *educator* role also promotes patient ***trust*** in participants and the care process, as opposed to seeking answers elsewhere.

> L525   Right after the initial injury I'll tell them like 'alright, this is what, you sprained your ankle.' I kind of give them the details, then I tell them, you know recovery time, just kind of explain the whole process, and then throw out the rehab program, and kind of educate them on why we're doing things, or why we're progressing you as slow or as fast as we are. Um, and then just kind of when we get closer to the return to play, you know educate them on what they can expect when they're, they're coming back and they might have days when it feels great. And they might have other days when it ah, it feels not so great. Kind of explain to them that they might have to keep getting their ankle taped or they might have to buy, or get a brace for it. So the educations a continuous, a continuous cycle of information for them. That way they don't feel like they're not getting any kind of information that might help them. Cause if they're not getting information, then they are more apt to go and find it on the internet, and then that just starts that downward cycle of them not, not trusting you, and not really believing in what you're doing.

Care roles link to various aspects of **establishing**. In some instances, taking on the ***care role*** *director* generates patient ***trust***. Seeking and integrating patient ideas and feedback to inform or guide care decisions as a partner helps **establish** a ***connection*** with patients. Fulfilling the care role *educator* can normalize patient education and incite patient comfort sharing concerns or lack of understanding, helping to establish a ***connection***. Last, the *educator* role generates patient ***trust*** in participants and the care process, as opposed to seeking answers elsewhere.

Care roles were also influential to **buy-in**, which received additional support in round two. Patients learn from the instruction and education offered by participants, enabling them to provide feedback, and encouraging them to partake in care. By being a

director and *educator*, first, participants can then *solicit* feedback from patients, thereby

encouraging **buy-in** *actions*.

> F535   So I've been like, the first few days teaching them how all of the exercises go and choosing for them what they're gonna do. And that's what they expect, I think that's what they expect when they come in. But then I like to throw in the, 'k, here ya go, you know what these all are, which ones do you want to do today? You have to choose one from this group, one from this group, one from this group.' …..Um, but, I think I, I see a little bit more, ah, I think ownership, and ah willingness to do the exercises. If they get to have some, some input.

Acknowledging the significance and value of patient contributions encourages

participants to uncover and integrate their feedback to guide care decisions. Embodying

the *partner* role and working with patients to identify and considerately integrate their

needs encourages patient **buy-in**.

> F288   It [giving patients ownership] does help, I think it does help with buy in, I think just because it gives them some control. And a lot of athletes you know, when they get hurt feel like they don't have any control over anything, and their sport is their life and they cant play that so. 'What can I do now? What am I good at now?' And if they have some control over their rehab and getting, getting back to their sport I think that helps with buy in and compliance and that sort of thing.

> A546   There's a lot of questions I'll start to ask of ' ok, how do you feel like things are going? So kind of be brief and understand where they are as kind of an individual of, how do you think things are going, do you think things are going slow or are they not going slow and sometimes it's related to the treatment course of plan or treatment plan. Some of it's just totally unrelated of well hey there's problems going on at home, or schools really bogged down right now and I'm busy with that, or you know there's a lot of other factors you know, we're having financial issues, I'm trying to find a way to pay for this. Or they are removed from the team and there's multiple roommate issues….But um, you kind of, be a little more creative of trying to solicit that information from them and, you know, and from that point, for me it's changing things up of ok, like do you [patient] want more feedback [from athletic trainer], or do you [athletic trainer] want more input from them [patient] of hey pick 3 exercises, or you know would they [patient] rather do stuff on their own if you can trust them to do that, instead of coming in because it's poor timing of when they can actually be there. And kind of, I think it's kind of

being flexible and adjusting, and um, kind of at the end of the day saying "hey, I'm here to help you." It's not about me, it's "how can I help you better? Or how can I help you." I ask that question a lot to people and I think it takes, takes a lot of kids by surprise. Cause it's like 'ah, I'll be good I just need to push through this' and it's "no, how can I help you?"…it's, stepping back, kind of debriefing, reassessing, and saying ok, like, what do you think about the plan? Is it working is it not working, um, what do you think will work better?

Valuing and seeking patient input as a care *partner* builds patient **trust** in

participants and the therapeutic relationship, and encourages patient **buy-in** to care.

F758   I have to say I think the um, well I think also part of them providing input can help to build that trust relationship too. Um which I think then helps with buy in. Um, trust in them doing the stuff for them and value their opinion, they might more easily buy into what I'm trying to do.

O527   But I think a lot of building that trust you know, within me that I know what I'm talking about and have a good idea of why I want you to do this or that. And I think some of that comes along with the fact that I talk to them about you know, how they feel and how they don't feel. Instead of just saying you know you should feel this way by now and if you don't it's just because you're crazy or something like that. I just ah, you know taking their input into consideration I think really helps with that patient buy-in as well because you know, they know you're worried about them as opposed to just kind of you know the injury being something that you treat the same way every time.

Collaborating with patients by incorporating their knowledge and expertise into

care decisions stimulates patient power and control over aspects of their care, thus

inciting patient **buy-in**.

K156   And also you know, I take their input a lot because I'm not an expert on every single sport. Like, when I get to sport specific activities, you know I'd rather talk to them or talk to their coach and 'ok, what's a good drill to incorporate, you know balance into shooting, or cutting into shooting?'….I think allowing them to be part of their rehab and allowing them to, kind let them think they're helping themselves progress.

Fulfilling the **care role** *educator* is also heavily linked to **buy-in**, such that simply

attending to patient education encourages **buy-in**.

O514   I think a lot of the patient buy-in does come with the education piece. Showing them that, or telling them how or why things could/should work. On why they're doing things. Um the education is probably the biggest piece of the patient buy-in for me.

Educating about *body awareness* helps lay the foundation for patient

understanding of their body and the ensuing care process, and leads to **buy-in**.

M835   That's like the groundwork I think, is like making sure they know what's going on with their body and that they, helps with buy-in too right, that they like know why you're recommending what you're recommending.

Providing information with the intent to support patient understanding of *purpose*

of treatment highlights how the <u>*educator*</u> role incites patient **buy-in.**

A294   For me it's patient education and then developing, ok, here is the plan and this is, kind of the quick road map. And sometimes that's, I give the full picture of a road map, of kind of here's the final step and here's all the little steps in between. Sometimes I'll just be like here's the final step, here's what we're gonna work on this week, and then we'll, we'll take the next step next week and kind of, kind of walk through it. . Um, and a lot of that depends on how much time you have with that patient of course, but. …. So, for me it's buy in, it's giving them the full plan and, um where we're going um.

K152   I think if you can help lay out a good chunk of the path, that, um, cause athletes want to know like 'ok, I can get back on the court shooting on this date, I can run on this day,' and talking obviously about a long term injury here. But I think that they want to know all about that, just because of their personality, who they are, but I think if you can unfurl a chunk of the road for them to work towards.

A267   For me it's education of explaining things. Um, of being able to back up and say kind of, the plan the road map and say hey, based on your injury, based on what we know through our evidence based practice now, um, you know this is kind of the course of treatment that you know, I have a background in or I've seen really great success with. So um, you know, lets go down this path if you will and kind of developing and explaining what's going on. I think, for me helps with buy in overall.

Patient efforts to self empower and *collaborate* on care are not always helpful.

Here, attempts to *collaborate* were tempered with patient education about *purpose of*

treatment and *understanding injury*. This was done to display appreciation for patients

attempting to play an active role in their care and to constructively redirect the care

process.

L228   Um one of the biggest barriers I've had in the past is I think the athlete
       might overestimate their readiness or their ability to do certain exercises.
       Um, and that's one where if I encounter that I just kind of sit 'em down
       and try to explain to them hey I don't think you're ready for this, you
       know specific exercise. We can try tweaking it a little bit, make it a little
       easier to see if you can handle the easier one before we, before we um try
       the exercises you want to do. And it's, I would say overall that approach
       has been generally positive. Some of them, most times they react
       positively. Like ok, we'll try the easier one first and then ease ourselves
       into it. I mean I've had a few cases where they get stubborn and they
       think that they can do it so, it's one where you just kind of gotta, either put
       your foot down or really try to guide them through it and make them go
       slow and see if they can actually handle it.

F720   One of my athletes, um loves the internet and web MD, and comes in and
       already knows what she has. Um, and tells me I need to do this, this, and
       this, and I need to see this doctor and I need this medicine. Um, and that's
       pretty frustrating. And, so that's difficult….It's frustrating to me because
       they, well I like, I appreciate the fact that they tried to take initiative, and
       come in prepared. Um, but at the same time there's often factors that
       they're not aware of that are contributing to what I'm doing, what I'm
       doing at this point….Um, and then there's, it's also frustrating because
       they don't understand, there are certain websites that are better than
       others. And some, like anybody can put whatever they want on
       Wikipedia, um, so like when they come in and tell me this stuff I try to
       (say) 'ok, I see where you're coming from, I appreciate the fact that you're
       prepared, but here's why we're doing what we're doing, this is the process
       we took to get here, um, and if you are interested in learning more, here's
       the Mayo Clinic website. … Or um, another reputable source for them to
       learn more from. Because I like that they take interest in what's going and
       want to learn more, but I want, I want to make sure they have the right
       information.

M559   You're like oh, Web M.D. Um, I think, yes they [patients] do that [do
       research on their injury and tell the athletic trainer this is what they have].
       But I don't think they ever do it, at least the kids that I interacted with
       mostly, for the most part, there are exceptions, but they mostly do that
       because they're trying to self empower, you know? And so like, yes,
       sometimes it's annoying because they're totally off base and they are
       overstepping bounds, but most of the time they're doing it because they're

trying to like, they're trying to figure out what's wrong with them, they're trying to self empower. So if you take that and then give them you know, whatever the real information is, however much of that is what they found on the Internet or not, um and making it like, 'you know, I can see why you thought it might be this but, this is what's actually happening.' Um, and making it a patient education and a, and like making sure they know what's going on with them, I think that's how you spin that into like a more positive use of patient information.

M588 I think the biggest thing for me is like taking a step back and not being like annoyed that that's what they've done, right? Um, because it's somewhat annoying when they come in and they're like 'I have this' and I'm like "ugh, god." So just like taking a step back, not expressing the annoyance. Not expressing it to the athlete, and then spinning it in like a helpful manner.

In sum, **navigating** different *care roles* facilitates patient **buy-in**. Patients learn from instruction and education provided by participants; being a *director* and *educator* first allows participants to then *solicit* feedback from patients, which encourages **buy-in actions**. Embodying the *partner* role inspires patient **buy-in** by working with patients to identify and integrate their needs. In addition, seeking patient input as a care *partner* helps build patient **trust** in participants and the therapeutic relationship, and generates patient **buy-in** to care. *Collaborating* with patients stimulates power and control over aspects of their care, which also promotes **buy-in**. The *educator* role is also influential to **buy-in**; simply attending to patient education incites **buy-in**. Educating about body awareness, understanding injury and purpose of treatment lays he foundation for patient understanding of their body, injury, and ensuing care. Last, tempering patient attempts to *collaborate* (which are not always helpful) with patient education about *purpose of treatment* and *understanding injury* enables participants to display appreciation for these collaborative attempts and to constructively redirect the care process.

When **navigating** *patient resistance*, participants respond in a number of ways to mitigate *resistance*. Conveying *holistic appreciation* by communicating value of patient roles and interests besides that of athlete helps participants attend to *patient resistance* and encourage patients to put effort into their care.

> K497   Yea, that's one of the conversations, like you know 'I know this sucks, you know, how can we get through this together?' 'Like you know I want to get you better, even if it means you know you're not gonna come back to the team, you're still gonna have a life and need to function as a you know, human being throughout your life. You know, you're gonna have to go to the grocery store, chase kids, you're gonna you know, have to walk around a new job. Like we have to get you back to that point. Like you know what can we do to get through this together and get you back to where you need to be for what you need to do in the next step of your life.

Participants also attempt to reduce *patient resistance* with *coach involvement*. When patients are not completing care tasks, participants will seek coach involvement to oversee patients and act as a motivator.

> O62   If it's somebody [patient] who I have a relationship with and I know isn't going to be kind of compliant in the way I need them to be then that's, I guess a little bit more of a battle with trying to ah coax it out of them through different things. With that, usually I try to change things to make it more fun for them so that they're more active doing it. Um, also I start to get like coaches to be more active in getting their rehab and stuff in since I'm not there all the time. Coaches being able to continually be on top of them to do stuff that they're supposed to, do so I can get that compliance that I'm trying to get.

In addition to seeking coach assistance, participants also respond to *patient resistance* with *boundarying* in an effort to protect their professional time and obligations.

> O417   …I'll kind of meet them [patients] as far as they meet me. But ah, I guess again with those un-compliant ones, again I do have the coaches and stuff, try to help me through all that. It's not like I'm going to give up on a patient, or something. But yea, I do kind of meet them where they'll meet me as far as what we can do and can't do.

When patients show ***resistance*** through lack of responsibility to attend care and lack of effort when completing exercises, participants respond with *boundarying*, choosing to devote time to other patients.

> K607 People [patients] who want to be there...I'm gonna devote my time to the people who I see, you know, want to be there and it's you know, it's just easier to do that.
>
> J *If they're putting in effort you're gonna be more likely to put in effort*
>
> K614 Yea, if they're putting in effort, you know if you're doing everything you can do for an injury, and you're still in pain, I have no problem with you complaining. I mean you can complain all you want. But if you're coming in like every other day for treatment and you're skirting stuff and you start complaining about how everything's not working and start mouthing off to the coach and stuff like that, I've got no tolerance for that whatsoever. Because you're not doing everything you can do, and therefore I can't do everything I can do, so no right to complain there.

While participants attempt to establish *caring*, without a positive response *coach involvement* is sought to reduce ***patient resistance***, and participants institute *boundaries* to protect professional time and patient responsibilities.

> L251 Um, as far as them not wanting to come in that's, I give them as much rope as I can you know, allow them to take. Um but it gets to a point where if they don't want to come in if they don't want to take responsibility for their own well-being. I mean I've got other athletes that I've got to take care of. And it might sound you know, cold and heartless but if they don't want to come in and put the time in then I'm not gonna give them, give them the time. But throughout that whole process I'm constantly talking to them like 'hey, you gotta keeping coming in.' I keep asking them 'why aren't you coming in?'…And then, they get a couple warnings and then they get to be the point where alright, now we're…but we're gonna be to the point were alright, you're not going to come in, I'm not going to see you today, and then there will be consequences, yea. You're not going to come in today and if it keeps up then that's when you know you get the coaches involved. And then if they you know keep getting worse or keep not wanting to come in that's when you tell them like alright, your not coming in anymore. But luckily um, I've never encountered that where I've had to tell somebody, tell somebody that they're not, I'm not treating them anymore. Usually after the coach gets involved and they get chewed out by the coach then it gets better.

Participants also attempt to diminish *patient resistance* by taking on the <u>educator</u>

care role to re-acquaint patients with aspects of injury and the care process and support

patient understanding.

A439   Someone who's not bought in, then has, you have to kinda back up and re-explain things every step of the way, of we're, we're doing this exercise and we're doing it this way so that we activate this muscle and, um. You know people who have bought in you can give em just a quick little correction and they're like 'ok got it". And they'll apply it. Where, um you have to really kind of spend more one on one time with people that haven't fully bought in yet to kind of walk them through the steps, to explain everything, to kind of hold their hand if you will. Um, just because they aren't going to be as independent and self motivated. So they're, they're gonna be a little bit more, just require more time and effort to kind of bring them back to that point, if they ever come. Um, some will never buy in completely, and um, that's kind of, we see that unfortunately. And it's not, normally not just us, normally it's an issue with coaches as well, um within strength and conditioning, they're just, they're there but they're not. They don't have that internal motivation to go to the next level to develop themselves as individuals.

In some instances, *patient resistance* in the form of lack of buy-in incites

participants to initiate <u>additional relationships</u> to support patient desire to seek a second

opinion from a physician on their injury. Supporting this <u>additional relationship</u> can then

generate patient **buy-in** and *trust* in participants and care.

A318   And sometimes as you know, if they [patients] aren't gonna buy in to your plan at all, some patients, which I've experienced a little, but more in the Midwest, is the doctor influence is a lot larger than what I was used to at my previous clinic. So, sometimes kids will be like, 'all right, well, I like where we're going, but I still want to see a doctor'. And I'm like "well, a doctor's not going to change anything." So there are times where I'll actually be like "alright, lets see the doctor." It's like "alright, the doctor just said exactly what I said as well", which isn't like a oh a pat on my back, but it's like ok, for them [patients] then they're like 'alright, I'll buy in now.' And it's like alright, ok, but ah, um….We kind of, we skip that step a lot. Which I mean it's a nice step to have. But um, at the same time it has been a unique aspect of sometimes just having the doctor look at them and say 'yea you're on the right track with where things are', um ,you know that will really change for that patient, that changes a lot of things. And um, for those individuals that have to hear it from a doctor.

But I think that's kind of where the humility side comes in in some ways where it's not about you it's about them buying in and getting better. If it takes a doctor to say 'yea , you look alright, just keep going'. Then, um, yea.

Second round analysis highlights that participants return to **establishing** *holistic appreciation*, *boundarying* and *coach involvement*, and taking on the *educator* role when met with ***patient resistance***. Conveying *holistic appreciation* by communicating value and appreciation of roles and interests besides that of patient or athlete is one way participant respond to ***patient resistance***. Gaining additional support in round two, participants also establish *boundarying* to protect their professional time and responsibilities with other patients, or seek *coach involvement* as a consequence or as a motivator to encourage patients to complete care tasks. Participants also attempt to diminish ***patient resistance*** by taking on the *educator **care role*** to support patient understanding of their injury and the care process, and initiating *additional relationships* (having patients see a physician to receive a second opinion on their injury), which can also generate patient **buy-in** and *trust* in participants and the plan of care.

Between **buy-in** and **navigating**, patient **buy-in** facilitates *collaboration*. When patients display **buy-in** and they *trust* in the athletic trainer and the plan of care, patients are able to *collaborate* on care decisions.

> M504 …two scenarios, one being like they've just come in you've just met them or whatever. Um, then it's, it's sort of, to me has to be somewhat, not immediate, but like in that first meeting you have to figure out like, what are their goals as far as like this injury or this you know the race this weekend. Like what, what are we working with for like timeline but also just sort of like general expectations. Um, and then I'm thinking also, like longer-term, like at what point do you let them start, I'm thinking of again like of the ribs and at what point do you let them start making exercise decisions on their own type of thing. Like at what point. And I think it's when, I think part of it depends on, again back to buy-in. Like if you know that they bought in and they trust that your exercise prescription is

what, like that, that's the key to return right, versus if they haven't, and it's very obvious when they haven't because they just keep trying to push and then their ribs still hurt, so it's like pretty obvious.

Also with patient **buy-in**, patient education changes such that participants take on the *care role* *educator* less, as seen in the following passage:

> A458 And I still think there's an aspect of patient education that needs to occur, but you don't have to go as in detail. It's hey, we're going to do this exercise for this muscle group, and they'll buy in. And, because normally at that point you've also developed why you're building that muscle group into your rehab. So if you're an ACL, and you're working on the abductors of the hip like, at that point you've already established why you're doing that. With someone who's newer it's hey, we want to work on this because this will help, you know, stabilize the hip as well as be a little bit more, keep your knees and not allow them to go into valgus. But, so it's kind of explaining that, and you kind of, it's hey we're gonna do this muscle and they'll remember why and they'll buy in of ok, this was already explained to me, I don't need an explanation again. I can just move on.

Patient *belief* and trust in participants and the plan of care, and evidence of **buy-in**

actions such as patient *engagement* (taking an active role in care by asking for more

exercises) and *effort* (staying motivated), decreases the amount of education participants

provide as *educator*.

> A421 Yea, um. But I think it's a lot more enjoyable cause you, you can keep them on that kind of, that plan, the road map of within things. And yes, you're gonna have to deviate as you know the body responds to things differently, but um. As they buy in, as they're motivated to do stuff you can, it's more fun when someone's bugging me to look for exercises than for when I have to be like 'oh, here's your next one' and they have kind of that 'oh I have to do that now?!'. Um, and it's, cause it just takes more time to just go back cause I think with people that buy in you don't have to explain things as much anymore. You can kind of say here's, here's, here's the next thing and, or here's the next course of treatment, whatever it is, and you don't have to explain things because they trust you. There's that element of trust. I think that's probably the biggest, they've bought in.

Patient **buy-in**, displayed as *engagement* (asking questions to promote

understanding) encourages participants to take on the *educator* role and offer patient

education.

> K517 So for me I like, I like to do that a lot, pull out an atlas. And some of them are like 'yea ok great, thanks.' And that's the end of it. But then some of them like want more. Some of them will want more. And I can gauge that like when they're 'ok, so what exercise, like this exercise is doing what?' For this, 'you know, I'm doing a quad set, how does this help my knee? Like I don't get it.' You know, things like that. Um, some of them want to know every little thing, some of them are just like 'yea I don't know what you're doing and I don't really care, just get me better.'

Patient **buy-in** stimulates participants' ***trust*** in patient responsibility and a

connection. With patient **buy-in**, participant-patient relationships are more sociable,

which strengthens ***connection***.

> O583 I think it's when somebody's not bought in and not doing you know what I want them to do as far as treatment wise, I think that shows itself and a lot more of, I don't want to say me being harder on them, but a lot more of me kind of always talking to them and kind of being on them for stuff all the time. You know, do this, do that. Whereas my people who are more compliant, um, instead of being kind of harder on them, I think because they're doing their exercises and because they're being compliant, um, the conversations I have with them are more you know social in nature than the ones who are non compliant….I think whenever…I already have the buy-in, and they're [patient] trusting me you know, I think it's, again more of a social dynamic between me and them. Whereas if they're not bought in, it's more of a continually you know, why you need to do this, always talking about the athletic training part of it and less of, you know did you see the football game and stuff like that. [My athletes] would say the ones who are bought in are the ones that I "like better", but I think that if ah, if you really looked at it, the people who are doing stuff while I'm in there, I'm more asking them about stuff, instead of talking about their exercises to people who are not kind of doing what they're supposed to be doing.
> *J So then it sounds like they, those patients who have bought in, in addition to the trust in the belief, they're responsible.*
> O615 Yea. Yes that's a good way of putting it. They're responsible, and I trust them so, you know they get talked to just a little differently than somebody who's not as responsible I guess in my opinion.

Patient **buy-in** and trust in their athletic trainer and care plan enables them to *collaborate* on care decisions. **Buy-in** can also increase or decrease the amount participants take on the *educator* role. Patient trust and displays of *effort* and *engagement* enables participants to be in the *educator* role less, however patient *engagement* can also encourage participants be in the *educator* role more. Patient **buy-in** also stimulates participant trust in patient responsibility, which enables participant-patient interactions to be more social, further strengthening *connection*.

Last, processes linking **contextual factors** to **establishing**, **navigating**, and **buy-in** are presented. *Patient load* stimulates participants to return to *care contract* and initiates *athletic trainer commitment* to support care by adjusting to patient needs. When unable to effectively manage patient needs due to *patient load*, participants refer patients to other care providers or triaging patient care with suggestions to meet injury needs in the interim.

> K562 We were basically running a triage unit because there was just too many people [patients], not enough of us [athletic trainers] to really do anything substantial. Like any rehab we had was pretty much being sent to a physical therapist in town, because we couldn't do it. You know our mornings were spent trying to catch up on the paperwork, or like people were coming in in the mornings for treatment because they weren't getting them at you know 230 when practice was starting. … But I mean ultimately, that's not how I want to practice athletic training, you know I don't, I didn't get a degree just to put Band-aids on and tape ankles, and wrap sprains just to send to a PT. Um when we are at a normal capacity it is much easier to, I mean obviously we're still completely outnumbered, and if you do the whole NATA calculations, we're still under staffed but it is much more manageable and a lot easier to do our jobs.

Patient load can also limit **establishing** a *connection* or showing adequate *caring*, secondary to limited time spent with patients.

> A514 I think there's a reality aspect of, kind of too, to athletic training in that sense of, a lot of times we have our patient load is a lot higher than what

we can, you know feasibly do all that time. And that's not right, it's still we have to try to manage things, and it's not right to push people out the door, but there are times where we have to kind of triage and say 'hey, this is a small issue right now, work on these 3 things, and if it doesn't get better get back in here and see me because I want to see it I want to look at it and I want to care about it, but I cant care about it right now.

L38   My last job for example…we only had 2 people on staff for 17 varsity sports. So, that was ah the biggest, I noticed that since I was stretched so thin with so many different, different teams, the uh, the relationships and the patient relationships and things like that where, the ones that were coming in every day, I mean we had good relationships. But if they [patients] were to come in maybe 2 or 3 times a week for random things, um, I might not have been as open or you know as caring. But just because you're spread so thin and you have so many other athletes to worry about, they kind of get lost in the fray a little bit. Whereas here now at my current job, I'm responsible for 4 sports. So it's easier to you know build those relationships with those teams, so you're only working with you know a certain number of athletes at a time, so that helps. Just to kind of build those relationships and just kind of, build that trust.

Additionally, a large *patient load* constrains working as a *partner* with patients when **navigating** care, limiting participants' ability to seek patient input and feedback or remember it.

O428   I guess that could be a little bit of a barrier too, all the other people I have to manage as far as getting all their feedback. Because you know sometimes they only have so much time to be in the training room and that time is maybe my busiest time and I might have 10 people trying to give me feedback to everything and you know trying to write that down. I mean I've gotten fast but, I don't know if I'm that fast. And trying to remember everything is ah, can be another barrier to getting all that because you know sometimes I've had people come in who aren't as wanting to talk over people, who will sit in a corner and want to talk to me but there's so much going on that eventually time runs out and they just leave. I've had that before, and I guess you can consider that another barrier to getting that input and developing that relationship as well.

To manage *patient loads*, participants will seek *coach involvement* by asking for their assistance with daily tasks and managing patient behavior.

K567   You know we had meetings with the coaches at the beginning of the year when we realized this was going to happen and just said 'hey, we need

your help with making sure you get your athletes to us on time, we need your help maybe with smaller or littler things, like you know helping us get the water bottles out there, maybe filling them. We need your help with, um, making sure people behave in the training room because we don't have time to be…you know, the parents in there as well… So, that being said like, the coaches rely on us to do their jobs, and we tell them that we rely on you to do our jobs too because, you hold a lot more power over the kids, if, if they're not doing what they're doing.

Patient care challenges imposed by *proximity to patients* (inability to be at practices due to attending other team responsibilities, or because the presence of multiple facilities affects access to injured patients) encourages participants to return to **care contracts** and seek *coach involvement*. Participants will ask for coach help to keep track of injured patients, or to motivate them to complete care tasks.

A786 The assigned sports I have now are cross-country, track and field, and hockey. And the downside is there's someone in the athletic training room right now at school, but I'm, um, I'm out at hockey practice every afternoon and that's off campus, so I'm never around for my track and field practices. Which is a terrible situation so it's, I have to rely on coaches to say to me "hey, I told so and so to come and see you, did they come and see you?" And it's 'no, I never saw them.' And then following up of. So whenever someone comes in it's, hey coach, so and so stopped by and this is what's going on. And they're like oh that's what I thought, so there's an extra communication piece that I have to kind of negotiate and so that we're all on the same pages and we're crossing our T's and dotting our I's if you will, so that I can balance everyone.

O159 Like they (coaches) do, I wouldn't say almost, they do. It's a very, they (coaches) kind of have to if they want stuff to happen. So they (coaches) know I'm not going to be there for everything so they know they have to keep them (patients) going on some of that stuff.

In addition to place and environmental **contextual factors** impacting care, ***patient variables*** also influences participants taking on the *educator* role. Understanding patient personality, a ***patient variable***, allows participants to adjust provision of education within **care role** *educator*.

F688   Depending on the athlete, um I will, educate them sooner or later and some of them just don't care about the why. So I'm not going to push all of this on them if they're like 'well I just want to play again, what do I have to do? I'll do whatever you ask.' Um, and some of them I wait until they ask. Um, then go from there. Try to tailor it to their personality I guess, and even like maturity level or, I'm not going to tell the same things to a freshman that I would a junior, right off the bat. I don't think.

In some cases, *additional relationships* are purposefully activated to encourage patient **buy-in**. Using previous patient successes as motivating examples, activating social support networks, and using former patients as advocates for the benefits of buying in to the care process, promotes **buy-in**.

F349   Well one of my girls who's fully bought in, she's had Achilles pain almost her entire career here. But um, she knows when she comes in regularly for rehab and does it right that her pain goes away, or gets less. Um, and she tells her teammates that. So, she like, she's become like an advocate for me. She like sees these girls come in and they're doing their exercises half way, and she will be like 'listen, you're in, Fiona's not having you come in to be mean, she doesn't want to take time away from your life, like if you do what she asks and do it well, you're not going to have any problems anymore!' Um, so that's probably the most obvious characterization of buy in. She's like being my hype girl. But um, I think that there are other, other girls who have truly bought in that aren't as vocal as she is.

F214   It helps sometimes if I have an example to show them. Um, another teammate that they respect, um, who has not necessarily been through the same injury, but an injury and followed through with what they needed to do when it was successful and they haven't been back in the athletic training room.

K288   [when patients aren't bought in] A lot of times I feel like it's because they're feeling isolated from the team. So I try to like get their rehab done while other teammates are in there, so they have that presence around them. And you know, I'll discreetly talk to their teammates like hey you know, check on this person, you know he's a little down, he's not gonna play the rest of the year, he's gonna miss a big game, like when he's in here talk to him, encourage him while he's doing his rehab.

Finally, connections emerged in round two initiating from ***athletic trainer variables***, both *personal influencers* and *professional influencers*. Personal injury

experiences increase participant attention to honesty and transparency when discussing

injuries and consequences secondary to injury with patients and coaches, linking *personal*

influencers to *information sharing*.

> F819   I think from you know, how I was treated through my injury, um. When we first found out that I got hurt, my parents didn't tell me right away, and that really upset me that they knew what was wrong. And I know now, I mean I know they were trying to get everything lined up and wanted to make sure that everything was ok before they dropped this bomb on me that I was going to have to have surgery and miss sports for a year. Um, but I think that's really played a big role in my focus on trying to be up front with athletes from the beginning, not only with my athletes but with my coaches to, about how long they're going to be out for, and what it's all going to entail. And it's gonna suck, it's not all going to be fun times. Ah, but then you know it's not all going to be bad either. You know there's going to be good days and bad, and I think that experience personally, has led to me trying to make them aware of what's going on right away and then making them aware of all of the options too, um, with their care. Not making them feel like this is the only way.

Moreover, *personal influencers*, such as previous work with an athletic trainer due

to injury, directly impacts participants' attention to displaying *caring*, *holistic*

appreciation, and *commitment* to their patients. *Personal influencers* directly effects

attention to **establishing** a ***connection***, and ***trust***.

> K695   Um, and people like that, that have gone above and beyond, I think have really shaped me into who I am. And some of them are the reason I'm still here today. Just because of that. But also, you know being away from home for the first time for a lot of kids is really hard, and I think that they need somebody that can kind of step in for their mom sometimes. And I needed that too when I first came, when I first went to college. So I'm really conscious of that, and I know that…having a mother that's constantly worrying when you know your kids not there, that they want to know that their kid is safe too. So I think stepping in and being that role, you know…because I would rather be there, be with them [patient], to know that they're safe, rather than sitting at home waiting for their roommate to text me, and say 'yea, everything's ok.'

Professional experiences also created awareness to the presence of an athletic

trainer-patient relationship and its importance for uncovering patient needs and

facilitating care. Specifically, experiences participants had as _students_ with CP's and

ACI's directly influenced how participants value **establishing** a *connection* and *trust*,

and demonstrate _caring_ when **establishing** participant-patient relationships and attending

to patient care as a professional.

> O673 Where I went to undergrad at, the head athletic trainer there was very, strict. It was very much a ah, you know come in, do your treatment, get out type of [person]. And ah, while I didn't dislike that really, when I got to ah, when I rotated to a different kind of preceptor who was more, um talkative, more social. [They] had better compliance in my mind and also people [athletes] were more comfortable coming to talk to [them]. And that was big for shaping how I wanted to, whereas my first, the stricter athletic trainer, you know everyone, the athletes were all scared to talk to [them]. And I felt like that was bad because you know that means that they were hiding maybe something that was maybe a little more, uh, maybe worse than they thought it was and they were trying to hide it because they didn't want to go talk to [the head athletic trainer]. Whereas the more social athletic trainer who I learned from, um you know they [patients] weren't afraid to tell [them] anything. And they weren't afraid to say anything and then, yea [they had] to I guess, take a little bit more time to kind of discuss whether that's a huge issue or small one, but at least [they] knew about everything that was going on. And I thought that was important. You know, the knowing at least if somebody's having these problems, even if they're small. As opposed to people being scared of coming in to talk to you which I think would be a huge barrier in patient care. And that definitely shaped how I was.

Finally, _professional influences_ as an *employee* promoted the value of learning

from patient care experiences and realizing the importance and value of the _educator_ role.

> M927 And then once you become a professional, I think the big difference is like once you become a professional then you're learning more from, I mean you're probably learning some from the student athletes when you're a student but mostly you're I think looking to other athletic trainers to like get, to get it right, you're a student, you're trying to get it right…Um, and then once you start um, like practicing on your own I think you, I anyway felt like that's where I started like learning from the student athletes, right. And often times you learn from things where either like there was a bad situation or like things could've gone better, like obviously those are the cases you remember the most. Um, but I think that to me is a big difference from like student and professional, is like I started learning from student athletes. Like these are the things that work, these are the

things that don't work, they respond better if they know what's going on. Like, I don't think my first year when I was working in a high school, I don't think I ever told anyone anything beyond basic anatomy. Like, because I was just young. And now I do a ton of that, like we just talked about patient [education] stuff takes longer than the [evaluation] does.

In sum, **contextual factors** have many influences on **establishing**, **navigating**, and **buy-in**. New within round two, *patient load* stimulates a return to *care contract* and initiating *athletic trainer commitment* to support care by adjusting to patient needs. Also, a large *patient load* can limit participants ability to show adequate *caring* and **establish** a *connection*, and work as a *partner* with patients when **navigating** care. Participants attempt to mitigate challenges imposed by *patient load* and *proximity to patients* by seeking *coach involvement* to assist with daily tasks, keep track of injured athletes, motivate patients, and manage patient behavior. In addition to place and environmental **contextual factors** affecting care, understanding patient personality, a *patient variable*, allowed participants to better navigate provision of education while in the *educator* role. *Additional relationships*, another *patient variable*, were purposefully activated to encourage patient **buy-in**. Using previous patient successes as motivating examples, activating social support networks, and using former patients as advocates for the benefits of buying in to the care process, promoted **buy-in**. Initiating from *athletic trainer variables*, personal injury experiences (a personal influencer) effects participants approach to *information sharing* with patients and coaches, generating attention to honesty and transparency when discussing injuries and consequences secondary to injury. Additionally, previous work with an athletic trainer due to injury, another *personal influencer*, directly impacts attention to **establishing** a *connection* and *trust*. *Professional influencers*, experience as a *student* working with CP's, also influenced how

participants attend to **establishing** participant-patient relationships, particularly by

establishing a *connection* and *trust*, and demonstrating *caring*. Finally, experience as an

employee fostered realization of the importance and value of providing patient education

as an *educator*, further supporting process that was present in round one.

In conclusion, round two interviews represent an emerging construction of

participants' experience of a working alliance in patient care by linking the **categories** of

establishing, **navigating**, **buy-in**, and **contextual factors** in process. *Care contract*

initiates *connection* and generates *trust*, and without attending to *care contract*,

connection is inhibited. **Contextual factors** stimulate a return to *care contract*.

Establishing an *environment* and *connection* generates *commitment* and *trust*, and

establishing coach *trust* generates patient *trust*. Patient and coach *trust* promote **buy-in**,

and **buy-in** strengthens *connections*. *Connection* influences participants taking on

various *care roles*, and *care roles* reciprocally help participants **establish** *connection* and

trust. *Care roles* are transitioned between as patients and the care process dictate and

also generate **buy-in**. Patient **buy-in** initiates a return to various *care roles*. *Institutional*

variables can inhibit **establishing** *connection* and taking on various *care roles* when

navigating care. However, a*thletic trainer variables* stimulate **establishing** *connection*

and *trust* and **navigating** care in various *care roles*. Without *connection*, participants are

more likely to respond by **establishing** *boundarying* and when met with *patient*

resistance, participants return to **establishing** *connection*, **navigating** *care roles*, and

initiate **contextual factors**, which can also generate patient **buy-in** and *trust*.

Conclusion

To conclude chapter four, I will review the emerging theory of the experience and process of the working alliance in collegiate athletic training, emphasizing how second round results modified or enhanced first round analysis. Next, I will discuss my context as the researcher as I co-construct with athletic trainer participants their experience and process of a working alliance in professional practice.

Emerging Theory

Round two analysis solidified participant experiences of **establishing**, **navigating**, and **buy-in**, as central to developing a working alliance with patients, and reinforced the influence of **contextual factors**. Here, I summarize significant changes and additions to the conceptual understanding generated in round one, and discuss corresponding implications for an evolving grounded theory of how collegiate athletic trainers develop and utilize a working alliance with patients.

The experiences of **establishing** continue to capture how athletic trainers enter into patient and coach relationships and how they prioritize holistic interest in patients and support patient well-being. The ***care contract*** focuses on expectations, obligations, and roles amongst the triad of athletic trainer, patient, and coach prior to and during the care process. In addition to supporting the concepts *athletic trainer commitments*, *athletic trainer expectations of patients*, and *coach involvement*, second round interviews added the *concept role induction*, which encompasses generating patient understanding of participants professional identity and capabilities when initiating relationships. *Athletic trainer commitments* remain grounded in their commitment to supporting the patients' agenda and flexibly adapting the care process to facilitate positive outcomes, inciting

firm *expectations of patient* accountability. Patient responsibilities (i.e. follow through on tasks and take ownership of care) in the care contract remain largely implicit; these *athletic trainer expectations* received additional support in round two. Participants intentionally seek *coach involvement* to support patient well-being and the care process, including: 1) to collaborate about care decisions: 2) to reach a better understanding of patients: and 3) to solicit coach support of care decisions. Beginning when patients seek care, these **care contracts** are a foundational element of the athletic trainer-patient and athletic trainer-coach dynamic necessary to ensure a healthy working alliance throughout the treatment period.

      Care contracts are precursors to **establishing** patient ***connection***, an essential part of a working alliance. When ***connection*** is present, patients readily seek care and feel comfortable sharing concerns, and participants are more responsive to their patients and are considered and included as a part of team successes. Additionally, with a ***connection***, patient interactions become less formal and participants become more responsive and available to requests and needs outside of basic expectations. Building ***connection*** takes time and begins with displaying and conveying interest and value of patients as unique individuals. Effectively utilizing time and having continuous interactions further supports ***connection***. Round two analysis provided additional insight into the importance of ***connection*** *concepts* (*caring, holistic appreciation, sharing of self, responsiveness, bonding, and boundarying*) and the pivotal role they play in a successful working alliance. Understanding patients through observation, recognizing patient challenges (physical or otherwise) acknowledging patient effort, and connecting patients with resources helps athletic trainers further establish *caring*. *Holistic appreciation* now

encompasses the triad of coach, patient, and athletic trainer, capturing the importance of mutual respect and the value of identities and roles beyond that of athlete to support patient care. *Sharing of self* across broader experiences to establish rapport and relate to patients in a more personal manner and *responsiveness* (being present during conversation, active listening, and responding in a manner that lets patients know what they are saying and feeling is appreciated and understood) further supports a **connection**. With a *bond*, or a deeper connection, participants are able to implicitly understand and know patients. Remaining present in the second round, participants intentionally navigate personal and professional ways of relating when connecting with patients. This *boundarying* helps maintain a balance between personal and professional, which upholds patient trust and respect. Without **connection**, participants are more likely to protect professional obligations via *boundarying*. **Establishing** **connection** is a critical aspect of patient care for participants. Just as critical is the **establishment** of **trust.**

Establishing **connection** creates opportunities for **trust**, a vital component of **establishing** successful relationships between participants, patients and coaches. Promoting patient understanding of professional identity and capabilities while **establishing** a conducive **environment** for care supports **connection** and generates **trust**. Second round analysis provided additional support for the importance of **trust** between patient and participant, and also clarified the importance of **trust** between participant and coach, calling attention to the essential role this dynamic can play in patient care. Establishing **trust** is both a cumulative and a circular process; coach **trust** in participants engenders patient **trust**, both of which foster mutual **trust** amongst the participant, patient, and coach. *Information sharing*, or honest communication and transparency

about what is shared, with whom, and under what circumstances, inspires *trust* about how patient information is protected and purposefully shared. *Sharing information* with coaches establishes coach-participant *trust* by fostering clarity about the care process and future planning, which enables soliciting coach input and inciting coach support for care decisions. *Trust* is further built through *properties of proving* (*credibility*, *commitment*, *advocacy*) and round two highlighted participant experiences of *proving* that further established *trust*. Participants *proved credibility* with patients and coaches by conveying successful patent outcomes and an understanding of sport demands, not over-reacting to injury, and supporting patient participation (even if in a limited capacity). Displaying actions that go above and beyond usual professional responsibilities shows *commitment*, and intervening on behalf of patients (with themselves or with coaches) enables participants to *advocate* for patient health above all else, further cultivating *trust*. In summary, round two analysis further clarified the important ways that **establishing** a *care contract, connection,* and *trust* within participant, patient, and coach relationships supports development of a solid foundation that allows progression through the care process.

  Establishing and continuous attention to a foundation rooted in *care contract*, *connection*, and *trust* supports successful **navigation** through the care process. During patient care, participants navigate amongst the *care roles* of *director*, *partner*, and *educator*, enabling them to adjust their approach to evolving patient needs. Round two analysis provided additional insight into the *care roles partner* and *educator*. Patients become *partners* in care when participants recognize patient contributions to the care process and integrate their ideas and feedback into care decisions. Importantly, there is a

circular process between the ***care role*** *partner* and **establishing *connection***. ***Connection*** (*caring*, *holistic appreciation*, and *responsiveness*) creates a framework for patient desires to surface that later inform patient-centered changes in care, thereby supporting the ***care role*** of *partner*. The *concept* of *partner* can be further understood through experiences of *soliciting* and *collaborating*, both of which provide opportunities for patient contributions, while retaining participant power to make final decisions. *Soliciting* specific feedback enables patients to be *partners*, but determining when (daily, before or after appointments, or at points throughout care process) and how to incorporate their input leaves participants with final decision-making power. *Collaboration* occurs when patient requests catalyze changes to care and when participants and patients jointly identify and integrate meaningful care decisions. Similarly, participants retain control by limiting aspects of care where true *collaboration* occurs. Round two clarified aspects of care appropriate for *collaborating* (therapeutic exercises, treatment times, treatment modalities/therapies, and goal setting) and when *collaboration* was unhelpful (e.g. when patient understanding of injury, plan of care, and variation in injury response is limited, and when participants do not have authority to change the plan of care). Closely tied to *collaborating* is the *educator* role, as this allows displaying appreciation for and constructively redirecting patients' collaborative attempts. Two dimensions further influence how participants navigate their experiences as *partners*: rehabilitation length (short----long) and severity of injury (simple-----complex). Length of rehabilitation influences seeking and trusting patient input, such that long-term care incites participant trust in patient input, whereas during short-term care, patients may be less likely to divulge how they are really feeling. In relation to severity of injury, complex (severe or

life threatening) injuries encourage participants to limit patient involvement, whereas with less severe (simple) injury, patient input is sought and integrated on a more frequent basis. Another essential role for **navigating** patient care and promoting a healthy working alliance is the ***care role*** *educator*. *Collaborator* and *solicitor* components of the ***care role*** *partner* can rely on participants functioning as *educators*. Facilitating understanding as an *educator* empowers patients to be a *partner* and provide feedback when *solicited* or as a *collaborator*. Round two analysis clarified the significance of patient education and educational content, including *body awareness*, *understanding injury*, and *purpose of treatment*. Encouraging body consciousness (patients learning to "listen" to their bodies) facilitates patient understanding and feedback through *body awareness* (added in round two). Patient *understanding injury* and the natural variation in injury response, and educating about variation in treatments, modalities, and exercises/exercise plan to generate understanding of the effect and *purpose of treatments*, embodies the *educator* role and directly supports the care process.

Participants pro-actively support the working alliance through ***care roles*** and **navigating *patient resistance***. Participant expectations of patient responsibility and active participation are at times met with ***resistance***. Efforts to **navigate *resistance*** can lead to limits at which athletic trainers are unable or unwilling to manage patient care, manifesting as meeting and not exceeding patient efforts to navigate their care. Round two illuminated various kinds of ***patient resistance*** (e.g. hesitation to divulge present condition, lack of responsibility, effort or commitment) and two new manifestations, lack of buy-in or compliance. Importantly, round two also clarified participants returning to **establishing** *holistic appreciation*, *boundarying* and *coach involvement*, thoughtfully

taking on *director*, *partner*, or *educator* roles, and initiating *additional relationships* in an effort to manage **patient resistance** and move through the care process.

　　Establishing and **navigating** are precursors to patient **buy-in**, which directly effects participant and patient interaction and therapeutic outcomes. ***Care roles*** *director*, *partner*, and *educator* also generate patient **buy-in**. Patient buy-in encourages participants to *solicit* and *collaborate* with patients and adjust delivery of information within the *educator* role. Gaining clarity and depth in round two, **buy-in** captures both patient ***actions*** and ***beliefs*** pertaining to investment in their athletic trainer, treatment tasks/modalities, and their plan of care, and participant expectations of certain patient behaviors. Round two analysis created four new patient ***action*** *concepts* that directly reflect **buy-in**: *accountability*, *communication*, *effort*, and *engagement*. Patients show *accountability* through responsibility and willingness to follow participant directives, and consistent *communication* by attending to sharing information and conveying interest in managing their care. Correct completion of tasks and exercises, hard work physically and mentally, and remaining motivated are how patients display *effort*, while asking for feedback and expressing willingness to collaborate on care decisions shows *engagement*. Collectively, patient displays of these ***actions*** verify **buy-in** to their care experience, which, in turn supports a healthy working alliance. Collectively, **buy-in** ***actions*** and ***beliefs*** generate participant trust in patient responsibility to complete tasks, supporting overall professional responsibilities and efficient management of the care process.

　　Finally, **contextual factors** broadly influence participants' efforts to develop a working alliance, from **establishing** athletic trainer-patient relationships, to **navigating** the care process and **buy-in**. These factors capture place and environmental

(*institutional*), and person (***athletic trainer*** and ***patient***) ***variables***. Second round analysis clarified the importance of ***institutional variables***, highlighting the influence of environmental and place factors on athletic trainer-patient relationships and the care process. Excessive *patient loads*, access challenges associated with reduced *proximity to patients*, and *institutional emphasis* on athletics over academics negatively impact (for example) participant-patient ***connection***, provision of comprehensive care, effective tracking of patient needs, and efficient management of care. *Patient load* and *proximity to patients* are also closely tied to ***care contract*** and ***care roles***. Large patient loads and reduced access to patients incite athletic trainer and coach responsibilities to support patient care and outcomes, and generate taking on a *partner* role.

Contextual factors also encompass ***patient*** and ***athletic trainer variables***, which have a similarly large influence across the care process. Patient personality and regional location emerged in the second round as ***patient variables*** that helped participants understand and interact with patients throughout **establishing** and **navigating**. *Sport valuation* encourages sensitivity to patient attitudes towards sport, and second round interviews exposed how participants' assessment of patient motivation towards sport results in adjustment to approaches to delivery of care. Round two also highlighted the influence of *additional relationships* on care outcomes and **buy-in**, exposing purposeful encouragement of *additional relationships* to promote the care trajectory and the often-challenging influence of physician and parental involvement on the care process.

Athletic trainer variables encompass personal and professional experiences influential to participants' lives and professional practice, and clearly impact the care process. *Personal influencers* (familiarity with a patient role, experience with injury or

illness, and/or previous work with an athletic trainer due to injury) continue to inform participants' efforts to **establish *connection*** and ***trust*** during patient care. Round two added depth to participant *personality*, exposing this variable as a driving force behind participants' approach to relationship development and provision of care. <u>*Professional*</u> <u>*influencers*</u>, including the properties *student* and *employee*, which were added in the second round, affected participants' value and appreciation of the patient relationship. Clinical learning experiences as a student, and on-the-job experiential learning as an employee influenced participants' valuation of <u>*caring*</u>, **connection**, and investment in patients to facilitate care. Collectively, these experiences textured participant approaches to **establishing** and **navigating** a working alliance and attaining **buy-in**.

This emerging theory hinges on the analysis of detailed interviews with six athletic trainers. These participants bring diverse backgrounds, personalities, and skills into their workplace, and speak to the vast range of situations and experiences, both common and unusual, that collegiate athletic trainers face on a day-to-day basis. Collectively understanding common elements of these diverse experiences creates the foundation for the emerging theory presented here.

Context of the Researcher

My context as the researcher continues to influence and shape analysis of the data as I work to co-construct the experience and process of a working alliance in collegiate athletic training. My interactions with the data and participants remained influential throughout second round analysis to my context as the researcher. These are discussed below.

During second round analysis I felt myself being pulled in two directions regarding athletic trainer participants taking on the care role partner and soliciting or collaborating with patients, and whether the data spoke to a clear separation between solicitor and collaborator. To address this I did two things. I encouraged myself to take a step away from analysis and writing about those properties. Second, I employed persistent observation to encourage increased awareness surrounding the elements in question. While at times complete immersion in the data has limited my ability to "see the forest through the trees," it has also encouraged me to deeply explore the data, allowing me to reach a more complete understanding of partner and the variation present in solicitor and collaborator.

I also continue to feel myself wanting to see parts of the working alliance emerge within the data, and at times I question whether I actually am, or if I am trying to encourage the data to fit when it may not. For example, I question whether I am looking for collaboration because it is a construct of the working alliance or if it is present within participant experiences and data analysis. To maintain credibility, I employed prolonged engagement and also I consulted with my chair, Dr. Murray, as an inquiry auditor. As we talked about the categories, sub-categories, and concepts, and the data that supports them, I became clear that I was not misinterpreting the data. Similar to my first round analysis, some experiences participants shared spurred me to want to protect information. However, with prolonged engagement, I was able to recognize possible distortions of the information they shared, fully consider the context of the experiences discussed by participants, and integrate these experiences appropriately within data analysis.

In relation to the concept responsiveness, two participants have referred to active listening and integrating those skills within clinical practice. My curiosity stimulated me to ask where they were introduced to/learned these skills. While one participant recalls being taught these skills within their ATP, and now personally teaches these skills in a classroom setting, the other participant was unable to recall specifically where they learned about active listening. While they believe there may have been some aspect of learning about active listening within their ATP, they do not recall specifically learning the construct. While their realities are a vital piece of conceptualization of the emerging grounded theory of a working alliance in collegiate athletic training, I am left feeling that that their particular experiences with active listening make the current understanding of responsiveness a slightly lopsided representation of the participant group. However, this encouraged me to be aware of participant experiences which arose during data analysis that were representative of the concept responsiveness, which allowed for a richer understanding of responsiveness from multiple participant realities.

As I remain within the data, I continue to reflect on the fact that participants experiences regarding care tasks and soliciting or collaborating with patients revolves around physical tasks (i.e. specific treatments or application of a manual therapy or rehabilitation exercises). This participant focus on physical tasks leaves out attention to agreement on behaviors (i.e. motivation, effort, responsibility) that may be relevant for patient care and achieving goals. While I did at times attempt to seek further clarification on this with participants while not trying to lead them, this line of inquiry did not result in inclusion of these behaviors. It seems as though these behaviors are recognized in patients when participants evaluate actions of buy-in. This may mean behavioral (and

psychological) tasks/behaviors are not considered or incorporated during patient care, or that participants simply did not speak to this, or that I may not have been explicit enough when seeking this information from participants.

There were many situations participants described that I closely related to. Specifically, the experiences participants shared with staffing challenges and the limits this placed on patient care and establishing a relationship. I recall experiences of spending minimal time with patients, working with multiple patients at one time, and asking patients to come back at another time to receive care. These became uncomfortable reflections for me, as I also know they were for the participants. I am feeling a greater appreciation that participants openly shared these struggles and challenges to managing patient care. Additionally, as I think about experiences within my counselor education program, knowledge gained regarding a working alliance, and experiences accumulated while completing this research project, I reflect a little differently on how I attended to patient care previously, and how I would like to approach patient care in the future. As I think about the opportunities that I have had to provide patient care while completing this project, it is clear to me that this experience has influenced the emphasis I place on how I am creating a connection with patients, seek their input, and try to uncover what it is that is most valuable to them regarding their care or outcomes. While this experience has brought awareness to how I manage patient care, I am mindful of this not overly influencing what I am seeing, or what I may be hoping to see during data analysis, as I continue to co-construct the experience and process of the working alliance in collegiate athletic training.

CHAPTER V

Final theory, Trustworthiness, Limitations and Implications

This study explored the experience and process of the working alliance in collegiate athletic training to develop conceptual clarity for professional integration. Despite the importance of patient-provider relationships and attention to a working alliance, these constructs remained largely unexplored in athletic training. The research question guiding this grounded theory research was: What is the collegiate athletic trainer's experience and process of developing a working alliance in athletic training? To best answer this question, an inductive grounded theory approach was selected to learn the conceptual understanding of the components of the athletic trainer-patient relationship and of attention to a working alliance.

In this chapter, I discuss how trustworthiness was established and present the final grounded theory of the experience and process of the working alliance in collegiate athletic training. Limitations of the study are examined, and implications for both athletic trainers and counselor educators are presented. Finally, I offer directions for future research and a conclusion of the knowledge offered by this study.

Establishing Trustworthiness

Trustworthiness is not achieved by following a prescribed set of methods, but by how close conclusions are to the reality of the knowledge gathered (Maxwell, 2005). I employed several techniques throughout the research process to help establish trustworthiness and ensure that the data, possible interpretations, and explanations of theory rang true to readers, participants, and myself. These techniques were purposeful sampling, prolonged engagement, persistent observation, member checks, rich thick

descriptions, reflexive journaling, and the use of an inquiry auditor. Next, I will discuss how I upheld each of these criteria during the research process.

Credibility

Credibility captures the "truth value" of the findings and the context and process by which the constructed theory was obtained (Lincoln & Guba, 1985). Grounding the developed theory in a co-construction of perceived reality between the participants and myself can offer experiential credibility (Maxwell, 2005). Since I am a tool in this qualitative research process and my perception of reality emerges from my experiences, this can introduce bias and challenge assessment of credibility. To limit bias, I engaged in bracketing throughout the research process by writing about my conceptual context and social embeddedness. I also concluded each round of data analysis by writing about my context as the researcher with attention to my experiences as a collegiate athletic trainer and doctoral student in counselor education, and my beliefs about the impact of relationships on outcome. Awareness of these beliefs and perceptions facilitated recognition as to whether they entered into or influenced data analysis and creation of the final grounded theory.

In addition to bracketing, I took steps to meet credibility by conducting purposeful sampling until all variations of participants' realities were represented and ensuring that the conceptualization of theory was believable to the participants (Lincoln & Guba, 1985). To enhance the probability that findings are considered credible, I also incorporated strategies of prolonged engagement, persistent observation, and member checks. These are described below.

Purposeful sampling. Construction of a grounded theory that explains a phenomenon and its processes from multiple perspectives (Charmaz, 2008) involves selecting participants who will shed light on the research question (Creswell, 2013) while ensuring that the population is accurately represented (Maxwell, 2005). Participants who were more likely to attend to building rapport with patients would best answer my research question. Therefore, participants who had a minimum of three years of clinical experience after completion of degree and certifying examination and identified the patient-provider relationship as a factor essential to quality patient care were purposefully selected. Furthermore, to embrace a breadth of realities and allow maximum variance to emerge, purposeful sampling included attention to differences in gender-identification, collegiate employment setting, and sport profile. Embracing and exploring these varied realities accounted for both similarities and differences that may have existed in the shared reality of developing a working alliance with patients.

Six participants were selected for and participated in this research study upon receiving approval from University of Montana's Institutional Review Board. Six collegiate athletic trainers (3 males, 3 females; athletic training experience = 4.33 ± 1.03 years; athletic participation association = (1) NAIA, (2) D1, (1) D2, (2) D3) agreed to participate. All participants had a minimum of 3 years of experience beyond completion of their degree and national certification exam that allowed for experiential growth and development of an individualized and competent approach beyond experience gained as a student. Collectively, the participants were responsible for provision of care across high and low profile sports that include: baseball, softball, volleyball, wrestling, cheer and

dance, men's ice hockey, basketball, crew, cross country, track, golf, tennis, swimming, and soccer.

Prolonged engagement. My second step, prolonged engagement, involved sufficient time in the setting that allowed me to define the purpose and scope of this research and build trust with the participants (Lincoln & Guba, 1985). Specifically, my experience as a collegiate athletic trainer and my work with injured patients oriented me to the profession, in effect allowing me to establish a shared reality with participants. It also qualified me to fully consider the context of information when completing data analysis. Long term engagement in the research process and with the data over a period of 7 months enabled me to better see misunderstandings or "distortions" of information provided by participants or in context development (Lincoln & Guba, 1985). In addition, my experience as a doctoral student in a counseling program helped me cultivate rapport and trust with participants by demonstrating empathy, respect, and honesty, and sensitively listening and responding. To further encourage trust, I maintained confidentiality, protected participant anonymity and did not hide the purpose of the research from participants. Moreover, I made sure participants understood their input was important, desired, and appreciated by providing opportunities for them to ask questions of me. In addition to prolonged engagement, persistent observation was employed to further establish credibility and trustworthiness in the research process.

Persistent observation. I employed persistent observation to support the probability of my research being judged credible while drawing attention to the depth of collegiate athletic trainer experience of a working alliance. Prolonged time with data facilitates increased awareness and identification of elements that are most salient,

allowing determination of relevance (Lincoln & Guba, 1985). Being completely immersed in the data over the course of 7 months assisted my ability to identify and hone in on relevant elements of the data. In-depth exploration and labeling these elements over an extended period of time allowed me to reach a deeper understanding or generate new structural conceptualization of the theory and adjust accordingly. My enhanced sensitivity to the data permitted me to make thoughtful, relevant decisions during conceptualization and creation of the final grounded theory. My final efforts when establishing credibility of findings culminated in the use of member check procedures.

Member checks. Member checks were utilized to ascertain credibility and trustworthiness of the research process. My goal was to uncover the meaning athletic trainers assign to the experience and process of developing a working alliance. Thus, participants were the primary source who could establish credibility of the constructed reality and verify the findings that emerged. Member checks occurred informally during interviews as participants confirmed or adjusted my reflections and clarifying questions to their responses. A formal member check occurred when the emerging theory was presented after two rounds of interviews and data analysis. Participants confirmed that interpretations of the data rang true and that their meanings, ideas, and values were sensitively and appropriately represented. What follows is a description of member check procedures.

Member check procedures. I contacted the six participants to discuss the results. Participants were emailed 2 conceptual maps for reference; one included shared experiences with processes included (Figure 3), and the other captured shared experiences without processes created specifically for member checks (Figure 4).
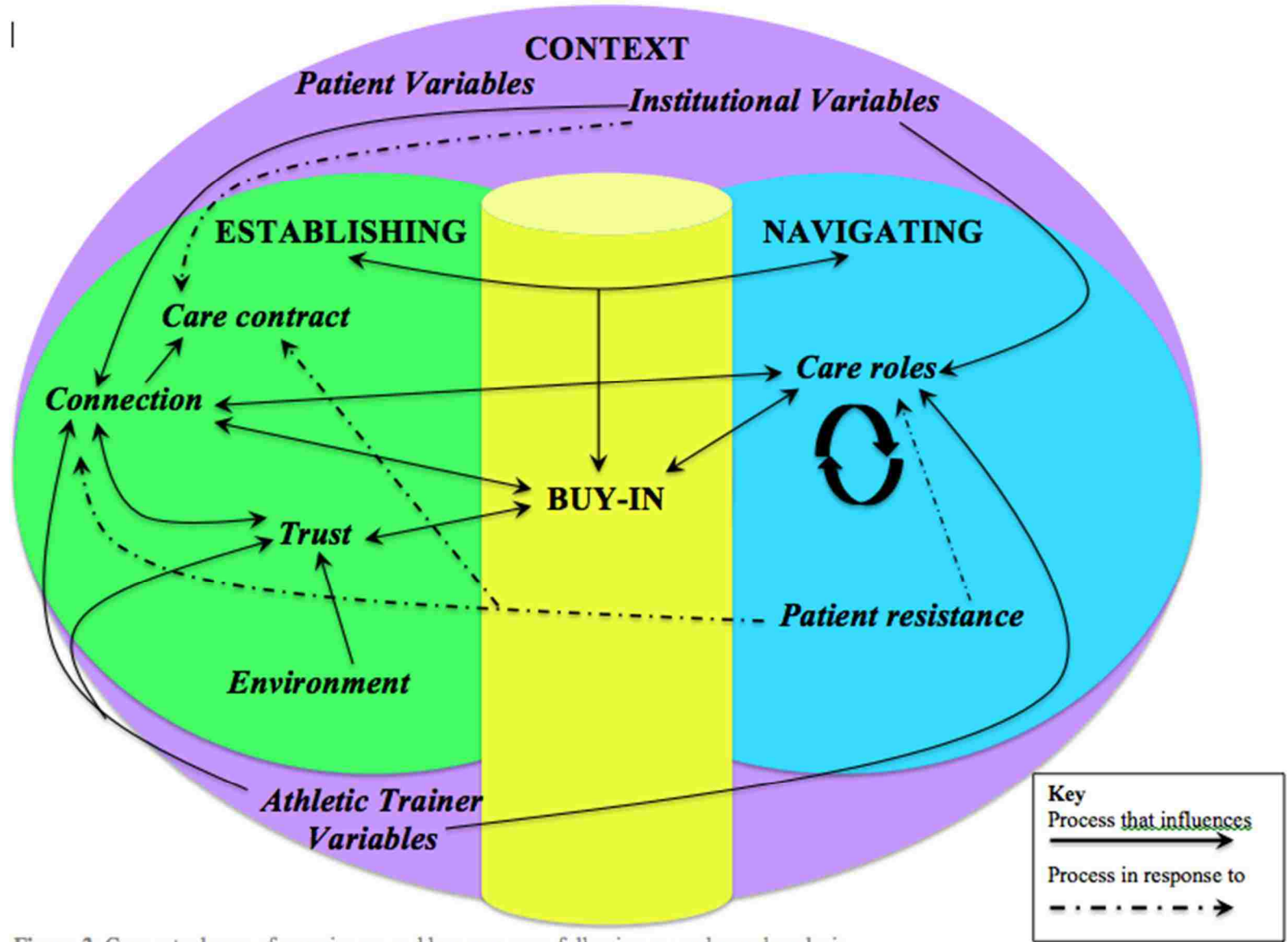
Figure 3: Conceptual map of experiences and key processes following second round analysis
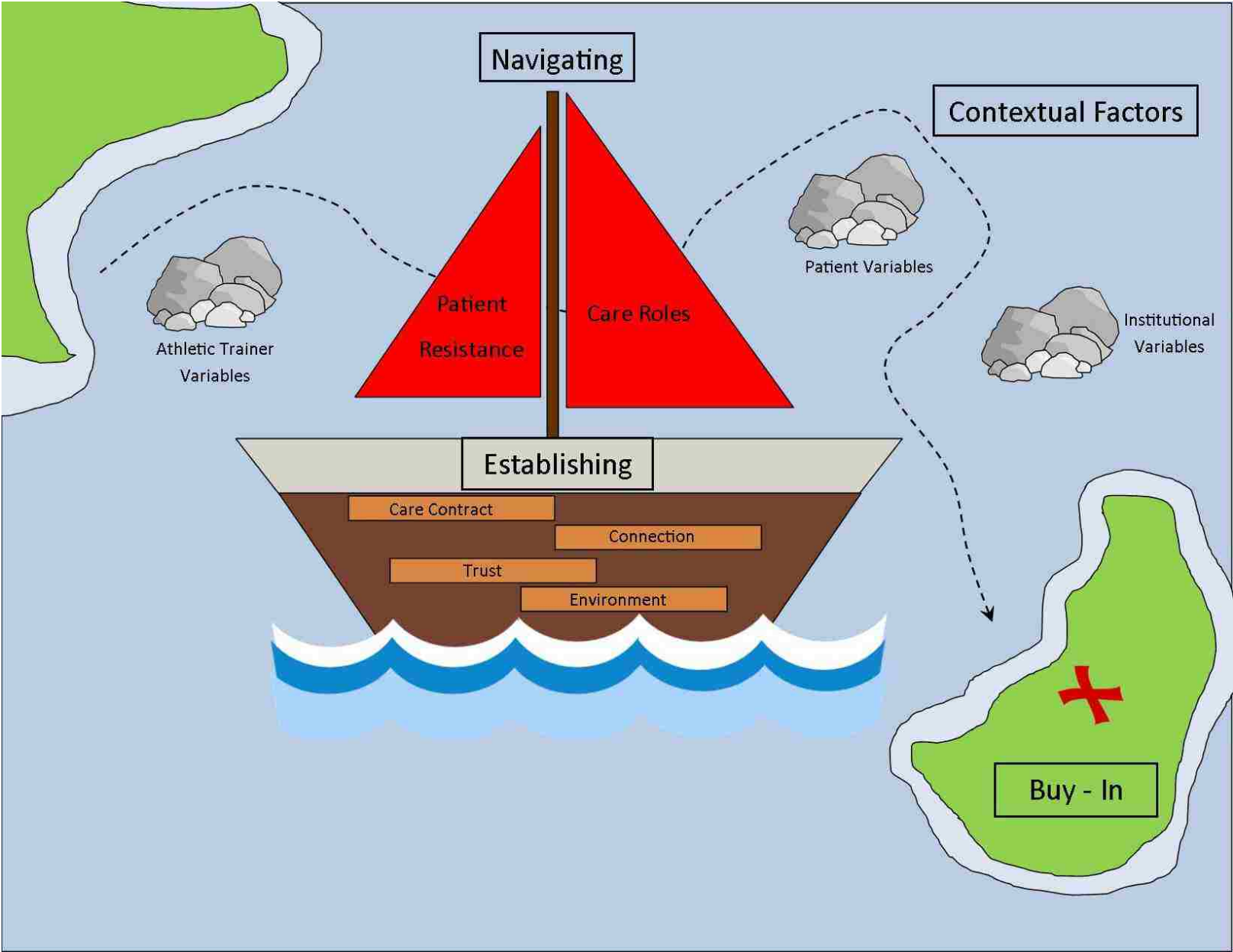
Figure 4: Conceptual map of shared experiences following round two analysis

Participants granted permission to record the interviews to ensure accuracy of their feedback, and I took notes throughout the discussions. Dialogue lasted 40-50 minutes. The emerging theory was summarized and relayed to participants by category and relevant process. Upon completion of each category and process summary, participants were asked to indicate: 1) what did or did not resonate with them, 2) what they believed was necessary to add, and 3) what they thought needed to be changed. Six participants shared their reactions to the presentation of the emerging theory via phone conversation. Participant feedback was reviewed and a description of their member check responses is detailed below.

Member check results. All six participants confirmed the presented theory. As I discussed the emerging theory with participants, there were many aspects they specifically related with, and some suggested additions. These suggestions are added to the final theory conceptualization in this chapter.

Orlando thought the emerging theory was really great and "hoped to see it published." He reiterated that the *sub-category environment* was a really big piece for him, believing that it connects everything (**establishing**, **navigating**, and **buy-in**). When exploring **navigating**, discussing patient resistance as athletic trainers meeting patient effort, he expressed not feeling good about this, or proud, but that it really resonates with him. In fact, this was so salient for him that he stated "I think it will catch peoples eyes when they read it." When discussing **establishing** and expectations of patient responsibility, Orlando questioned whether patient load was present within the theory. I assured him that it was and when it was discussed in **contextual factors**, it was a very big and relevant piece for him. He was glad it was addressed and believed that it fit well

within **contextual factors** when I asked him if it would fit better elsewhere. Finally,

Orlando was very happy to hear that clinical preceptors (CPs) were a big factor in

influencing ATS professional development, and re-emphasized that his experiences with

CPs helped him develop his style of **establishing**, **navigating**, and working to achieve

buy-in.

Maeve emphasized the interconnected nature of *care contract*, *connection*, and

trust and also felt it made sense these pieces of **establishing** were separated out. When

discussing *care roles*, she questioned the role and influence of physicians in patient care,

as this was very salient for her. I explained that physician was included within

contextual factors, and when this was presented to her she agreed with its placement and

was happy it was represented in the emerging theory. While discussing **contextual**

factors, the influence of CPs on developing ATS professional practice was something

Maeve really connected with. She also questioned whether anything came up within

institutional variables about administrative support, financially or otherwise. In her

current position, she believes she receives good support from the head athletic trainer and

the administration. As such, when faced with challenging situations, she feels she has

more support and backing from the institution than she had in the past. Since this was a

very relevant experience for her, she agreed that it would fit best in the *sub-category*

institutional variables. Administrative support was added to *institutional variables* and

integrated into the final theory.

When speaking with Liam after relaying **establishing** he emphasized the

importance of displaying confidence in treatment, ability to design care plans, and

achieve successful outcomes to help establish *trust*. As such, we discussed emphasizing

athletic trainer confidence as part of ***establishing trust***, and Liam was in agreement with this. This suggestion is incorporated into the final theory. Liam also asked about limitations to creating a connection related to managing a large amount of patients during our discussion of **establishing**. I assured him this is captured in *patient load*, which rests in **contextual factors**. When *patient load* was discussed, he confirmed it accurately represented his experiences and expressed frustration that it limits his ability to give quality time to patients. Liam also really resonated with the dynamic nature of care roles, emphasizing that changing these roles is very individual specific. He also reiterated the presence of both the partner and director role, but emphasized, "you still have to lead." When the member check was complete, Liam asked if he could have a copy of the final theory when it was completed.

After relaying the emerging theory to Aiden, he stated, "all the stuff included sounds great." ***Trust*** was something that Aiden also related with, restating that it takes work to build ***trust*** with patients and coaches, and communication is vital for this. Aiden also agreed with athletic trainers meeting patient effort when **navigating *patient resistance***, and ***care roles***. Specifically, he liked that care roles were described as a set of keys. That based on the situation, participants determined which key (director, partner, or educator role) would progress the care process, and whether participant or patient would be contributing to or directing care. Aiden states "that really sounds great to me because you hand off those keys throughout the whole process…" As we talked about **contextual factors**, Aiden confirmed the CP-ATS relationship is a huge factor, the CPs he interacted with were influential to developing the way he currently practices. This is especially significant for him now because he is a CP and is very aware of his role as a mentor.

Fiona also confirmed the presence and importance *connection* and *trust* have when **establishing** relationships with patients. Furthermore, she talked about the fact that coaches play a larger role on the medical side of things than they realize, confirming **establishing** *coach involvement*. As we talked about **navigating** *care roles*, Fiona asked about physician involvement and influence on patients care. After talking about *patient variables*, and specifically the placement of physician within *additional relationships*, she confirmed that it was adequately represented and located appropriately. After sharing about **buy-in**, Fiona mentioned she "agreed with everything", and "could think about examples with every piece of **buy-in**." Fiona also agreed with *institutional emphasis*, mentioning that it is a very important aspect. At her institution, she believes a larger emphasis is placed on sport participation rather than academics, and in her perception athletes are not supported as much academically.

Keeley also confirmed the overall content of the emerging theory. She spoke to *boundarying*, and the importance of coaches respecting athletic trainers boundaries between personal and professional life. Specifically, when coaches make changes to practice and event schedules, she is not included in those discussions, nor is schedule changes relayed to her in a timely manner. This encroaches upon her professional responsibilities and personal time. For Keeley, *boundarying* also includes communicating the presence and importance of her life outside of professional responsibilities to coaches. This experience was integrated into the final theory. After sharing about **buy-in**, Keeley mentions the importance of patient *belief* and trust in their athletic trainer, and that it was accurately represented in the final theory. After completing the member check, Keeley also asked for a copy of the final theory.

In sum, all six participants confirmed during member checks that the emerging

theory summary and conceptual models accurately represented their experiences. After

completing member checks, the importance of confidence for **establishing** *trust*,

establishing <u>*boundarying*</u> with coaches, and the presence of administrative support

within ***institutional variables*** were integrated into the final theory. Next, I will discuss

how transferability was upheld and established during the research process.

Transferability

Transferability enables readers to determine if the findings apply to similar

contexts. Providing significant explanation and description of the data and final

grounded theory allows the reader to determine whether information is applicable to their

experience or other contexts. To support transferability I incorporated rich thick

descriptions.

Rich thick descriptions. Rich thick descriptions offer explanation, allowing

readers to judge whether comparisons with other situations are possible (Lincoln & Guba,

1985). Rich thick descriptions, encompassing a myriad of information provided by

athletic trainers, were useful in supporting transferability. These detailed narratives

offered readers examples of the data and findings, enabling them to evaluate information

as meaningful and applicable. Use of rich thick descriptions supports transferability and

helps further establish the "truth value" and trustworthiness of the findings. Last, I will

discuss how I attended to establishing dependability and confirmability of my research.

Dependability and Confirmability

Dependability seeks to ascertain potential instabilities in the context and process

of research, in addition to methodological design changes. Confirmability captures how

much the established results are based on participant experiences as opposed to

researcher influence (Lincoln & Guba, 1985). I used two methods to enhance

dependability and confirmability findings: reflexive journaling and an inquiry auditor.

Reflective journaling. To support the auditing process and help maintain

transparency of data collection and analysis, I kept a journal. I wrote about my mental

processes regarding participants, questions that arose when analyzing data (regarding the

nature of the data, lingering questions, and matters to follow up on), and created diagrams

and mental thought processes. I also wrote about my perceptions and reactions to the

data and thoughts on bias during analysis. Journaling allowed me to be aware of personal

factors influencing the study and to take steps to prevent such influence while remaining

responsive to the messages contained within the data (Corbin & Strauss, 2008). In

addition to reflexive journaling, I also utilized an inquiry auditor.

Inquiry auditor. An inquiry auditor can assert dependability of the research by

thoroughly examining and finding acceptable the process of inquiry, and confirming that

the final product is actually supported by the data and interpretations. Moreover, an

auditor can also account for confirmability by attesting to how much of the established

results are based on participant experiences (Lincoln & Guba, 1985). Throughout this

research process I worked closely with Dr. Murray, my chair, and she served as auditor of

data collection, analysis, findings, and formation of emerging and final theory.

Throughout the data collection and analysis process, Dr. Murray and I had working

conceptualization sessions and weekly meetings. During coding and analysis, I took

notes and wrote questions and remarks to create a paper trail. This facilitated discussion

of raw data, conceptualization and structure. Dr. Murray questioned and we discussed

interpretation of the data, and accuracy of conceptualization. Dr. Murray and I also

dialogued about potential bias and whether the results and final theory were grounded in

the data, truthfully captured participants' realities, and represented their experience and

process. I considered and appropriately integrated Dr. Murray's feedback. What follows

is the final grounded theory of the experiences and process of the working alliance in

collegiate athletic training.

A Theory of the Experience and Process of a Working Alliance in Collegiate Athletic

Training

After analysis of first and second round interviews and member check procedures,

I have arrived at a final theory of the experience and process of the working alliance in

collegiate athletic training. How collegiate athletic trainers develop and utilize the

working alliance is best captured in the experiences **establishing**, **navigating**, and **buy-**

in, and is continually influenced by **contextual factors**. **Establishing** embodies creating,

entering, and managing relationships with patients and coaches, and how they prioritize

interest in patients and support patient well-being. Participants spoke about **establishing**

care contract, connection, trust, and *environment*. Establishing a *care contract* sets

responsibilities, roles, expectations, and obligations amongst the triad of athletic trainer,

patient, and coach prior to and during the care process. These expectations define

involvement (particularly for the coach), and clarify responsibilities and obligations for

all involved. Athletic trainers aim to initiate relationships by promoting patient

understanding of professional identity and capabilities via *role induction*. Athletic

trainers also aim to share dedication and commitment while forming a ***care contract***,

making a point to support patient agendas and remain flexible to adapt as needed to

facilitate positive outcomes. Patient responsibilities in the ***care contract*** are implicitly communicated and patients are expected to take ownership in the process and outcomes. Patients are expected to be responsible to follow through on commitments and, at a minimum, match athletic trainer effort in the care process. ***Care contracting*** with coaches is guided intentionally to support patient well-being. Athletic trainers selectively seek coach involvement, knowledge, and expertise to meet four primary aims of improving the care process for patients: (1) collaborate on care decisions, (2) help athletic trainers better understand their patients, (3) support athletic trainer care decisions, and (4) act as tools for commitment and discipline. Beginning when patients seek care, care contracts are a foundational element of the athletic trainer-patient and athletic trainer-coach dynamic necessary to ensure a healthy working alliance.

Another key component of establishing rests on experiences of ***connection***, or how athletic trainers show patients they are important, valued, and cared for as unique individuals. To establish a ***connection***, athletic trainers attend to *caring*, *holistic appreciation*, *sharing of self*, *responsiveness*, *bonding*, and *boundarying*. **Establishing** a ***connection*** takes time; effectively utilizing this time for continued interactions with patients (even prior to injury) and purposefully using time to garner a richer understanding and appreciation for patients beyond their injury, illness, or role as an athlete supports a ***connecting*** experience. *Caring* is communicated by working to learn about and understand patients through interaction or observation, recognizing patient effort and challenges, and connecting patients with healthcare resources. Listening attentively to patients and reflecting understanding of their thoughts and feelings helps athletic trainers gain a complete and *holistic appreciation* of patients and supports

individualized care. *Holistic appreciation* also encompasses the triad of coach, patient, and athletic trainer, capturing the importance of mutual respect and the value of identities and roles beyond that of athlete to support care. As athletic trainers recognize patient experiences and challenges (physical or otherwise), they become a helpful resource, **connections** deepen, and **trust** is further established. This **connection** has mutual aspects too. When athletic trainers effectively share personal and professional pieces of their lives, patients understand more about them and *share* more about themselves. **Connection** also requires setting limits that balance personal and professional ways of relating as well as obligations with patients and coaches. Examples of this *boundarying* occur when athletic trainers protect patient health and safety irrespective of patient desires, safeguard their own time and obligations, and communicate the presence and importance of their lives outside of professional responsibilities. Should experiences of **connection** continue, some patients and athletic trainers establish a *bond*, or a deeper connection accompanied by the ability to sense, understand, and attend to patient needs beyond physical ailments and provide comprehensive care that resonates best with patients.

Establishing **connection** creates opportunities for **trust**, another core component part of establishing relationships between participants, patients, and coaches. Promoting patient understanding of professional identity and capabilities and attention to **establishing environment** also supports **connection** and generates **trust**. **Trust** is cultivated when patients and coaches have confidence in athletic trainer competence and ability to support and protect patients. Establishing **trust** is both a cumulative and a circular process; coach **trust** in participants engenders patient **trust**, both of which foster

mutual *trust* amongst the participant, patient, and coach. How information is communicated and disseminated in this triad is vital. Honest and transparent communication about treatment assessments and goals, practicing consistency with communicated expectations, and respecting confidentiality are all ways athletic trainers inspire *trust* about how patient information is protected and purposefully shared via *information sharing*. How and if patient information is shared with coaches is particularly critical. Facilitating coach understanding of patient ability and progress while also respecting patient confidentiality is a delicate balance. Beyond *information sharing*, athletic trainers also *prove* themselves when establishing *trust*. They seek to verify their dedication, professional capacities, and worth to patients through avenues of *credibility*, *commitment*, and *advocacy*. *Credibility* is established multiple ways: displaying confidence, sharing successful patient outcomes, understanding sport demands, and attending practices and events. When **establishing** *credibility* with coaches in particular, not over-reacting to injury, seeking coaches out for consultation, and supporting patient ability to engage in team and athletic events are important. *Commitment* is proven when athletic trainers go above and beyond usual professional responsibilities. *Commitment* is also closely tied to **establishing** *connection*, as this in turn informs *caring* and *responsiveness*. When a *connection* is present, interactions become less formal and athletic trainers become more responsive and available to requests and needs outside basic expectations. The final property of trust, *advocacy*, promotes and protects patient health and safety above all else and intervenes on behalf of patients with the coach and sometimes with patients themselves. Advocacy furthers *trust* in athletic trainer ability to hold patient health as central to their jobs.

Establishing is not limited to athletic trainer-patient and athletic trainer-coach communication and interaction, but also relates to the care *environment*. Creating an *environment* where patients feel comfortable entering and returning, that is also fun and stimulating, helps establish relationships and supports the care process. Talking to patients while they are completing treatment and rehabilitation activities and bringing humor to the *environment* are ways athletic trainers **establish** an *environment* where patients are welcome and more likely to return and stay.

Establishing and continuous attention to a foundation rooted in *care contract*, *connection*, and *trust* supports successful **navigation** through the care process. **Navigating** represents athletic trainer experiences moving through *care roles* and managing *patient resistance*. The *care roles* *director*, *partner*, and *educator* define who is guiding the care process and decision-making. Participants frequently transition between *care roles* as evolving patient and care needs dictate. Athletic trainers embody the *director* *care role* by unilaterally making decisions to guide the care process and reach conclusions they deem necessary for patient care. Choosing aspects of care like patient goals, therapeutic exercises, and treatments, are ways the *director* role is embraced. The *partner* role, however, seeks and integrates patient ideas and feedback, while valuing the patient perspective when making care decisions. While athletic trainers and patients act as *partners* to varying degrees, athletic trainers retain power to make final decisions. **Establishing** *connection* has a reciprocal relationship to the *partner* role; *caring*, *holistic appreciation*, and *responsiveness* unearth patient desires informing patient-centered care. Though at times patients want to be directed, encouraging them to provide input can incite patients to work as *partners* in the decision-making process.

Athletic trainers also act as both *solicitors* and *collaborators* when seeking ideas and feedback from patients. Athletic trainers embody the *solicitor role* when they ask for specific feedback from patients to inform changes to the care plan. While in the *solicitor* role, athletic trainers maintain power over care decisions and determine when and how to utilize patient input and feedback. Even with this power, patient input is the stimulus for changing care decisions. Jointly identifying and integrating meaningful care decisions characterizes the *collaborator* role. Pursuing patient knowledge and experience to guide and select therapeutic exercises, treatment times, treatment modalities and therapies, and goal setting represent athletic trainers' experience of *collaborating*. Moreover, *collaborating* promotes patient power and control over their care. Variation in seeking and integration of patient input in a <u>*partner*</u> role adds depth to athletic trainers' experience **navigating** patient care. The partner role can also vary across <u>dimensions</u> of <u>rehabilitation</u>, <u>severity of injury</u>, and <u>relationship</u>. In response to <u>rehabilitation</u> (length of rehabilitation and timing of input), athletic trainers seek input <u>early</u> to encourage patient activation. Athletic trainers also wait to seek input <u>later</u> in <u>rehabilitation</u>, enabling patients to build knowledge about their bodies before they seek input, which supports patients' ability to effectively contribute to care. Seeking patient input during <u>long</u>-term <u>rehabilitation</u> is perceived as more effective. Time, secondary to length of <u>rehabilitation</u>, facilitates athletic trainer trust in the input patients provide, and enables athletic trainers to fulfill a *collaborator role*. The *solicitor* role is motivated by awareness that patient desire to participate in sport may confound their ability to be truthful about how they really feel. This compels athletic trainers to act more as *solicitors* due to patients not being forthcoming. <u>Severity of injury</u> also influences athletic trainers' experience as

partners. While *soliciting* patient input regardless of severity is important for accurate assessment, athletic trainers avoid seeking patient input with <u>complex</u> (severe or life threatening) injuries. When managing <u>simple</u> injuries, athletic trainers seek and integrate patient input on a more frequent basis. However, care also becomes less collaborative with <u>simple</u> injuries, as care is seen as more "cut and dry" and patient input is not considered essential. For some athletic trainers, a <u>strong</u> <u>relationship</u> rooted in a deeper and trusting connection and mutual respect allows them to better *collaborate*.

Educator is another role vital for **navigating** patient care. Facilitating understanding as an *educator* generates patient ability to later be a *partner* and provide feedback and input in the care process. Athletic trainers wholly attend to the *educator* role by changing the detail and depth of patient education throughout the injury and care process based on patient understanding and progress. Embodying the *educator* role involves attention to educations intent, and can encompass topics like *body awareness*, *understanding injury*, *purpose of treatment*. Supporting patient understanding of each aspect of the care process as an *educator* further establishes patient ***trust*** in their athletic trainer and the care process. Education about anatomy and physiology, tissue healing, and body consciousness (patients learning to "listen" to what their body is telling them) enhances patients' *body awareness*, enabling them to provide feedback and create a foundation for understanding the care process. Providing detailed information about injuries, what patients can expect from the care process, and unique response variation encourages *understanding injury* and facilitates patients' ability to move through care. Last, education about the *purpose of treatment* supports patient understanding of the purpose and effect of treatment and exercises.

Navigating is not limited to choosing *care roles*, but also relates to various kinds of *patient resistance*, or encountering patient barriers in care. *Patient resistance* is a lack of responsibility, effort or commitment, buy-in, compliance, or hesitation to divulge injury/illness. Implicit expectations of patient responsibility and active participation are at times met with *resistance*. Efforts to **navigate** *resistance* can lead to limits at which athletic trainers are unable or unwilling to manage patient care, manifesting as meeting and not exceeding patient efforts to navigate their care. Athletic trainers wait for patients to experience consequences of ineffective injury management, institute repercussions, or counter with collaborative efforts to **navigate** *patient resistance*. Returning to *connection*, the *care roles* <u>director</u> and <u>educator</u>, or requesting <u>coach involvement</u> are ways athletic trainers respond to *resistance* to care.

Continuous attention to **establishing** *connection* and *trust*, and **navigating** *care roles* and *resistance* build a foundation for athletic trainers' experience of **buy-in**, the third **category**. Embodying patient investment with their athletic trainer, treatment tasks/modalities, and their plan of care, and participant expectations of certain patient behaviors, **buy-in** is a circular experience rather than the final result. Gaining and returning to **buy-in** throughout the care process was continuously influential to athletic trainer and patient interaction and therapeutic outcomes. Patient *actions* and *beliefs* in relation to their athletic trainer, treatment tasks or modalities, and plan of care further capture the experience of **buy-in** throughout care, whether initially achieving or re-gaining. Patients who are eager to please, push too hard, or fail to seek guidance when necessary hold negative consequences for **buy-in**. Matching patient effort, spending less time generating patient trust and responsibility and more time on casual conversation,

supports athletic trainers' **buy-in** experience. **Establishing** coach *trust* and <u>*proving*</u> *credibility* is also tied to **buy-in** such that it encourages patient *trust*. Patient trust and confidence in athletic trainer knowledge and ability, recommended treatments/modalities, and plan of care are *beliefs* that support **buy-in**. These in turn generate athletic trainer trust in patient responsibility to complete tasks, making it easier to attend to professional responsibilities and efficiently manage the care process. Patient *actions* that show **buy-in** are multifaceted, and verified through avenues of *accountability*, *communication*, *effort*, and *engagement*. Patients display *accountability* through responsibility and willingness to follow directives and convey interest in managing their care by consistently *communicating*. Concentrating on correct exercise and task completion, staying motivated, and working hard mentally and physically shows *effort*. Taking an active role by asking for feedback and attempting to collaborate on care decisions illustrates patient *engagement* and further supports the presence of **buy-in**. *Care roles* enable *soliciting* or *collaborating* with patients, further generating **buy-in**. When **buy-in** is present, patients become easier to work with, athletic trainers are encouraged to *collaborate* and they display more *commitment* to patients, enhancing *connections* and fostering mutual *trust*.

Finally, **contextual factors** broadly influence participants' efforts to develop a working alliance, from **establishing** athletic trainer-patient relationships, to **navigating** the care process and **buy-in**. These factors capture place and environmental (***institutional***), and person (***athletic trainer*** and ***patient***) ***variables*** that affect athletic trainer-patient relationships and the care process. ***Institutional variables*** include: employment setting, patient/athletic trainer accessibility, resource availability, and administrative support. These variables directly influenced athletic trainers' professional

responsibilities to patient care. Athletic trainer experience of the work environment dynamics such as institutional size and religious orientation, were **variables** that had impacts on patient relationships. *Patient load*, *proximity to patients*, and *institutional emphasis* further elucidate the effect of **institutional variables** on patient care. *Patient load*, the number of patients athletic trainers manage has both positive and negative effects on care. *Patient load* challenges athletic trainers' capacity to deliver comprehensive care by reducing time spent with patients, limiting their ability to establish a **connection**, show *caring* and seek patients' input as *partners*. *Athletic trainer expectation* of patient responsibility and requests for *coach involvement* are ways athletic trainers attempt to mitigate the impact of *patient load*. Also affecting delivery of care is *proximity to patients*. Patient access to athletic trainers and location of brick and mortar care facilities relative to practice/competition facilities challenges athletic trainers ability to effectively track patient needs and manage care. When faced with *proximity* obstacles, creating broadly applicable rehabilitation protocols and increasing coach communication to manage care were ways athletic trainers can adapted to *proximity* challenges. Limited access also generates implicit trust in patient responsibility, linking to athletic trainers **navigating** care as *partners* and encourages intentionally *involving coaches* to help track and motivate injured patients. Institution-specific emphasis on academics versus athletics and philosophies of sport success versus sport participation affects **navigating** patient care. While this prominence can result in experiences of undue pressure from the institution, patients, or coaches to return patients to activity before they may be ready, institutional atmosphere emphasizing student athlete welfare supports a balance between athletics and academics.

Contextual factors are not limited to place and environment factors, but also comprise factors that are person-specific. Features unique to each patient and the collegiate athlete population group, including personality and regional location, ***patient variables*** help define how patients may respond to **establishing** a ***connection*** while **navigating** care. Athletic trainers also contend with *sport valuation* and *additional relationships*, distinctive ***patient variables*** when providing care. *Sport valuation* encourages athletic trainer sensitivity to patient attitudes towards sport participation versus other commitments. Assessment of patient motivation towards sport results in adjustment to approaches to delivery of care. *Additional relationships* (interaction and influence of other patients, teammates, friends, parents or physician) are also integrated into the athletic trainer experience of person-specific **contextual factors**. Athletic trainers purposefully encourage *additional relationships* to promote the care trajectory in the following ways: activating social support networks and using previous patients as advocates or motivating examples. *Additional relationships* also have the potential to negatively impact patient care by impeding relationship development, trust, and management of the care process. Therefore, effective care depends on managing and integrating these relationships throughout the care process.

Athletic trainer variables were critical foundational **factors** to participants' experiences with **establishing, navigating,** and **buy-in**. Recognition of fundamental differences between athletic trainer-patient versus doctor-patient relationship development brings further attention to athletic trainers' unique placement. Athletic trainer awareness of the role and impact they have on patient care generates opportunities to develop athletic trainer-patient relationships. *Personal* and *professional influencers*

encompass personal and professional experiences influential to participants' lives and professional practice, and clearly impact the care process. *Personal influencers* were critical to informing how athletic trainers approached patient care and attended to patient needs. Familiarity with a patient role, experience with injury or illness, and/or previous work with an athletic trainer due to injury were formative experiences that aided athletic trainers when **establishing *connection*** and displaying *caring* and *holistic appreciation*, and while cultivating ***trust*** through honest and transparent *information sharing* and *commitment*. *Personality* an interpersonal characteristic also plays a role in care by shaping athletic trainers approach to patient interaction and resistance, and informing their treatment philosophy or method of care. *Personality* can be a barrier to patient interaction and fostering connection, and recognizing this enables athletic trainers to limit its impact. *Professional influencers*, including *student* and *employee* experiences, affected participants' value and appreciation of the patient relationship. Experiences as a *student* are closely tied to **establishing** with patients, as these informed athletic trainers' valuation of *caring*, *connection*, ***trust***, and investment in patients. Clinical experiences with CPs enable ATSs to observe other athletic trainer interactions with patients, subsequently adapting their approach to patient care. Additionally, on-the-job experiential learning as an *employee* and recognizing the value of learning from patient experiences, informs adjustment in athletic trainers approach to care and meeting patient needs. Experiences gained as an employee also generate athletic trainers' realization of the importance and value of patient education and the *educator* role. These varied **contextual factors** rest beneath all experiences of **establishing** and **navigating** a working alliance with patients, and **buy-in**.

Limitations

Even with establishment of rigorous methodology and trustworthiness procedures, limitations emerged. For the purpose of discovering the experience and process of the working alliance in collegiate athletic training, I utilized a purposeful sample. Six collegiate athletic trainers, (3 males, 3 females) employed in athletic participation associations (1) NAIA, (2) D1, (1) D2, and (2) D3 completed two semi-structured interviews. Subsequent rounds of interviews may have produced new information. While saturation is a goal of qualitative research, it is not completely attainable. Purposeful sampling across athletic participation associations and divisions (NAIA, NCAA D1, D2, and D3) captured 1-2 participants within each setting, potentially limiting transferability of the grounded theory to these settings. As such, the reader must judge if the results of this study are transferable to a larger population of athletic trainers within NAIA of NCAA athletic participation associations and divisions.

Another potential limitation to transferability centers on participants value of the patient relationship. I sought to gain perspectives from athletic trainers who believed the athletic trainer-patient relationship was essential for quality care. Thus, there is some question as to whether these findings accurately represent relationship development in athletic training professional practice overall. Furthermore, participant interest in this research was completely voluntary. Additionally, participants who were less inclined to volunteer may have a different impression of athletic trainer-patient relationship development and the working alliance.

Speaking to professional experience, purposeful selection included participants who had a minimum of 3 years of experience working as athletic trainers. This selection

factored in time and experience as developmental factors for participants, assuming establishment of individualized and competent approaches to patient care. Participants in this study had 4.33 ± 1.03 years of clinical experience. As such, a large range in experience was not present, representing a homogeneous sample of participants in the early stages of their professional careers. Additionally, if participants worked as a graduate assistant (GA) in a supervised mentor model, as opposed to working completely independently as an assistant athletic trainer, participants' years of independent practice experience could be reduced by one to two years. As such, additional realities could exist for athletic trainers who have practiced longer, and the transferability to long-practicing athletic trainers may be compromised.

In the initial proposal, I recommended a methodology that would seek formal member checks after each round of interviews. After first round data collection and analysis was completed, a formal review of the transcripts with participants was not sought, nor were they presented with my interpretation of the data after first round analysis. Nevertheless, informal member checks occurred during interviews when participants confirmed or adjusted my interpretations of their responses, and participants were presented with the emerging theory after both rounds of interviews for a formal member check to review the theory in its entirety and confirm or change the findings. As a result of the formal member check, confidence for establishing trust, establishing boundarying with coaches, and the presence of administrative support in institutional variables were integrated into the final theory.

In sum, a homogeneous sample of participant professional experience, participant value of the athletic trainer-patient relationship for provision of quality care, and a formal

first round member check presented as limitations. These limitations leave unexplored voices and experiences of athletic trainers who have been practicing for longer periods of time, or who feel differently about whether the athletic trainer-patient relationship is essential for quality care. Another potentially buried element includes completion of one formal member check. While these limitations are essential to consider, they are not uncommon when examining transferability in qualitative research. Theory development can lead to many questions that remain unanswered in single studies but lead to rich opportunities for further research.

Implications

The rich and varied realities of six collegiate athletic trainers' experience and process of the working alliance have been co-constructed and abstracted into a descriptive grounded theory. The information drawn from the exploration of athletic trainer-patient relationship development provides valuable knowledge for professional practice, athletic training education, and counselor educators. Below, I discuss relevant implications for these fields.

Athletic training professional practice

This research provides conceptual clarity and understanding of the working alliance in the practice of athletic training. The findings illustrate a working alliance construct in athletic training, clarifying the suggestion that a working alliance may be universally applicable (Bordin, 1979; Meissner, 2006). This theory can be used as a guide to assist athletic trainers' integration of a working alliance.

Informed consent involves all decisions and interventions throughout care, and must explicitly include all treatments or procedures considered imperative to, and

logically included with the initial description of care (O'Neill, 2003). Education of patients to support comprehension and knowledge about their illness/injury, and their involvement in care decisions can improve an informed consent process and support patients' ability to have an active role in care (Dunn, George, Churchill, & Spindler, 2007, Hall, Prochazha, & Fink, 2012 in Testoni et al., 2013). This grounded theory reveals the presence of a largely implicit care contract, and defines how and when athletic trainers take on an educator role. Implementing an informed consent process can support patient understanding and involvement in care. By explicitly communicating patient expectations and obligations, athletic trainers support patient understanding and facilitate the beginning of a working alliance. Changing education in response to patient understanding, patient location in the care process, and by means of varying detail and depth aids athletic trainers in attending to the continuous and evolving nature of informed consent throughout care. Creating and presenting patients with an informed consent can promote dialogue surrounding responsibility and ownership in care. Knowing more about how to develop and incorporate a informed consent in athletic training patient care can facilitate collaborative efforts with patients overall, specifically with task selection, integration, and goal setting. Informed consent becomes a precursor to establishing connection and trust, and is an essential part of a working alliance, as suggested by this grounded theory.

Because poor relationships between athletic trainers and patients can present a barrier to therapeutic outcome (Fisher et al., 1993; Granquist et al., 2014), preparing athletic trainers' to effectively build and repair relationships has potential to improve treatment and outcomes. This grounded theory draws attention to skills athletic trainers

can use to establish connection and trust, and effectively build or repair relationships. With these findings in mind, effectively utilizing time to establish connection, displaying caring, and purposefully garnering a holistic appreciation of patients as unique individuals can support athletic trainers establishing connection. Moreover, this theory draws attention to athletic trainer attention to responsiveness to establish connections. Demonstrating patients' disclosures are appreciated and understood stresses the presence and importance of effective interpersonal communication. Moreover, attention to creating a shared reality can help athletic trainers establish rapport and relate personally to patients. Trust is also important in patient care. Patient-provider relationships established with trust can become a driving force behind patient activation and therapeutic outcomes (Leach, 2005). This grounded theory clarifies methods athletic trainers already use to build trust, and provides a guide for athletic trainers to develop patient trust. Garnering coach trust is also important, and this theory outlines ways athletic trainers can establish trust with coaches. Knowing how to cultivate trust with patients and coaches can link athletic trainers with a patient-centered approach to incite patient activation and therapeutic outcomes. This grounded theory shows us that rapport, connection, and trust are all essential to developing athletic trainer-patient relationships. These relationship factors are fundamental to a quality working alliance and effectively attending to these can support creation bonding and of a working alliance in athletic training patient care.

Athletic trainers are encouraged to recognize professional boundaries (Makarowski, 2007; Moulton et al., 1997) and avoid overly emotional reactions to concerns of patients (Gourlay & Barnum, 2011), which could affect the relationship

between athletic trainer and patient. When developing a working alliance, athletic trainers may find themselves furthering a more personal and less professional relationship, or developing an emotional reaction fostering a "do anything for the patient" mindset. As this grounded theory outlines, this may occur when establishing trust and proving commitment and advocacy to patients. As such, boundaries and ethical responsibilities between athletic trainer and patient may become blurred, causing athletic trainer and patient to loose sight of what is in the best interest and welfare for the patient. To uphold principles of ethical behavior, athletic trainers are encouraged to provide professional services that are guided by moral, ethical, and legal directives (Makarowski, 2007) and follow all NATA Standards, the Code of Ethics, local, state, federal laws, and state practice acts (NATA, 2016).

Involving patients in decision-making, establishment of goals, and checking for comprehension can improve the informed consent process (Hall, Prochazha, & Fink, 2012 in Testoni, Hornik, Smith, Benjamin, & McKinney, 2013), and it is also central to a patient-centered approach to care and a working alliance. In fact, with an overarching goal of health profession reform and enhancing quality care, the Institute of Medicine (IOM) recommends health professionals attend to patient-centered care delivery (Greiner & Knebel, 2003). Attention to involving patients in decision-making can enhance athletic trainers ability to address patient values, gain agreement on goals, collaboratively select and integrate tasks, and develop a working alliance. Consideration of patient values is also foundational to evidence based practice. This theory reveals successful navigation of patient care involves various care roles, and specifically outlines how and when athletic trainers can involve patients in their care. A partner role values patients' perspective and

integrates their ideas into care decisions, emphasizing a patient-centered approach to care. This theory stresses the various ways athletic trainers can gather or identify patient feedback or encourage involvement to support the partner role, aiding athletic trainer proficiency in involving patients in decision-making. Awareness to variation in patient involvement, generated by this theory, can encourage athletic trainers to effectively navigate ways of being a partner throughout the care process. This grounded theory also brings attention to how and when patient education is provided during care. Athletic trainer knowledge of how to effectively take on an educator role enables them to support patient ability to offer informed consent and involvement in decision-making. Effectively navigating these care roles can improve working alliances and align athletic trainers with a solid foundation to construct holistic patient-centered care.

Valuing patients as contributors to their healthcare enhances motivation for change, self-reliance, and adherence (Dorflinger et al., 2013; Fuertes et al., 2007). Collaborating with patients enables patients to contribute and supports moving through the care process. When and how athletic trainers collaborate with patients is outlined in this theory. When patient attempts to contribute to care are unhelpful, this theory demonstrates how athletic trainers can respond to patients' collaborative attempts. Confidence and proficiency attending to collaboration with patients can strengthen everyday practice for athletic trainers and encourage patient motivation and adherence. This can also engender athletic trainer ability to gain agreement on goals and collaborate with patients on task selection and integration, generating athletic trainer ability to develop a working alliance with patients.

Athletic trainers play a critical role in promoting buy-in. While buy-in was the term that emerged within this study, similar experiences are referred to as adherence and compliance. Adherence emphasizes patient control and direction of their care (Robinson, Callister, Berry, & Dearing, 2008). Patients possess the right to choose to follow treatment recommendations, and emphasis is given to provider attention to factors limiting patients' ability to follow recommendations. Compliance, aligned with a more patriarchal model, suggests patients simply obey provider instructions (Robinson et al., 2008). Implicit within compliance is an understanding that patient failure is the reason for not completing treatment or meeting provider goals. Shifting athletic training professional practice towards adopting the adherence construct can support joint responsibility and a patient-centered approach to care and emphasis on patient autonomy, and this theory can provide structure athletic trainers can follow. The theory outlines numerous ways athletic trainers can navigate patient resistance. Providing athletic trainers with various avenues to eliminate barriers connects them with skills to support patients moving through care and encourage buy-in.

The 5th edition of the athletic training *Educational Competencies* outlines possession of skills to apply and interpret clinical outcomes assessments, such as disability models, to maximize patient outcomes (NATA, 2011). Though the *Educational Competencies* do not identify a specific model, one such model, the World Health Organizations (WHO) International Classification of Functioning (ICF) calls for providers to consider the interaction of health conditions, environmental factors, and personal factors with attention to functioning and disability secondary to a biopsychosocial approach (World Health Organization, 2013). While athletic training has

been moving toward use of disability models, care contract, connection, and navigating care, aspects in this grounded theory, may support athletic trainers management of patient care from a biopsychosocial approach with consideration of environmental and personal factors. While this theory emphasizes athletic trainer commitment to adapt care to facilitate positive outcomes, to support a biopsychosocial approach athletic trainers must also include attention to psychosocial aspects of care. If attention is focused purely on the physical effects of injury, environmental, personal, and psychosocial components may be missed. A connection between athletic trainer and patient, as demonstrated in this grounded theory, enables patients to feel comfortable sharing concerns and enhances athletic trainer responsiveness to patients. With these findings in mind, athletic trainers can discover important interactions between health, environmental, and personal factors, enabling them to approach care holistically. This theory also underscores that continuous attention to establishing connection can generate a deeper connection between athletic trainer and patient, enhancing athletic trainers ability to sense, understand, and attend to patient needs beyond physical ailments and provide care that resonates with patients. Connection is also tied to navigating care as partners, as attention to connection unearths patient desires that inform patient-centered changes to care. This theory offers athletic trainers strategies to effectively take on a partnership with patients, which can help athletic trainers uncover relevant patient goals and collaboratively establish a care plan that is significant to patients. Attention to care contract, connection, and working as partners with patients may help athletic trainers discover the interplay of environmental and personal factors on health conditions and support management of care from a biopsychosocial perspective.

Athletic trainers are encouraged to self-reflect and critically evaluate current care practices when working with patients. While this theory has significant implications for professional practice, it is also relevant to athletic training education.

Athletic training education

Integrating skills training into professional and educational programs to develop effective communication (Arbuthnott & Sharpe, 2009), improve patient-provider understanding and agreement (Kerse et al., 2004), and enhance collaboration (Arbuthnott & Sharpe, 2009; Flickinger et al., 2015) is effective for advancing patient outcomes. Athletic trainers actively contribute to building relationships and facilitating patient care, therefore they can benefit from professional and educational programming addressing establishing relationships and navigating care to promote patient buy-in (adherence) and positive outcomes.

Classroom training. Clinical education opportunities and coursework positively influence student attitudes and perceptions towards a therapeutic relationship and patient-centered care (Byrne, Soundy, & Roskell, 2015; Ross & Haidet, 2011). In athletic training, educational interventions have also proved effective in changing athletic training student attitudes and beliefs towards patient care (Clement, 2008; Harris, Demb & Pastore, 2005; Stiller-Ostrowski, Gould, & Covassin, 2009). With this in mind, skills training developed from recommendations from this grounded theory can influence athletic training students' attitudes and beliefs towards patient relationship development and a working alliance.

Establishing rapport, trust, empathy, and effective interpersonal communication forms a foundation for relationship development (Kottler & Brown, 1996; Sommers-

Flanagan, 2015) and enables accurate conceptualization of patient needs and realization of effective treatment (Bordin, 1979; Williams, 1998). Athletic trainers believe establishing trust and rapport with patients is paramount for treatment and rehabilitation adherence (Fisher et al., 1993; Granquist et al., 2014; Tracey, 2008). This belief, and proficiency establishing trust and rapport, can be further supported and enhanced in the classroom. This grounded theory shows how athletic trainers attend to rapport-building and trust at the onset of care and throughout the care process. This theory also emphasizes the importance of and trust with patients and coaches, and how trust is established. Additionally, athletic trainers hold the belief that communication is important in patient care, while also desiring further training and education to augment their skills (Clement et al., 2013; Larson et al., 1996). Athletic trainers also perceive a lack of adequate educational exposure to communication skills (Stiller-Ostrowski & Ostrowski, 2009) calling attention to whether athletic trainers are effectively obtaining and utilizing communication skills foundational to patient care. This theory shows that athletic trainers attend to communication when establishing connection with patients through various ways of being responsive. Knowing more about when and where these skills surface in athletic training practice can help athletic training educators integrate these skills into the classroom, which can also enhance ATS comfort and proficiency integrating these skills into clinical experiences.

To integrate these skills into the classroom, athletic training students are first introduced to the concepts of patient-centered care, a working alliance, relationship factors (rapport, trust), empathy (cognitive and affective aspects and the difference between empathy and sympathy), and interpersonal communication (open ended

questions, reflecting, reframing, and summarizing). Students are then provided guided opportunities to practice skill application for experiential learning by role-playing within small groups. First, students practice empathic versus sympathetic responses, perspective taking, and being non-judgmental, with instructor provided scenarios. Next, students practice use of relationship building factors and interpersonal communication skills by role-playing scenarios in which one partner (the patient) presents a "problem" that the other partner (the care provider) has to uncover while and refraining from asking 'yes' or 'no' questions. Students are also encouraged to pay attention to underlying feelings (affective aspect of empathy) such as sad, angry, happy, scared, etc. while role-playing, and reflecting these feelings to their partners. These role-play sessions are observed by classmates within the smaller practice groups, allowing immediate student provided feedback, and by faculty who can provide immediate feedback and guidance. Additionally, students can complete a role-play assignment in which they video-record an interaction with a partner (who provides a "problem" while role-playing as a patient), and then the student role-playing the care provider reviews and offers critique and assessment of their use of the aforementioned skills.

Accurate use of relationship factors and interpersonal communication supports bond creation, reaching agreement on goals, and collaboration between patient and provider on task selection and integration (Bordin, 1979; Sommers-Flanagan, 2015). Patient involvement is central to a patient-centered approach to care and a working alliance. In addition to skills training to enhance ATS use of relationship factors and interpersonal communication, this theory offers suggestions on when and how to involve patients in care. Athletic training educators can use these findings to develop educational

content generating ATSs' proficiency involving patients in their care, which supports

working as partners in a working alliance. With understanding of and confidence using

relationship factors, interpersonal communication, and involving patients in care, ATS

can achieve agreement on goals and collaborate with patients on task selection and

integration, concepts vital for developing a working alliance.

Patient education is critical for promoting understanding and generating

collaborative interactions (Sommers-Flanagan, 2015). Patient education can be effective

in supporting patient activation and collaboration in care (Tracey, 2008). This theory

offers a template on how and when to provide patient education during patient care.

Knowing more about when and how patient education surfaces the treatment process can

guide athletic trainer educators scaffolding these skills into the classroom to enhance ATS

proficiency and confidence in providing patient education. Promoting ATS

understanding that effective education is adapted throughout the injury and care process,

and requires attention to the intent of education provided, can connect ATS with skills to

promote patient understanding and collaborative care experiences. Integrating focused

education and skills training into ATPs can connect ATSs with skills to enhance clinical

learning and patient-centered care experiences prior to professional practice.

Clinical preceptor training. Pitney and Ehlers (2004) recommend addressing

the critical roles athletic trainers occupy as role models and mentors while clinical

preceptors (CPs) to athletic training students (ATSs). Clinical preceptors occupy

influential positions within ATP's and with ATSs. This grounded theory highlights

establishing and navigating skills that may be most beneficial to training CPs and can

provide a training framework to enhance these skills. Understanding what skills are most

influential to ATSs' clinical growth can support scaffolding these skills into trainings for CPs, and then CPs can model these skills during patient care. Focused skills training on establishing rapport, trust, and interpersonal communication can enhance CPs confidence and proficiency in integrating these relationship factors into patient care. Additionally, CPs are in an ideal position to model navigating patient care as partners and educators. This theory highlights the importance of patient education and involving patients in care, and offers a framework for how and when these care roles are most effective. Knowing when and how these skills surface can guide training for CPs, enabling them to model these skills for ATSs and introduce ATSs to their importance and value sooner during clinical education. This theory also has implications for counselors and counselor educators, explored next.

Counselor Educators

Recognition of professional knowledge and capability and ability to work with other healthcare providers to support positive patient outcomes is requisite for athletic training professional practice (NATA, 2011). Interdisciplinary provision of care is also a core value of the Institute of Medicine (IOM), such that care providers work together in a collaborative manner to promote complete and continuous patient care (Greiner & Knebel, 2003). Developing an understanding of professional responsibilities, such as scope, rigor, and demands, can lay the groundwork to support provision of care within interdisciplinary teams (Arenson et al., 2015), and support cross-disciplinary skill development. Counselor educators are well versed in preparing counselors to attend to communication skills such as active listening, summarizing, checking for understanding, and empathy, and are poised to expand this counselor-specific training into other

domains. Educational programming can successfully these enhance counselor-specific communication skills (Gysels et al., 2005; Maguire & Pitceathly 2002). This theory provides a scaffold for expanding working alliance training into a different professional context and is vital for counselor educators understanding what working alliance skills are most beneficial for the athletic training treatment process. Knowing more about when, how, and where working alliance skills surface in the athletic training treatment process supports counselor educators in scaffolding these skills for trainings in the athletic training discipline. A theory grounded in how athletic trainers establish connection, rapport and trust with patients offers a unique starting point for counselor educators to expand their expertise into the experiences, processes, and contexts of athletic training treatment. With these findings in mind, counselor educators can enhance current proficiency and introduce skills focused on interpersonal communication, rapport, and trust building for certified athletic trainers. Connecting athletic trainers with these skills may also enhance bond formation, which can generate gaining agreement on goals, and collaborating on tasks, supporting development of a working alliance. Counselor educators can also work collaboratively with ATPs to introduce and develop these skills in the classroom.

This grounded theory highlighted that care contracting was often done implicitly. Patient comprehension and knowledge of their injury or intervention is necessary if they are to provide informed consent (Dunn et al., 2007). Athletic trainers are encouraged to consider informed consent as a proposition describing every intended action throughout care. Initial description of action does not implicitly include all treatments or interventions considered imperative to, or logically included with, the initial description

(O'Neill, 2003). Creating and attending to informed consent, a form of care contract, is inherent in counselor education, however, in the counseling discipline, informed consents are explicit. Counselor educators can contribute to training athletic trainers through focused education on how to make care contracting explicit by creating and integrating an informed consent into patient care. This can bring clarity to expectations and obligations sooner in the care process.

This grounded theory can be used to inform counselors and counselor educators where athletic trainer strengths lie and where focused skills training would be most beneficial. Integrating skills training across disciplines increases the breadth and application of these skills and arms athletic trainers with knowledge that can help them best meet the needs of patients from a holistic patient-centered perspective. In sum, the findings of this research have clear implications for athletic training professional practice, athletic training education, and counselor educators and counselors. Results also draw focus to additional areas of investigation. A discussion of recommended future research follows.

Future Research

The goal of this innovative research was to understand collegiate athletic trainers' experience and process of patient relationship development. How relationships are developed in professional settings outside the collegiate setting remains unknown, as well as the influence of relationship development on patient outcomes. Additionally, this research sought provider perspective of relationship development, leaving other perspectives unexplored. While selection and integration of tasks and interventions was present during care, use of certain strategies merits further investigation. Last, other

methodological designs could be used to explore patient relationship development for additional depth and diversity.

Further depth within collegiate setting

As this is the first study to look at the experience and process of athletic trainer-patient relationship development within the context of a working alliance, further study can support, refute, or shed additional light on these findings. First, this study included participants from collegiate settings (NAIA, NCAA D1, D2, and D3). As such, contextual factors were varied and had different implications for these various athletic participation associations and divisions. Qualitative study specific to each collegiate setting may yield more information on inherent contextual factors within and across athletic participation associations and divisions. Second, it may also be pertinent to capture the experiences of those who do not specifically indicate the presence of a relationship as being essential to quality care. This would account for potential differences in relationship development and the working alliance with athletic trainers who do not believe an athletic trainer-patient relationship is vital to quality patient care. Last, the aim of qualitative research is transferability as opposed to generalizability. This study brings attention to relationship development in collegiate athletic training and generates depth and detail around the experience and process of this construct. Clarity and depth about the experience and process of relationship development primes this concept for future quantitative research.

Additional professional setting

Characteristics of patient relationship development within the context of a working alliance in other athletic training settings remain unearthed. In the collegiate

setting, athletic trainers have daily access and interaction with patients at practices and events, and from time of injury to full return to participation. Patient interaction increases in the collegiate setting when instead of attending practices or other events, they complete treatment and rehabilitation. Athletic trainers in other professional settings may not have this kind of exclusive daily access and interaction with patients. Furthermore, patient characteristics (i.e. age, maturity, employment versus sport participation, necessity of sport or job, etc.), and contextual factors (i.e. patient load, proximity to patients, organizational emphasis and resources, etc.) can be inherently different within other professional settings. Purposefully sampling athletic trainers employed in other settings (i.e. professional sports, high school, industrial, and occupational settings) would provide further insight into inherent differences within, and allow for comparison across these settings.

Psychosocial Interventions

Based on my conceptual context I expected to find attention to psychosocial strategies (goal setting, imagery, relaxation techniques, motivation techniques, positive self-talk, social support, communication, counseling skills, etc.) present during patient care. The presence of some interventions (goal setting, social support, communication) gives a nod to some interventions I anticipated. However, other strategies were absent, even though they had been present in the literature. Underutilizing or ineffectively selecting and implementing these skills may limit athletic trainer-patient relationships, and therefore negatively affect therapeutic outcome. Though these techniques are tools to support treatment and rehabilitation success, how athletic trainers collaboratively select

and integrate them into patient care is unclear. This merits further investigation into whether and how athletic trainers utilize these strategies.

Patient perspective

Provider perspective is only one aspect of the provider-patient dyad. It is also necessary to seek patients' perspective on the structure and presence of relationship development and a working alliance. Differences may exist between athletic trainers and patients, so it is relevant to assess patients' perceptions. Qualitative research would allow for exploration of the athletic trainer-patient relationship from the patient's perspective.

Further research could also take a quantitative approach, such as using the Working Alliance Inventory (WAI) instrument. Based off Bordin's (1979) theoretical conception of the working alliance, the WAI has both patient and provider versions to assess attitudes and feelings related to the therapeutic bond, agreement on goals, and collaboration on therapeutic tasks. The WAI could be used to assess the presence of a working alliance, and uncover how perceptions of the working alliance may differ. Furthermore, the WAI could also be used to identify components of the working alliance that are most relevant to patients.

Relationship between working alliance and therapeutic outcomes

The presence and influence of a working alliance in athletic training on therapeutic outcomes remains unknown. Future research in athletic training can explore whether a relationship exits between a working alliance and therapeutic outcomes (pain, quality of life, adherence, motivation, patient satisfaction, etc.), and whether the strength of a working alliance influences therapeutic outcomes. Athletic training research can also model research completed in other health professions (i.e. medicine, nursing, physical

therapy, occupational therapy) as both a starting point for initiating research, or to allow comparison with other healthcare professions.

Uncovering a relationship between a working alliance and therapeutic outcomes can inform skill development in educational preparation and professional practice to enhance knowledge and proficiency building a working alliance. Quantitative research can be conducted (i.e. pre-post test) to assess the effectiveness of these interventions on athletic trainer knowledge and proficiency immediately, and at various times post skills training intervention. Following skills intervention, research that aims to uncover whether increasing knowledge and proficiency of building a working alliance has a specific effect on therapeutic outcomes can support future educational and professional training. Research in this vein can begin to align athletic trainers with an approach to patient care relevant across psychotherapy and healthcare professions.

To summarize, exploring the experience and process of a working alliance in collegiate athletic training has lead to rich opportunities for further research. Future research includes further exploration within athletic participation associations and divisions and initiating research within additional professional settings. It is also relevant to investigate the experiences of athletic trainers who do not indicate the athletic trainer-patient relationship as essential to quality care. How athletic trainers collaboratively select and integrate psychosocial strategies into patient care is unclear and merits further investigation. Exploring the presence and strength of a working alliance from patients' perspective is another relevant avenue for research. Furthermore, the WAI could also be used to reveal differences in provider and patient perceptions of the working and identify components of the working alliance that are most relevant to patients. Because the

presence and influence of a working alliance in athletic training on therapeutic outcomes remains unknown, uncovering whether a relationship exits between a working alliance and therapeutic outcomes, and whether the strength of a working alliance influences therapeutic outcomes, is relevant for future exploration. Since uncovering a relationship between a working alliance and therapeutic outcome may inform skills training, research evaluating the effectiveness of skill development on athletic trainer knowledge and proficiency building a working alliance, and whether increased proficiency has a specific effect on therapeutic outcomes, would also be an important future research direction.

Conclusion

The final grounded theory of the experience and process of the working alliance in collegiate athletic training has been presented and evaluated for trustworthiness and limitations. Purposeful sampling, prolonged engagement, persistent observation, member checks, reflexive journaling, and an inquiry auditor were undertaken to ensure trustworthiness. Limitations that emerged included homogeneity of participants in regards to years of clinical experience, purposeful selection of participants who believe athletic trainer-patient relationship is essential for quality care, which leaves out the voices those who may feel differently, and completion of one formal member check. Implications for athletic training professional practice, athletic training education, and counselor educators and counselors was presented and discussed. Within the collegiate setting, further study can include exploration into each athletic participation association and division to yield more information on setting-specific contextual factors, athletic trainer experiences who do not directly indicate a patient-provider relationship is essential to quality care, and initiating quantitative inquiries to further explore athletic

trainer-patient relationship development and the presence of a working alliance. Additionally, research that aims to discover how athletic trainers select and integrate tasks and interventions into patient care can provide clarity as to whether this is approached in a collaborative manner. Research within additional professional settings can unearth potential differences in patient relationship development within these settings, allowing for comparison, and potential transferability, across settings. Research capturing patient perspective can shed light on the presence and structure of patient-provider relationship development and a working alliance, identify components a working alliance that are most relevant to patients, and uncover if patient and provider perceptions of the working alliance differ. Last, it is relevant to uncover whether there is a relationship between a working alliance and therapeutic outcomes and whether outcomes are affected by the strength of a working alliance. The various directions of future research can shed additional light on the presence and influence of a working alliance in athletic training and connect athletic trainers with an approach to patient care that generates positive therapeutic outcomes, and fosters a holistic patient-centered approach to support return to function.

This grounded theory study sought to uncover athletic trainer-patient relationship development within the context of a psychology and counseling construct, a working alliance. The final theory hinges on the analysis and detailed interviews with 6 collegiate athletic trainers on their experience of patient relationship development and attention to a working alliance during patient care. Participants stressed the importance of creating, entering, and maintaining relationships with patients through avenues of establishing care contracts for all involved in care, connection, trust within the athletic trainer-patient-

coach triad, and an environment patients feel comfortable entering into and returning to.

These factors provide the foundation from which athletic trainers move through care with

patients by taking on various care roles, which capture experiences directing the care

process, working as partners with patients and collaborative efforts, and attending to

various aspects of patient education to generate patient understanding of their injury and

the care process, and responding to barriers encountered during care. Continuous

attention to establishing connection and trust, and navigating care roles and patient

resistance were influential in generating patient investment with their athletic trainer,

treatment tasks/modalities, and their plan of care. Environmental, place, and person

variables, though not always negative, were continuously influential to experiences

developing relationships and a working alliance with patients during care.

APPENDIX A: University of Montana Institutional Review Board Approval

UNIVERSITY OF
MONTANA

INSTITUTIONAL REVIEW BOARD
for the Protection of Human Subjects in Research
FWA 00000078
Research & Creative Scholarship
University Hall 116
University of Montana
Missoula, MT 59812
Phone 406-243-6672 |Fax 406-243-6330

Date: July 13, 2016

To: Jessica Moore, Counselor Education
                  Kirsten Murray, Counselor Education

From: Paula A. Baker, IRB Chair and Manager

RE: IRB #146-16: "Exploring the Working Alliance in Collegiate Athletic
Training"

Your IRB proposal cited above has been **APPROVED** under **expedited review** by the
Institutional Review Board in accordance with the Code of Federal Regulations, Part 46,
section 110. Expedited approval refers to research activities that (1) present no more than
minimal risk to human subjects, and (2) fit within the following category for expedited
review as authorized by 45 CFR 46.110 and 21 CFR 56.110:

7. Research on individual or group characteristics or behavior (including, but not limited
   to, research on perception, cognition, motivation, identity, language, communication,
   cultural beliefs of practices, and social behavior) or research employing survey,
   interview, oral history, focus group, program evaluation, human factors evaluation, or
   quality assurance methodologies.

Each consent form used for this project must bear the dated and signed IRB stamp. Use
the PDF sent with this approval notice as a "master" from which to make copies for
subjects. You will need two copies for each subject: one that they will sign and return to
you, and one for them to keep.

Amendments: Any changes to the originally-approved protocol, including the addition of
any new research team members, must be reviewed and approved by the IRB *before*
being made (unless extremely minor). Requests must be submitted using Form RA-110.

Anticipated of Adverse Events: You are required to timely notify the IRB if any
unanticipated or adverse events occur during the study, if you experience an increased

risk to the participants, or if you have participants withdraw from the study or register complaints about the study. Use Form RA-111.

Continuation: Federal regulations require you to file an annual continuation report (Form RA-109) for expedited studies. You must file the report within 30 days prior to the expiration date, which is **July 12 2017**. *Tip: Put a reminder in your calendar now*. A study that has expired is no longer in compliance with federal regulation or University IRB policy, and all project work must cease immediately.

Study Completion or Closure: Finally, you are also required to file a Closure Report (Form RA-109) when the study is completed or if the study is abandoned. See the directions on the form.

Please contact the IRB office with any questions at (406) 243-6672 or email irb@umontana.edu.

Form RA-108
(Rev. 04/16)

[Stamp: Institutional Review Board — JUL 1 1 2016 — University of Montana]

THE UNIVERSITY OF MONTANA-MISSOULA
Institutional Review Board (IRB)
for the Protection of Human Subjects in Research
APPLICATION FOR IRB REVIEW

IRB Protocol No.:
146-16

At the University of Montana (UM), the Institutional Review Board (IRB) is the institutional review body responsible for oversight of all research activities involving human subjects as outlined in the U.S. Department of Health and Human Services' Office of Human Research Protection and the National Institutes of Health, Inclusion of Children Policy Implementation.

Instructions: A separate application must be submitted for each project. IRB proposals are approved for no longer than one year and must be continued annually (unless Exempt). Faculty and students may email the completed form as a Word document to *IRB@umontana.edu*, or submit a hardcopy (no staples) to the Office of the Vice President for Research in University Hall 116. Student applications must be accompanied by email authorization by the supervising faculty member or a signed hard copy. *All fields must be completed. If an item does not apply to this project, write in: N/A.* Questions? Call the IRB office at 243-6672.

1. **Administrative Information**

Project Title: Exploring the Working Alliance in Collegiate Athletic Training	
Principal Investigator: Jessica Moore	UM Position: Ed.D. Candidate
Department: Counselor Education and Supervision	Office location:
Work Phone:	Cell Phone: 802-345-0263

2. **Human Subjects Protection Training** *(All researchers, including faculty supervisors for student projects, must have completed a self-study course on protection of human research subjects within the last three years and be able to supply the "Certificate(s) of Completion" upon request. If you need to add rows for more people, use the Additional Researchers Addendum.*

All Research Team Members (list yourself first)	PI	CO-PI	Faculty Supervisor	Research Assistant	DATE COMPLETED IRB-approved Course mm/dd/yyyy
Name: Jessica Moore Email: Jessica4.moore@umconnect.umt.edu	☒	☐	☐	☐	10/1/2014 ✓
Name: Kirsten Murray Email: Kirsten.Murray@mso.umt.edu	☐	☐	☒	☐	12/15/2015 ✓
Name: Email:	☐	☐	☐	☐	
Name: Email:	☐	☐	☐	☐	

3. **Project Funding** *(If federally funded, you must submit a copy of the abstract or Statement of Work.)*

Is grant application currently under review at a grant funding agency? ☐Yes *(If yes, cite sponsor on ICF if applicable)* ☐No			Has grant proposal received approval and funding? ☐Yes *(If yes, cite sponsor on ICF if applicable)* ☐No		
Agency	Grant No.	Start Date	End Date		PI on grant

IRB Determination: For UM-IRB Use Only

_____ Not Human Subjects Research
_____ Approved by Exempt Review, Category # _____ *(see memo)*
☒ Approved by Expedited Review, Category # 7 *(see Note to PI)*
_____ Full IRB Determination
    _____ Approved *(see Note to PI)*
    _____ Conditional Approval *(see memo)* - IRB Chair Signature/Date: _____
        _____ Conditions Met *(see Note to PI)*
    _____ Resubmit Proposal *(see memo)*
    _____ Disapproved *(see memo)*

Risk Level: Minimal

Final Approval by IRB Chair/Manager: *[signature]*   Date: 7/13/2016 Expires: 7/12/2017

> **Note to PI:** Non-exempt studies are approved for one year only. Use any attached IRB-approved forms (signed/dated) as "masters" when preparing copies. If continuing beyond the expiration date, a continuation report must be submitted. Notify the IRB if any significant changes or unanticipated events occur. When the study is completed, a closure report must be submitted. Failure to follow these directions constitutes non-compliance with UM policy.

1

APPENDIX B: Participant Information and Informed Consent

STUDY TITLE: Exploring the Working Alliance in Collegiate Athletic Training

INVESTIGATORS: **Principle Investigator**
Jessica Moore
University of Montana
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SPECIAL INSTRUCTIONS TO THE PARTICIPANTS:
This consent form may contain words that are new to you. If you read any words that are not clear to you, please ask the person who gave you this form to explain them to you.

INCLUSION CRITERIA
- Collegiate athletic trainer with a minimum of 3 years of athletic training experience after completion of athletic training degree and certification examination
- Employed in either a National Association for Intercollegiate Athletics (NAIA) institution, or in athletic participation Divisions (I, II, or III) sanctioned by the National Collegiate Athletic Association (NCAA).
- You identify the patient-provider relationship as a factor that is essential to quality patient care

PURPOSE
Jessica Moore, MSEd, LAT, ATC, and Dr. Kirsten Murray, PhD, LPC invite you to participate in a research project about how collegiate athletic trainers develop patient-provider relationships. I am asking you to participate in this research study because you are a collegiate athletic trainer.

The purpose of this qualitative research study is to understand collegiate athletic trainers' experience and process of patient-provider relationship development. While you may not benefit directly by participating in this study, your contribution helps to identify collegiate athletic trainer-patient relationship development.

PROCEDURES
If you agree to be a participant in this study, you will be asked to engage in a minimum of two face-to-face or Skype (or other form of video conference) interviews that will be audio recorded. Interviews may last up to 30-45 minutes. You will need to sign this informed consent document in order to participate in this study. Once a signed copy of the informed consent is returned to the principle investigator via email (scan or take a photo), you the participant will designate interview format (face-to-face or video conference), location (if necessary), and time. If the principle investigator is unable to travel to you, video conference will be organized. If video conference, the principle investigator will interview from a private, confidential office setting, and your location will be of your choosing, to provide for confidentiality and privacy. First round interviews will focus on how you work with patients and develop a patient-provider relationship. The first round of data analysis will inform second round interviews. Second round interviews will be used to help develop initial constructs to form an emerging theory of athletic trainer-patient relationship development.

You will also be asked to participate in a member check reviewing the final theory. You will be asked to review the emergent theory and offer input, changes, and clarification as needed. Further, throughout the interview process your feedback will be solicited in an ongoing manner to check for clarity and correctness of interpretations of the data.

I understand that audio recordings will be taken during the study. Further, I understand that if transcribed data from audio recordings are used for presentations or publications of any kind, names and/or other identifying information will not be associated with them. I understand that audio recordings will be destroyed immediately following transcription by the primary investigator, and that no identifying information will be included in the transcription.
* Your initials _____ indicate your permission and consent to audio record the interview.

RISKS/DISCOMFORTS
Although any risks or discomforts are not anticipated, answering the questions may cause you to reflect on experiences that are sad or upsetting.
You will be informed of any new information that may affect your decision to remain in the study.
No form of coercion will be communicated at any time.

BENEFITS
There is no promise that you will receive any benefit from taking part in this study. Although you may not directly benefit from taking part in this study, your contribution helps further educational understanding and endeavors to improve collegiate athletic trainer-patient relationship development and patient outcomes.
In addition, participation may bring a deeper clarity to your understanding and development of patient-provider relationships and athletic training responsibilities.

CONFIDENTIALITY
- Your data will be kept private and will not be released without your consent except as required by law.
- Your identity will be kept confidential.
  - The principle investigator will be the only one to listen to audio recordings.
  - The principle investigator will transcribe audio recordings of the interviews.
  - Once transcription of audio recordings is complete, the audio recording will be erased.
  - To protect privacy and confidentiality, you will be provided a pseudonym, known only to the principle investigator.
- Only the principle investigator, their faculty supervisor, and dissertation committee will have access to the interview transcripts.
- To support theory development, data in the form of quotes will be pulled from the transcripts and will be available to other readers.
- If the results of this study are written in a scientific journal or presented at a scientific meeting, your name and any other identifying information will not be used.
- The data will be stored on its own password protected hard drive and kept separate from the pseudonym code and informed consent documentation.

VOLUNTARY PARTICIPATION/WITHDRAWAL
Your decision to take part in this research project is completely voluntary. You may refuse to take part in or withdraw from this research study at any time without risk of repercussion, penalty, or loss of benefits to which you are normally entitled.
You may be asked to leave the study for any of the following reasons:
1. The Principle Investigator thinks it is in the best interest of your health and welfare; or
2. The study is terminated.

QUESTIONS
If you have any questions about the research now or during the study, please contact: Jessica Moore at 802-345-0263.
If you have any questions regarding your rights as a research participant, you may contact the UM Institutional Review Board (IRB) at (406) 243-6672.

STATEMENT OF YOUR CONSENT
I have read the above description of this research study. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I may have will also be answered by the principle investigator, the faculty supervisor, or the Institutional Review Board at The University of Montana. I voluntarily agree to take part in this study. I understand I will receive a copy of this consent form.

_____
Printed Name of Participant

_____   _____
Participant's Signature   Date

APPENDIX C: NATA Research Request

Dear Fellow Certified Athletic Trainer,

I am a doctoral degree candidate at the University of Montana and I am requesting your help to complete part of my degree requirements. I invite you to participate in a qualitative research study about how collegiate athletic trainers develop patient-provider relationships.

One thousand randomly selected certified NATA members with a listed email address are being asked to consider participating. You have the right to choose not to participate. The University of Montana Institutional Review Board has approved this study for the Protection of Human Subjects.

To meet inclusion criteria for this study
- You must be a collegiate athletic trainer with a minimum of 3 years of athletic training experience after completion of your athletic training degree and certification examination
- Be employed in either a National Association for Intercollegiate Athletics (NAIA) or a National Collegiate Athletic Association (NCAA) Division I, II, or III institution
- You identify the patient-provider relationship as a factor that is essential to quality patient care

If you meet the above criteria and are interested in participating in two interviews (each approximately 30-45 minutes in length) and a member check to review findings, please respond via email to Jessica4.Moore@umconnect.umt.edu, with the following information:
1. Number of years of experience as a certified athletic trainer
2. Current employment setting (indicate the one that applies to you)
    a. NCAA: DI, DII, or DIII
    b. NAIA
    c. Other
3. Gender
4. List sport(s) you are primarily responsible for
5. Do you identify the patient-provider relationship as a factor that is essential to quality patient care?
    a. YES or NO

Those responding with interest that meet the inclusion criteria will be purposefully selected and contacted via email with an informed consent and invitation to participate. All your information will be kept strictly confidential.

As a fellow certified athletic trainer, your knowledge and experience regarding this topic is invaluable. Thank you very much for your time and consideration.

Sincerely,

Jessica Moore, MSEd, LAT, ATC
Doctoral Student, Counselor Education and Supervision
     University of Montana
     32 Campus Drive
     Missoula, MT 59808
     Jessica4.Moore@umconnect.umt.edu

Participants were selected at random from the NATA membership database according to the selection criteria provided by the student completing this research study. This student research study is not approved or endorsed by the NATA. It is being send to you because of NATA's commitment to athletic training education and research.

APPENDIX D: First Round Interview Questions

1. Tell me about how you build relationships when working with patients?

    a. How is rapport created?

2. When working with patients, how do you develop goals?

3. Tell me about selecting tasks and interventions during patient care?

4. Describe your experiences attending to adherence and compliance with patients.

APPENDIX E: Second Round Interview Questions

1. When you have, or don't have, a personal connection with patients how does your provision of care change?

2. Tell me about how you facilitate patient buy-in?

3. Help me understand how you seek out and incorporate patient input?

4. Help me understand how patient education changes during the care process?

5. How does your employment setting influence patient care?

    a. How does the coach influence patient care?

    b. Help me understand how these experiences have a direct influence on what you do with patients?

APPENDIX F: Table 1

Description of Participants

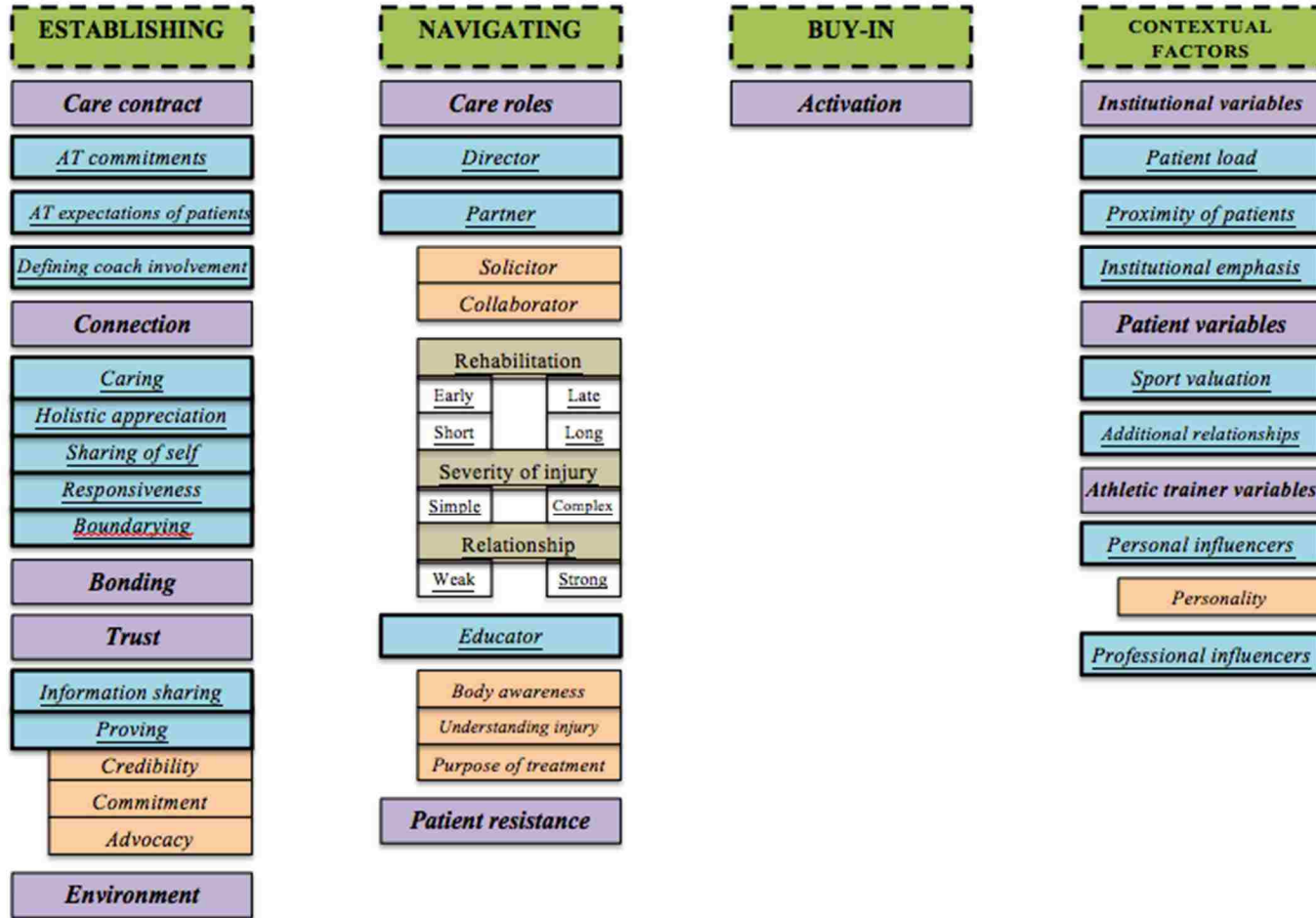| Pseudonym	Gender	Years of experience
Aiden	M	6
Maeve	F	5
Keeley	F	4
Liam	M	4
Orlando	M	3
Fiona	F	4

APPENDIX G: Figure 1

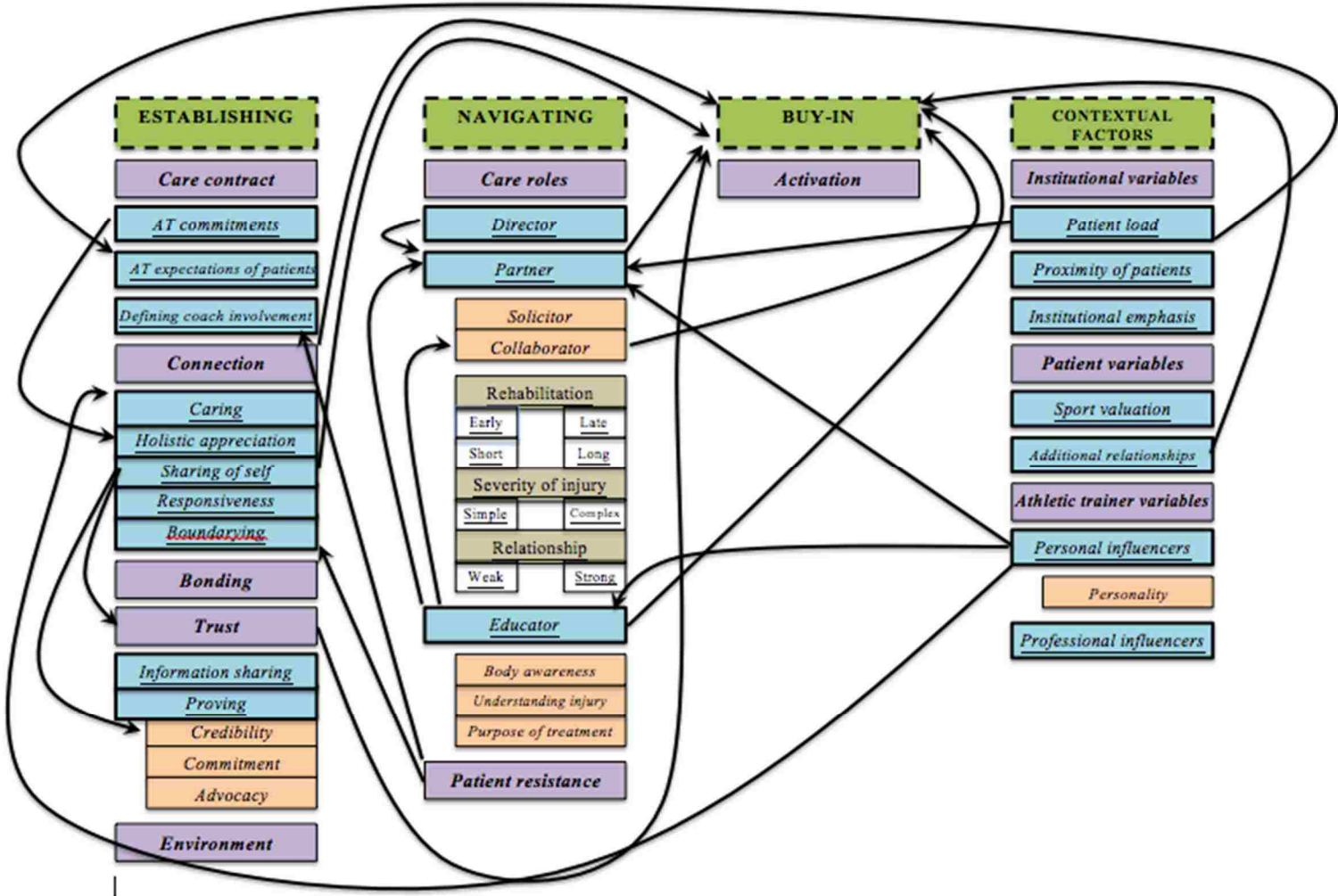Figure 1: Conceptual map of experiences following first round analysis

APPENDIX H: Figure 2

Figure 2 Conceptual map of processes following first round analysis
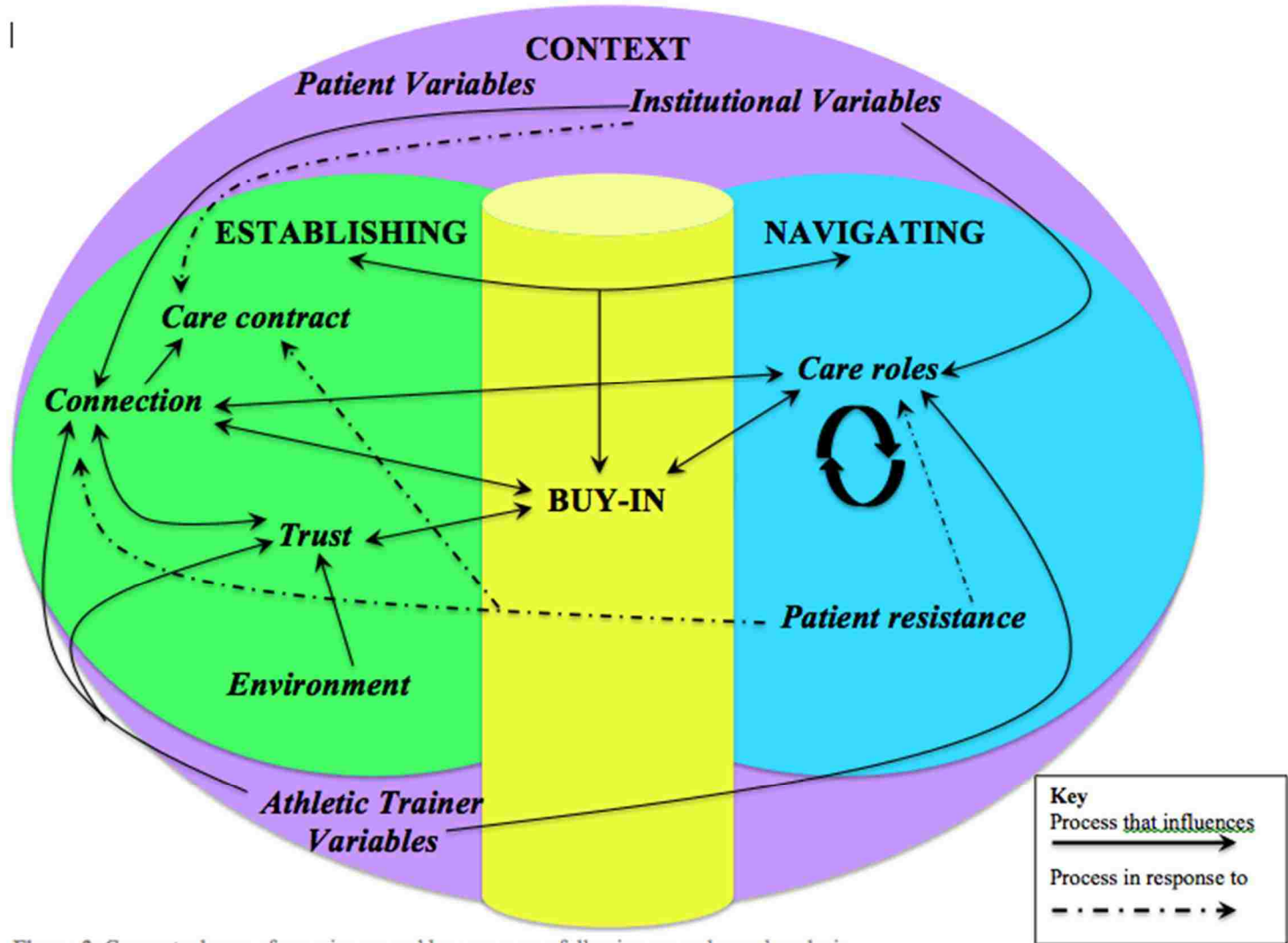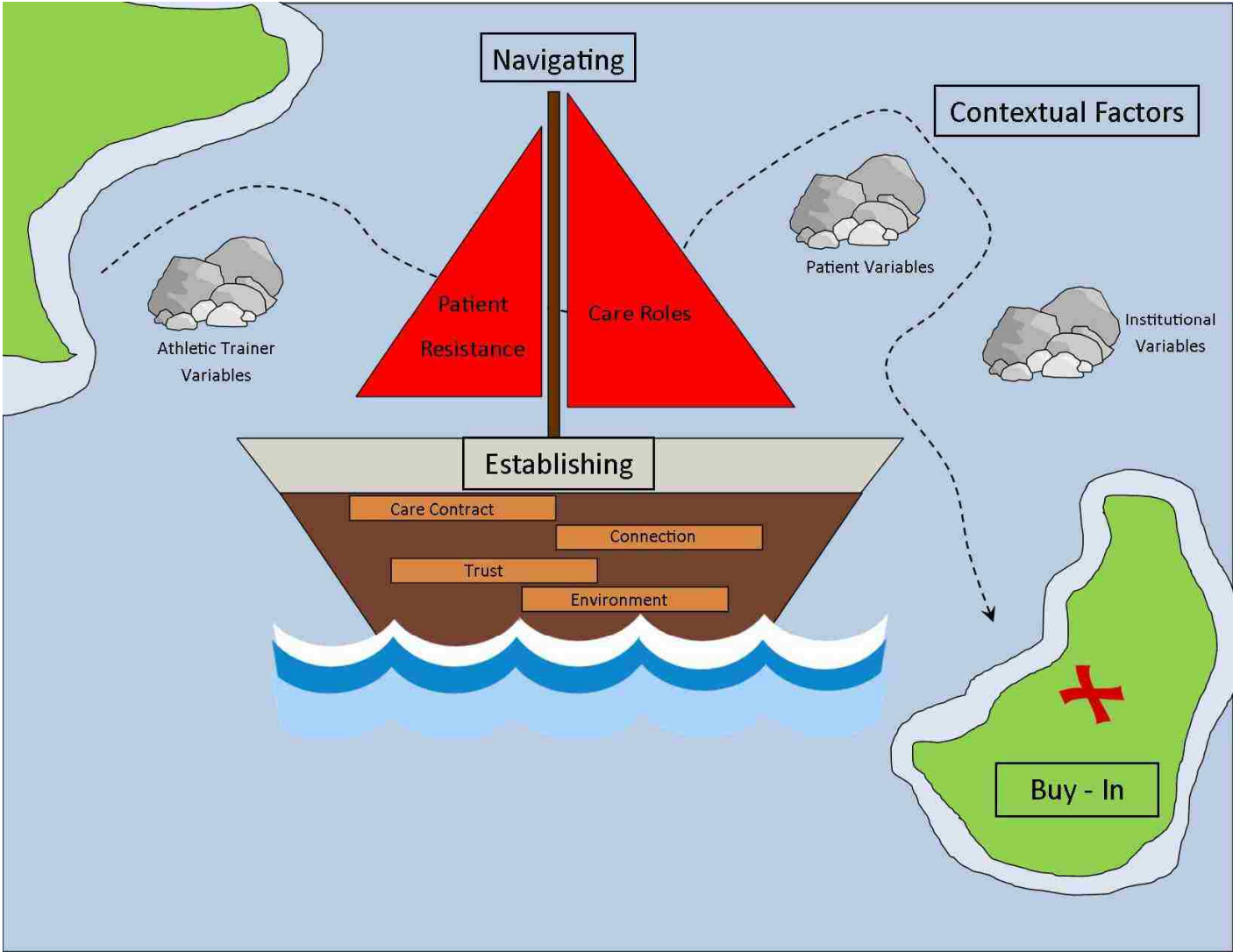
APPENDIX I: Figure 3

Figure 3: Conceptual map of experiences and key processes following second round analysis

APPENDIX J: Figure 4

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