Academic Preparation of Athletic Trainers as Counselors

Sharon P. Misasi, MS, ATC; Charles F. Davis, Jr, MEd, ATC; Gary E. Morin, MS, ATC; Donnaleigh Stockman, BS

ABSTRACT: Athletic trainers have assumed several roles and responsibilities over the years, but perhaps there is no more important role than that of a counselor. Are they prepared to do so? One hundred and thirty-two modified Revised Wylie Inventories were mailed to college/university athletic trainers to examine their educational preparation and experiences with counseling in various areas. Most athletic trainers surveyed reported that they were predominantly counseling in the areas of injury prevention, injury rehabilitation, and nutrition, and felt academically prepared to do so. However, it was reported that preparation to counsel in other less common areas (eg, family matters, financial matters, etc) was not adequately addressed in academic programs. The athletic trainers surveyed sought continuing education in order to meet the other counseling needs of student-athletes. Although they used several psychological referral services, it was apparent that most athletic trainers frequently served as counselors on many nonorthopedic topics. We suggest that athletic training educators consider incorporating both academic knowledge and clinical experience in a wider variety of counseling areas into their curricula.

Athletic trainers have many roles and responsibilities which are described by the NATA in the five professional domains. In addition to the more obvious responsibilities, such as injury prevention, recognition, evaluation, treatment, and rehabilitation, athletic trainers must be concerned with organizational and administrative tasks as well as serve as educators and counselors on these and other topics.

Several articles have been published concerning the role of athletic trainers as counselors.[1–10,12] Athletic trainers typically maintain unique relationships with student-athletes in that they work closely with the student-athletes from the time they become injured to the day they return to participation. Athletic trainers are often privileged participants in many conflicts that student-athletes experience.[2–9] In this study, we examined the counseling practices, educational background, and referral sources of athletic trainers at the college/university level.

METHODS

Every seventh (a randomly chosen number) college or university listed in the *1993–1994 National Directory of College Athletics* (Gray Printing Co) was selected to receive a survey, provided the name of the institution's athletic trainer was included in the listing. If the institution's athletic trainer was not listed, the next college or university in line was chosen. We mailed 132 surveys along with a cover letter explaining the basic procedures of the study and a self-addressed, stamped envelope.

The survey instrument was a modified version of the Revised Wylie Inventory.[3,11] One side of the instrument was used to gather demographic data and background information on the responding athletic trainers and their institutions. Subjects were asked to indicate the athletic level of their institutions, their educational route to certification, their highest degree earned, and their title/position. In addition, they were asked to indicate any counseling or psychology courses they had participated in and where their student-athletes were referred for additional assistance (Table 1).

On the other side of the survey, subjects were asked to rank order the following 11 counseling areas from the most to the least counseled according to their past experience: alcohol-related problems, nutrition, drug use/abuse, injury prevention, injury rehabilitation, relationship issues, sexual issues, suicide, family matters, racial issues, and financial issues. They were also asked if they felt their academic and clinical programs prepared them to counsel in these 11 areas and if more emphasis should have been placed on these areas in their athletic training education. They were then asked in what setting the emphasis should have been placed, ie, course work, clinical setting, or both settings equally, and whether they had participated in any course work, seminars, or workshops addressing any of these 11 areas. Finally, subjects were asked if, given the opportunity, they would participate in the same.

RESULTS

Of the 132 surveys mailed, 90 (68%) were returned. Of those returned, 23 (29%) represented Division I, 32 (36%) were from Division II, 25 (28%) were from Division III, and 9 (11%) were returned from NAIA colleges or universities. Additional subject data is presented in Table 1.

Most subjects surveyed had matriculated through an introductory psychology course, and more than half had enrolled in a sports psychology and/or developmental psychology course. Abnormal psychology and adolescent psychology courses had

All authors are associated with Southern Connecticut State University in New Haven, CT 06515.
Sharon P. Misasi is Program Coordinator of Athletic Training and an assistant professor in the Department of Physical Education.
Charles F. Davis, Jr is an assistant professor in the Department of Physical Education and Assistant Athletic Trainer.
Gary E. Morin is an assistant professor in the Department of Physical Education and Head Athletic Trainer.
Donnaleigh Stockman is a graduate assistant athletic trainer.

Table 1. Demographics and Referral Sources

	No.	(%)
Athletic level of institution:		
Division I	23	29
Division II	32	36
Division III	25	28
NAIA	9	11
Route to certification:		
NATA curriculum program	42	43
Internship program	47	54
Highest degree earned:		
Bachelor's	8	9
Master's	69	81
Doctorate	6	7
Other degree	2	2
Title/Position:		
Head Athletic Trainer	47	54
Head Athletic Trainer/Instructor	32	37
Assistant Athletic Trainer	1	1
Assistant Athletic Trainer/Instructor	2	2
Program Director	11	12
Program Director/Instructor	1	1
Courses taken:		
Introduction to Psychology	82	93
Group Dynamics	7	9
Sports Psychology	52	59
Introduction to Counseling	20	23
Group Facilitation	4	4
Abnormal Psychology	40	46
Adolescent Psychology	34	41
Developmental Psychology	44	52
Multicultural Psychology	1	1

Where do you refer student-athletes for assistance?
Please rank: 1—Always; 2—Often; 3—Sometimes; 4—Rarely

	1	(%)	2	(%)	3	(%)	4	(%)
Sport Psychologist	1	(1)	3	(3)	17	(19)	45	(52)
Counselors on Campus	23	(27)	27	(31)	18	(21)	7	(8)
Health Center	9	(10)	40	(48)	21	(23)	9	(10)
Outside Agency	1	(1)	4	(6)	22	(24)	42	(48)

been taken by less than half of the subjects. A smaller percentage of the athletic trainers surveyed had enrolled in the remaining courses (Table 1).

When asked where student-athletes were referred for additional assistance, 23 (27%) responded "always" to a counselor on campus, 40 (48%) responded "often" to the Health Center, and 27 (31%) responded "often" to a counselor on campus. The response of "sometimes" was applied to many areas: outside agency (22 (24%)); health center (21 (23%)); counselor on campus (18 (21%)); and sports psychologist (17 (19%)). Those services "rarely" considered by those surveyed included referral to a sports psychologist (45 (52%)) and an outside agency (42 (48%); Table 1).

Tables 2 through 8 summarize the data regarding the 11 counseling areas. Table 2 indicates the ranking of counseling areas from most to least counseled. Injury rehabilitation and injury prevention were ranked 1 and 2, respectively, followed by nutrition, alcohol problems, and drug use/abuse. The least counseled areas included family matters, financial issues, and suicide, in order.

Table 2. Rank Order From Most to Least Counseled Areas According to Past Experience

1. Injury rehabilitation
2. Injury prevention
3. Nutrition
4. Alcohol problems
5. Drug use/abuse
6. Sexual issues
7. Relationship issues
8. Racial issues
9. Family matters
10. Financial issues
11. Suicide

Table 3 represents the subjects' responses regarding their academic preparation for counseling in these areas. The injury rehabilitation and injury prevention areas received strong affirmation, as did nutrition and drug use/abuse. The subjects did not feel that their educational programs prepared them well enough to address racial issues, suicide, financial issues, family matters, relationship issues, sexual issues, and alcohol problems.

Table 4 demonstrates that the subjects' clinical programs prepared them to counsel in the areas of injury prevention, injury rehabilitation, and nutrition. However, the subjects did not feel that their clinical education prepared them to counsel in the remaining areas.

Table 5 shows that the majority of the subjects believe that more emphasis should be placed on all of the counseling areas in academic education. Table 6 indicates that the exposure should come from neither course work nor the clinical setting alone, but from both equally.

Table 7 reflects that the majority of those surveyed had participated in additional course work, seminars, and workshops since their initial training, especially in the areas of injury prevention, injury rehabilitation, drug use/abuse, nutrition, and alcohol problems. Again, the majority of those surveyed indicated that they had received very little additional training in the following areas: relationship issues, sexual issues, suicide, family matters, racial issues, and financial issues. Table 8 indicates that the subjects would participate in additional course work, seminars, and workshops that addressed all of the areas studied.

DISCUSSION

The top three areas counseled (Table 2) concurred with the same areas in which subjects felt their academic programs had adequately prepared them to counsel (Table 3). These same top

Table 3. Do You Feel Your Academic Program Prepared You to Counsel in These Areas?

	Yes	(%)	No	(%)
Alcohol	40	(44)	50	(56)
Nutrition	70	(78)	18	(20)
Drug use/abuse	45	(50)	7	(8)
Injury prevention	85	(94)	3	(3)
Injury rehabilitation	84	(93)	4	(4)
Relationship issues	21	(23)	69	(77)
Sexual issues	26	(29)	59	(66)
Suicide	5	(6)	80	(89)
Family matters	8	(9)	70	(78)
Racial issues	6	(7)	81	(90)
Financial issues	8	(9)	79	(88)

Table 4. Do You Feel Your Clinical Program Prepared You to Counsel in These Areas?

	Yes	(%)	No	(%)
Alcohol	32	(36)	50	(56)
Nutrition	56	(62)	32	(36)
Drug use/abuse	37	(41)	45	(50)
Injury prevention	77	(86)	6	(7)
Injury rehabilitation	75	(83)	8	(9)
Relationship issues	19	(21)	62	(69)
Sexual issues	21	(23)	60	(67)
Suicide	7	(8)	75	(83)
Family matters	16	(18)	65	(72)
Racial issues	17	(19)	64	(71)
Financial issues	14	(16)	66	(73)

Table 5. Do You Feel That More Emphasis Should Be Placed on These Areas in Academic Education?

	Yes	(%)	No	(%)
Alcohol	79	(88)	8	(9)
Nutrition	75	(83)	11	(12)
Drug use/abuse	83	(92)	6	(7)
Injury prevention	72	(80)	14	(16)
Injury rehabilitation	72	(80)	14	(16)
Relationship issues	52	(57)	7	(8)
Sexual issues	66	(73)	21	(23)
Suicide	60	(67)	27	(30)
Family matters	52	(58)	32	(36)
Racial issues	61	(68)	25	(28)
Financial issues	48	(53)	38	(42)

Table 6. Should This Emphasis Come in Course Work, Clinical Setting, or Both Equally

	Course Work		Clinical Setting		Both Equally	
	No.	(%)	No.	(%)	No.	(%)
Alcohol	25	(28)	5	(6)	55	(61)
Nutrition	23	(26)	3	(3)	63	(70)
Drug use/abuse	18	(20)	4	(4)	62	(69)
Injury prevention	12	(13)	4	(4)	65	(72)
Injury rehabilitation	11	(12)	7	(8)	64	(71)
Relationship issues	26	(29)	7	(8)	40	(44)
Sexual issues	30	(33)	5	(7)	40	(44)
Suicide	29	(32)	6	(7)	44	(49)
Family matters	23	(26)	6	(7)	50	(55)
Racial issues	24	(27)	4	(40)	48	(53)
Financial issues	33	(37)	2	(2)	35	(39)

three areas matched the results of a study completed by Furney and Patton,[3] in which it was found that high school athletic trainers felt qualified to counsel in the areas of injury prevention, injury rehabilitation, and nutritional concerns.

Issues related to alcohol and drug use/abuse were ranked 4th and 5th, respectively. Subjects responded that they did not feel that their academic programs prepared them to counsel in these areas. In a survey of varsity athletes at a Division I university, Schneider and Morris[7] reported that 12% of the respondents were at least occasionally using banned substances, and that 57% had at least some experience with illicit drugs. Based on this, it can be expected that the athletic trainer would be involved at some level in counseling athletes with alcohol and

Table 7. Have You Participated in Any Course Work, Seminars, Workshops in the Areas Listed Since Initial Training?

	Yes	(%)	No	(%)
Alcohol	62	(69)	25	(28)
Nutrition	67	(74)	19	(21)
Drug use/abuse	68	(76)	18	(20)
Injury prevention	83	(92)	4	(4)
Injury rehabilitation	83	(92)	5	(6)
Relationship issues	28	(31)	57	(63)
Sexual issues	42	(47)	43	(48)
Suicide	16	(18)	70	(78)
Family matters	21	(23)	61	(68)
Racial issues	24	(27)	57	(63)
Financial issues	19	(21)	61	(68)

Table 8. Would You Participate in Workshops, Seminars, or Classes in These Areas?

	Yes	(%)	No	(%)
Alcohol	77	(86)	10	(11)
Nutrition	82	(91)	6	(7)
Drug use/abuse	81	(90)	8	(9)
Injury prevention	85	(94)	1	(1)
Injury rehabilitation	82	(91)	4	(4)
Relationship issues	57	(63)	28	(31)
Sexual issues	68	(76)	17	(19)
Suicide	58	(64)	28	(31)
Family matters	56	(62)	30	(33)
Racial issues	57	(63)	29	(32)
Financial issues	54	(60)	31	(34)

drug-related problems. Unfortunately, there is no specific course required of student athletic trainers addressing the issue of alcohol/drug abuse or any of the other areas surveyed. These problems are touched upon in other classes such as health and psychology, but, based upon the results of the survey, it does not seem to be effective. Since their initial education, a large percentage of respondents have sought continuing education in the form of seminars or workshops on counseling alcohol drug abuse, and other problems.

In addition to their academic programs, the athletic trainers surveyed affirmed that their clinical education was helpful in preparing them to counsel in the areas of injury rehabilitation, injury prevention, and nutrition. However, their clinical education did not seem to prepare the subjects to counsel in the remaining areas. Perhaps student athletic trainers need to be included in discussions with the athlete so as to develop necessary counseling skills.

One interesting problem encountered in the study was the interpretation of the term "clinical setting." Some of the responding athletic trainers considered "clinical setting" to indicate work performed in a physical therapy/sports medicine clinic rather that the "on-the-job training" student athletic trainers receive as part of their overall academic education. It appears that there was confusion between clinical hours and clinical practice. Perhaps specifying "hands-on learning in an academic setting" would have been more beneficial and descriptive, and should be considered in future studies.

The instructions given to subjects before each question on the questionnaire were implicated as another problem with the

study. Some of the subjects either did not answer all of the questions or responded more than once to a specific question on the survey instrument. For example, regarding the title/position (Table 1), some subjects selected all choices that applied, which resulted in a percentage total greater than 100%. In the future, the Modified Revised Wylie Inventory needs to include more specific instructions that will facilitate a single response to all questions on the instrument.

Due to their daily availability to their athletes and their roles as health care providers, athletic trainers often assume the role of "father/mother/confessor." As the data indicate, the respondents' scope of counseling goes beyond that of orthopedic care into areas not traditionally applied to athletic trainers. Entry-level student athletic trainers are required to complete course work in injury prevention, management, rehabilitation, and nutrition, but, unfortunately, only an introduction to psychology course is required before sitting for the NATA-BOC examination. Although 34 respondents (just over 40%) had completed an adolescent psychology course, a much smaller percentage had enrolled in course work pertaining to counseling. It may be appropriate, therefore, that future revisions of required academic course work include a counseling course and/or courses related to the various areas addressed in this survey.

Most subjects who ranked the top five counseling areas also participated in additional educational sessions addressing the same five areas. The general opinion was that they would continue to seek additional education and experience in order to increase their abilities to counsel in these areas. Thus, it may be prudent to include counseling topics in future athletic training workshops and conferences. Certified athletic trainers can use these experiences as continuing education units which are imperative to maintaining good status within the NATA-BOC.

CONCLUSION

As athletic trainers establish relationships with their athletes that are mostly based on trust, their opinions are often sought by athletes regarding topics other than injury prevention, injury rehabilitation, and nutrition. Although counseling is part of the fifth domain of the NATA Roles and Responsibilities, athletic trainers do not always have the time and/or experience to deal with the numerous psychological problems which occur on a daily basis. Referral to more qualified professionals is how counseling problems are usually handled in the training room setting. However, athletic trainers should have a basic understanding of counseling techniques, especially since student-athletes often confide in them on a multitude of nonorthopedic and personal topics.

Athletic trainers must recognize their professional and ethical limitations in caring for athletes; they cannot be all things to all people. Athletic trainers should also recognize that they are neither prepared nor equipped to deal with all of the various concerns that student-athletes may possibly present. What is important is to seek out and welcome any and all resources that can assist them in the overall care of the student-athlete.[2] However, educators of student athletic trainers should recognize counseling as an important aspect of the athletic training profession. Therefore, changes in curricula should include the appropriate academic and clinical preparation in this area. Finally, certified athletic trainers should continue to participate in course work, seminars, and workshops that address counseling situations that occur in the athletic training setting.

REFERENCES

1. Anderson MB, Alden MF. Incorporating sport psychology services into collegiate athletics. *Athl Admin.* 1991;6:23–25.
2. Compton R, Ferrante AP. The athletic trainers—helping professional partnership: an essential element for enhanced support programming for student athletes. In: Etzel EF, Ferrante AP, Pinkney JW, eds. *Counseling College Student-Athletes: Issues and Interventions.* Morgantown, WV: Fitness Information Technology; 1991;221–230.
3. Furney SR, Patton BP. An examination of health counseling practices of athletic trainers. *Athl Train, JNATA.* 1985;20:294–297.
4. Kane B. Trainer counseling to avoid three face-saving maneuvers. *Athl Train, JNATA.* 1984;19:171–174.
5. Kane B. Trainer in a counseling role. *Athl Train, JNATA.* 1982;17:167–168.
6. Pedersen P. The grief response and injury: a special challenge for athletes and athletic trainers. *Athl Train, JNATA.* 1986;21:312–314.
7. Schneider D, Morris J. College athletes and drug testing: attitudes and behaviors by gender and sport. *Athl Train, JNATA.* 1993;28:146–148, 150.
8. Singer RN, Johnson PJ. Strategies to cope with pain associated with sports-related injuries. *Athl Train, JNATA.* 1987;22:100–105.
9. Tuffy S. The role of athletic trainers in facilitating psychological recovery from athletic injury. *Athl Train, JNATA.* 1991;26:346–354.
10. Tunick R, Etzel E, Leard J. Counseling injured and disabled student-athletes: a guide for understanding and intervention. In: Etzel E, Ferrante AP, Pinkney JW, eds. *Counseling College Student-Athletes: Issues and Interventions.* Morgantown, WV: Fitness Information Technology; 1991: 176–199.
11. Wylie WE. *Needed Health Counseling Competencies of Ministers.* Knoxville, TN: University of Tennessee; 1981. Dissertation.
12. Zeske M. ATCs—counselors in sports medicine. *NATA News.* 1994;6: 4–5.