CHAPTER

4

# Understanding Difference

## Learning Objectives

Upon completing this chapter, students will be able to do the following:

1. Define social location
2. Identify the factors that compose an individual's social location
3. Give examples of how these factors can affect the way in which health care providers view themselves
4. Give examples of how these factors can affect the way in which health care providers view and treat patients
5. Explain the relationship between social location and cultural competence

### George Pujalte, MD

Photo courtesy of George Pujalte

I was born on May 2, 1975, in Manila, Philippines. Since the age of 5, I had always wanted to become a doctor in order to follow in the footsteps of my father, who is an orthopedic surgeon. I was educated in the premiere science high school of the Philippines, the Philippine Science High School, then took up pre-med studies in biology at the University of the Philippines in Manila before pursuing the study of medicine at the same institution. I went on to serve as chief resident at Mount Sinai Hospital in Chicago and am currently doing my sports medicine fellowship at the University of Michigan. I have always been involved in medical and surgical missions in the Philippines, and I hope one day to return to the Philippines with the knowledge I have gained in the United States. My goals are to help indigent patients in the Philippines and improve the country's quality of medical care and education, particularly in the fields of primary care, sports medicine, and orthopedics.

As health care providers, athletic trainers spend many hours with their patients (e.g., practice, competitions, performances) and often become confidants or advisors. However, the relationship does not occur in a vacuum. Every interaction is mediated by the **social location** of both the patient and the health care provider. Social location is one's position in, and place relative to, society; it may be based on differences in race, class, gender, sexuality, religion, geography, nationality, ability, or age. This chapter focuses on race, class, gender, sexuality, and religion. Social location informs how one sees, experiences, and understands the world (Shingles, 2001). As an athletic trainer, how does one's social location affect one's view of the athletic training and health care environments? How does one's social location affect the ways in which one interacts with people—namely, patients and colleagues—perceived to be of similar or different social location? In other words, how does it affect one's cultural competence?

As when carrying luggage on a trip, we each carry our social location and particular world view with us wherever we go (see figure 4.1). Thus patients and athletic trainers alike bring their own luggage into the health care environment. The question, then, is what happens when each person begins unpacking and exploring her or his luggage and that of others?


**Figure 4.1** The process of developing cultural competence begins with unpacking one's luggage.

# UNPACKING THE LUGGAGE

Just as unpacking luggage is a process, so too is developing cultural competence. As stated in chapter 1, the process of developing cultural competence takes time, energy, and commitment; it is an active, conscientious choice. The first step in the process involves engaging in cultural awareness, which entails an in-depth, self-examination. To begin the self-examination, the athletic trainer should identify and understand his or her social location. To help you with the unpacking process, this section discusses various components of social location: race, ethnicity, class, gender, sexuality, religion, and spirituality. In order to illustrate the relationship between social location and cultural competence, the case of a person we call "Jane" is referenced throughout the chapter.

### Jane

Jane is an athletic trainer in a midsized, outpatient sports medicine clinic located on the East coast. She grew up in a small Midwestern farming community, where, aside from a few migrant families of Mexican descent, the townsfolk were Caucasian, as is Jane. She is a member of the Christian Reformed Church. She also believes that homosexuality is a sin against God.

## Race and Ethnicity

Racial formation in the United States occurred as Europeans left their shores and encountered people who did not look and act as they did (Omi & Winant, 1994). In fact, James Baldwin suggested that "no one is white before he/she came to America. . . . It took generations, and a vast amount of coercion, before this became a white country" (as cited in Johnson, 2001, p. 21). The creation of racial categories is a transformational process. **Race** is **socially constructed**—its meaning changes over time based on systems of privilege and oppression (Johnson). It functions as a social marker of difference, differentiating treatment based on perceived physical characteristics. **Ethnicity**, which is different from race, involves the cultural heritage of a group. It may be based, for example, on common geographic region, language or dialect, migratory status, food, traditions, music, literature, kinship, race, religious faith, settlement and employment patterns, or internal sense or external perception of distinctiveness (Spector, 2004).

### History

Racial groups have been defined differently throughout U. S. history, both socially and legally. In fact, the racial categories used by the U. S. Census have changed in every decade from 1889 to 2000. For example, in 1890, the categories were White, Black, Mulatto, Quadroon, Octoroon, Chinese, Japanese, and Indian. In 2000 and

2010, citizens could check as many categories as they wanted. Some of the categories were White, Black, African American or Negro, American Indian or Alaska Native, Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Native Hawaiian, Guamanian or Chamorro, and Samoan. Spanish/Hispanic/Latino formed a separate category considered as an ethnic group whose members can be of any race (Davis, 2005; Schaefer, 2007; U. S. Census, 2010).

Just as racial groups overall have been redefined broadly, so too have individual groups, such as Whites and Blacks. At the initial time of immigration to America, the Irish, Italians, Greeks, Jews, and other people from Eastern and Southern European countries were considered "non-White" by Anglo-Saxon Protestants in England and the United States (Barrett & Roediger, 2005; Johnson, 2001). The immigrants were met with prejudice and scorn and were merely tolerated because they provided a source of cheap labor. After World War II, however, in the mid-1940s, the United States had a tremendous need for professional, technical, and managerial workers. The GI Bill of Rights provided veterans with the opportunity to obtain an education and move into the middle class (Brodkin, 2005). Over time, the new immigrants and their descendants acculturated into White culture, which provided additional means for upward social mobility (Diller, 2007). As stated by Rubin (2007),

> *"Then, too, the immigrants—no matter how they were labeled, no matter how reviled they may have been—were ultimately assimilable, if for no other reason than that they were white. As they began to lose their alien ways, it became possible for native Americans to see in the white ethnics of yesteryear a reflection of themselves. Once the shift in perception occurred, it was possible for the nation to incorporate them, to take them in, chew them up, digest them, and spit them out as Americans—with subcultural variations not always to the liking of those who hoped to control the manners and mores of the day, to be sure, but still recognizably white Americans" (p. 192).*

On the other hand, historically, African Americans were classified according to their amount of African Black ancestry, regardless of their White ancestry. For example, using historical terminology and phrasing, an offspring of a "pure" White and a "pure" African Negro (i.e., Black) was labeled a Mulatto, which means hybrid in Spanish. The offspring of a Mulatto and a White was labeled a Quadroon—the second-generation result of "mixing with Whites," who had three White grandparents and one Black grandparent. The third generation of mixing with Whites—the offspring of a Quadroon and a White—was called an Octoroon. Such a person usually looked White and had seven White great-grandparents and one Black great-grandparent. Neither Mulatto, Quadroon, nor Octoroon was considered White, because "any person with *any* known African black ancestry" (Davis, 2005, p. 5) was considered Black. This definition of who is Black developed out of American slavery, was sustained through Jim Crow segregation, and is maintained even today as the "one-drop rule," which holds that a single drop of "Black blood" makes you Black (Davis). The twist of the one-drop rule is that it applies only to American Blacks—no other groups. Likewise, it is applied only in the United States; it is not found in any other nation in the world (Davis). For a complete discussion of the one-drop rule and the definition of Blackness, see *Who is Black?* by James Davis.

### Implications of Racial and Ethnic Differences

How does race affect the ability to provide culturally appropriate care? For example, for Jane (see case study on page 49) who is White, how does her social location shape her reality? How might she view patients and colleagues who are White and those who are not? How might her views affect how she treats them? Jane might say, "I don't see color. Mine or theirs, color is not important to me when treating patients." In a study of female certified athletic trainers from a variety of cultures (Asian/Asian American/Pacific Islander, American Indian/Native American, Hispanic, and Caucasian/White), Shingles (2001) found that race was not perceived by the athletic trainers to be important in the relationships they developed with their athletes or in how they treated their athletes. The majority of women studied were more likely than not to say that they "treated all athletes the same" regardless of race/ethnicity. However, African American women also tended to say that they shared a cultural connection with their African American athletes in particular, especially when working in a predominately White environment. The athletic trainers indicated that the athletes perceived them as someone with shared cultural values whom they could look up to as a role model and talk to about almost everything, including family issues and adapting to the classroom. American Indian or Native American, Asian and Pacific Islander, and Hispanic women athletic trainers rarely worked with athletes of their racial or ethnic group. However, when they did, they expressed a similar cultural connection. White or Caucasian female athletic trainers routinely worked with athletes in their racial group. Although their relationships were predominately positive, they did not overtly express having a cultural connection with their athletes (Shingles).

The notion of "color-blindness"—which may be taught in athletic training and health care curricula and constructed in society as politically correct behavior—is problematic. So too is the notion of "treating all athletes or patients the same." When athletic trainers are taught to treat injury and illness without regard to who is being treated, the assumption is that the injury (and subsequent treatment) occurred within a vacuum and not within a sociocultural context. For example, one might say that an ankle injury is an ankle injury, regardless of whose body the ankle is part of. But to assume that an ankle injury is disconnected from the person to whom the ankle is attached suggests a fragmentation of mind and body (Shingles, 2001). Such an assumption denies the patient's social reality and presupposes that racial, ethnic, and cultural differences are insignificant (Burton, 1995).

## Social Class

Since **class** is socially constructed, it involves more than the amount of money one has amassed. Social class affects the way in which people dress, speak, and compose ideas; it affects where one works and lives, the type of car one drives (and whether a person owns a car at all), and the type of health care (if any) that one receives (Langston, 2007). Ehrenreich (1995) and Langston contend that the lasting myth of the United States as a classless society allows the ruling class to maintain the status quo. In fact, "the richest 10 percent of the U.S. population holds more than

two-thirds of all the wealth, including almost 90 percent of cash, almost half the land, more than 90 percent of business assets, and almost all stocks and bonds" (Johnson, 2001, p. 45). On the other hand, in 2005, 37 million people (13 percent of the population) and 7.7 million families lived in poverty (U.S. Census Bureau, 2006). Of those 37 million, about 25 percent were American Indian* or Alaskan Native,* 25 percent Black, 22 percent Hispanic, 12 percent Native Hawaiian,* 11 percent Asian, and 8 percent White (U.S. Census Bureau; *average over three years due to small population size). U.S. Census data suggest that social class is linked to race, because many racial and ethnic minority groups are disproportionately represented at or below the poverty level (Sue & Sue, 2008).

In health care, classism is manifested through lack of access, lack of opportunity, and socioeconomic conditions. For example, poor people (those with total family income below 100 percent of the federal poverty level) received lower-quality care and less access to care than did high-income people (those having family income above 400 percent of the federal poverty level) (Agency for Healthcare Research and Quality, 2007). The disparity in health care is associated with the poor lacking a source of ongoing care, lacking a usual primary care provider, and experiencing an inability to access care or a delay in receiving care (Agency for Healthcare Research and Quality). Furthermore, as of the most recent census data, one of every six people in the United States is uninsured—specifically, one in three American Indians,* Alaskan Natives,* and Hispanics; one in four Native Hawaiians*; one in five Asians and Blacks; and one in nine Whites. Likewise, one of every nine children is uninsured (U.S. Census Bureau, 2006; *average over three years due to small population size). Lack of health insurance produces a large negative impact; it decreases access to and opportunity for high-quality health care (Agency for Healthcare Research and Quality, 2007). When provided, however, the services of an athletic trainer are typically free of charge to athletes at the high school, collegiate, and professional sport levels. Salaries of athletic trainers are paid by the employer, and services are not typically reimbursed by the athlete or third-party payers, such as insurance companies.

How might Jane's social class shape the ways in which she views and treats patients? Here is one example—an excerpt from an athletic training student's reflective journal entry on how people from a different class are viewed:

> *One question in particular that sticks out in my mind asked what ethnic group makes me the most uncomfortable and why. I knew right away my answer but it took me a few moments to explain my reasoning. I came to the conclusion that it was not any one ethnic group in particular that made me the most uncomfortable to be around, but rather a certain social class. Throughout my life I have found myself to instinctively put up my guard or avoid eye contact with those from lower class societies, regardless of their ethnicity or culture. My realization of this bothered me because I have never been one to judge a person's character based on their social status or income. . . . I thought more about my answer and found that my upbringing and way of life is very different from people living on welfare and in lower class, therefore there is a difference in culture. I was*

*raised in a comfortable suburban neighborhood, ranked in the top five safest cities in America, and those in poverty grow up around crime everyday [sic]. My little cousins who are in fifth grade, first grade, and kindergarten live in poverty, and already I notice how their daily living situations are influencing their personalities and culture. For Christmas my cousins all received a copy of the Soulja Boy cd, whereas if I were their age, I probably would have gotten the Hannah Montana album. I can already see how my culture varies vastly from my cousins', even at their tender ages. These kids will grow up learning to be tough in order to survive, and it is this "toughness" that makes me the most uncomfortable.*

In the journal excerpt, the athletic training student wrote about being uncomfortable around people "from lower class societies, regardless of their ethnicity or culture" and noted "instinctively put[ting] up my guard or avoid[ing] eye contact." The student also wrote about feeling uncomfortable when confronted with the "toughness" associated with surviving in harsh circumstances. As a future athletic trainer, the student might create barriers between self and patient due to this lack of comfort and the associated body language ("putting up my guard"). This kind of nonverbal communication might be perceived by patients as a lack of respect (Robert Wood Johnson Foundation, 2007), and such barriers could render the athletic trainer ineffective. At the extreme, the athletic trainer might even choose not to treat patients perceived to be from a lower class in order to avoid feeling uncomfortable.

It is important for athletic trainers to "understand how poverty affects the lives of people who lack financial resources" (Sue & Sue, 2008, p. 151). Unintended class bias or classism affects an athletic trainer's ability to deliver appropriate services, from accurate assessment through to diagnosis and treatment (Sue & Sue).

## Gender

As with race and social class, the social construction of gender has evolved from biological theory to a view of gender as differentiated and hierarchical, and from there to a conception of gender as a social institution (Lorber, 1994). **Gender** is different from biological sex in that gender refers to social practices, rituals, and learned behaviors (Shingles, 2001). Such differences were historically posited in Western society as being binary—that is, either one or the other (man or woman). Some societies posit a third gender or alternate genders, such as two-spirits (berdaches), hijras, or xaniths, who are biologically male but dress, behave, and are treated as women. Some African and American Indian societies include "manly hearted" women, who are biologically female but work and marry as men, due to their economic status (Lorber). For a continued discussion of berdaches, read *The Zuni Man-Woman* by Will Roscoe (1992).

Another gender category is transgender. As a term, transgender is usually associated with "people whose appearance and/or behaviors do not conform" (Crooks & Baur, 2008, p. 62) to the historical gender roles of man and woman and who do not want to change their biological sex. Transgendered identities include

transvestitism (usually cross-dressing to achieve sexual arousal); assuming the role of a drag queen or drag king (usually cross-dressing to achieve psychosocial gratification or to entertain [Crooks & Baur, 2008]); gender bending (as done by radical faeries, tranny bois, and tranny girlz); and questioning (questioning one's gender identity) (DeMark, 2007). The term transsexual, different from transgender, is usually associated with people who want to change their biological sex. However, someone who is transsexual may cross-dress to conform to one's sense of self by wearing clothing that is deemed as normal and congruent with self-identity (Denny, Green, & Cole, 2007).

Biological sex is determined by sex chromosomes and refers to differences in external genitalia and reproductive organs, which are ascribed as female or male. Historically, biological theories purported that men were naturally superior to women. In this paradigm, men were born to be strong and aggressive, and women were born to nurture (Crooks & Baur, 2008). Women were also considered too weak to engage in physical activity, because to do so would damage the uterus, thus endangering procreation (Coakley, 2004). Once the biological myth of the male/female (strong/weak) binary and associated gender roles was dispelled, other theories evolved.

Based on ideology, gender was then reconstructed as society redefined femininity and masculinity and ascribed different behaviors to each gender. For example, men were to work outside the home, while women were to work within it. "Making men and women *different* from one another is the essence of gender. It is also the basis of men's power and domination" (Baca Zinn, Hondagneu-Sotelo, & Messner, 2005, p. 2). Theorizing gender in terms of differences between women and men thus served to treat each as a homogenous category in conflict with the other.

Among others, Lorber (1994) argued that gender as a social institution was used to "construct women as a group to be subordinate to men as a group" (p. 35). Connell (1992), while not denying that male authority was evident and socially constructed, nonetheless argued that there was a "gender order" within masculinities—that is to say, masculinity was not fixed. Rather, masculinities are expressed differently depending on one's social location. Therefore, subordination is relative (i.e., changes with circumstances) and relational to race, social class, and sexuality.

How might Jane's gender affect the ways in which she treats her patients? She might treat women differently than she treats men because of her gender, the gender of a given patient, and each person's notions of gender roles. For example, in a study of female athletic trainers, the women interviewed expressed that their relationships with female athletes were more informal or comfortable than were their relationships with male athletes. "Women athletes wanted the athletic trainers to get to know them" and were more likely to "divulge more things." One female athletic trainer indicated that she "could gossip with the girls." On the other hand, the interaction with men athletes was considered "professional" by some women. In other words, the women had to watch what they said around the men, because their words and actions might be misinterpreted as sexual (Shingles, 2001).

Jane might also believe racialized stereotypes about women and thus respond inappropriately and treat the patient ineffectively. For example, Retha Powers (1989), an overweight Black woman, struggled with compulsive overeating and

dieting. When she divulged her struggles to a white female high school counselor, the counselor said, "You don't have to worry about feeling attractive or sexy because Black women aren't seen as sex objects, but as women. . . . Also, fat is more acceptable in the Black community—that's another reason you don't have to worry about it [battle with compulsive overeating]" (Powers, 1989, pp. 78, 134). The counselor's "presumption of Black women's strength and physical deviance completely overshadows and rejects Powers' reality of having an eating problem" (Beauboeuf-Lafontant, 2005, p. 87).

Regardless of gender, athletic trainers need to be careful not to assume gender roles or make sexist assumptions. If a patient identifies as a man or as male, refer to the patient as *him* and *he*. Likewise, if the patient self-identifies as a woman or as female, use *her* and *she*. If an athletic trainer is unsure of a patient's gender or sexual identity, one should ask, keeping in mind that such information is privileged and confidential (Crooks & Baur, 2008).

## Sexuality

The more progressive discourses on **sexuality** have shifted from deviance to lifestyle to social construction (Baca Zinn et al., 2005). In the social construction paradigm, sexuality is no longer thought of as dualistic or universal, such as homosexuality versus heterosexuality. Rather, sexualities are viewed on a continuum based on behaviors, identities, and ideologies. They include gay, lesbian, bisexual, transsexual, down-low (in which men have sex with men and women but do not consider themselves gay or bisexual), straight, and questioning (DeMark, 2007). Sexual experiences and attitudes are shaped by gender, race, age, culture, and nationality (Baca Zinn et al.). Sexualities provide a "potential source of both pleasure *and* danger, both empowerment *and* oppression" (Baca Zinn et al., p. 159)—for example loving relationships (pleasure), rape (danger), sexual freedom (empowerment), and prostitution (oppression).

**Heterosexism**, consisting of "the institutionalized structures and beliefs that define and enforce heterosexual behavior as the only natural and permissible form of sexual expression" (Andersen & Collins, 1995, p. 6), can be seen as a system of oppression that affects everyone. In a society where heterosexuality is privileged, valued, and rewarded while all other sexualities are stigmatized and punished (Griffin, 1998), how might Jane's sexuality affect the ways in which she treats patients? If Jane is heterosexual, she might erroneously assume that a patient is also heterosexual and thus ignore the patient's actual needs. For example, if a female patient indicates that she is sexually active, Jane might ask if she is using a contraceptive method. If the patient says no, then Jane might ask, "Are you trying to become pregnant?" The patient again says no, and Jane discusses issues of preventing unwanted pregnancy and provides information about several forms of contraceptive. By failing to realize that the patient is sexually active with another female, Jane provides inappropriate advice. Therefore, Jane should directly ask about sexuality in order to provide appropriate counsel and treatment, but then keep the information confidential. As with gender and sexual identity, information about a patient's or athlete's sexuality is privileged and confidential.

## Religion and Spirituality

"Religion and social class play a huge role in my eyes with a person's desire to know their identity. For me, I choose to seek judgment of how to treat others in the Bible through my identity with Christ" (excerpt from an athletic training student's reflective journal entry).

**Religion** can be defined as an organized set of beliefs, practices, and ethical values focused on a "divine or superhuman power or powers to be obeyed and worshiped as the creator(s) and ruler(s) of the universe" (Abramson, as cited in Spector, 2000, p. 81). As distinct from religion, **spirituality** may be viewed "as primarily relational—a transcendent relationship with that which is sacred in life (Walsh, 2000) or with something divine beyond the self (Emmons, 1999)" (as cited in Miller & Thoresen, 2003, p. 27). The U. S. Census Bureau does not collect demographic data about religious affiliation (doing so is prohibited by law). However, in 2001, there were an estimated 160 million self-identified Christian adults in America. Of those who identified as Christian, the top five religious groups were Catholic (about 51 million), Baptist (34 million), Methodist/Wesleyan (14 million), Lutheran (9.5 million), and Presbyterian (6 million). Americans who identified with other religions totaled about 8 million, and the top groups in this category were Jewish (about 3 million), Muslim/Islamic (1 million), and Buddhist (1 million) (Info Please, 2007). In 2007, about three-quarters of Americans identified as Christian (51 percent Protestant, 24 percent Catholic, 1.7 percent Mormon), and about 5 percent identified as being in other religions, which included Judaism (1.7 percent), Buddhism (0.7 percent), and Muslim/Islam (0.6 percent). About 16 percent of Americans were unaffiliated with a religion (PEW Forum on Religion and Public Life, 2008).

Churches, mosques, temples, and other places of worship are agencies of socialization that teach their members how to behave. As religious organizations, they provide a frame of reference and meaning, based on doctrine, for why health and illness occur, and how to treat others. For example, some occupational therapists who considered themselves to be religious were more likely to pray for a client and use spiritual language with a client (Taylor, Mitchell, Kenan, & Tacker, 2000). They were also more likely to have a positive view of spirituality in the practice of occupational therapy. Similarly, in a nationwide study of 2000 physicians, 55 percent indicated that "their religious beliefs influence[d] their practice of medicine" (Curlin, Lantos, Roach, Sellergren, & Chin, 2005).

Given that Jane is religious, how might her religious beliefs affect the ways in which she views and treats patients? Jane might believe that religious teachings "are related to health in that adherence to a religious code is conducive to spiritual harmony and health. [In this light, Jane might view illness as] punishment for the violation of religious codes and morals" (Spector, 2000, p. 82). Thus it is possible that Jane might believe that an injured or ill patient is suffering justly; as a result, Jane might not be sympathetic or treat the patient positively. She might push or impose her personal religious beliefs onto the patient. On the other hand, Jane might find through her religious beliefs that it is incumbent on her to help others in need. She might also feel comfortable helping patients deal with religious questions

and issues (Egan & Swedersky, 2003) or choose to refer the patient to appropriate spiritual or religious leaders.

## REPACKING THE LUGGAGE

### Intersection of Race, Class, Gender, Sexuality, and Religion

One cannot always separate pieces of one's cultural luggage. To do so would be akin to disassembling a piece of travel luggage. For example, during the 2008 U.S. presidential campaign season, many pundits argued that African Americans would support Barack Obama, whereas women, particularly those older than 35, would support Hillary Clinton. If this were so, then one of the authors of this text, who happens to be an African American woman over the age of 35, would, if voting for a Democrat, be left in an impossible quandary! It raises the question, "Which part of me do they want—my African American half or my woman half?" In reality, of course, the two cannot be separated. Similarly, Jane cannot be torn apart from her conservative Christian upbringing as a straight White person in a farming community. Her "class and race privilege may blind her to issues of race and class, or her experience of gender inequality may foster the illusion that this automatically prepares her to know everything she needs to know about other forms of privilege and oppression" (Johnson, 2001, p. 52). Thus fragmentation ignores the complexities, social realities, and experiences of people at different social locations that intersect race, ethnicity, class, gender, sexuality, and religion. Fragmentation also presupposes that social categories are dichotomous or dualistic—that is, it hinges on "either/or" thinking (Andersen & Collins, 1995; Collins, 1991), in which gender means either woman or man and sexuality means either straight or gay. When forced into a dichotomy, social locations become dependent on their polar opposites. The assumption is that one side of the dichotomy is superior to the other, which does not recognize the interlocking dimensions of social inequality (Baca Zinn & Dill, 2005).

In health care, for example, social locations intersect in such a way that men may have different realities. Men may be both privileged and disempowered simultaneously, rather than either privileged or disempowered. Working-class White men, gay Chicano men, and middle-class African men may all enjoy gender privilege, but the privileges may or may not be fully realized, experienced, or perceived when they intersect with class, sexuality, ethnicity, and race (Messner & Sabo, 1990). In the movie *Crash*, the White male police officer played by Matt Dillon is empowered by race and gender when he sexually assaults an African American woman (played by Thandie Newton) during a traffic stop. However, his race and gender do not empower him in his interactions with a different African American woman (played by Loretta Devine) who prevents him from obtaining health care for his sick, working-class father. Nor did race and gender privilege prevent Lindsy McLean—the real-life, longtime head athletic trainer for the San Francisco 49ers football team—from being abused because of his sexuality. McClean is a member of the National Athletic Trainers' Association Hall of Fame, yet he was victimized because he is gay, "starting in the early '90s, when a 350-pound lineman would

chase him around, grab him from behind, push him against a locker and simulate rape" (Bull, 2004, p. 93).

## SUMMARY

Class (Ehrenreich, 1995; Langston, 2007), race (Omi & Winant, 1994), gender (Connell, 1992; Lorber, 1994), and sexuality (Jordan, 1995) are socially constructed. The meaning of social locations such as race, gender, and sexuality have evolved and changed throughout history in relation to differing social contexts, as well as religious and scientific movements. "The dominant categories are the hegemonic ideals, taken so for granted as the way things should be that white is not ordinarily thought of as a race, middle class as a class, or men as a gender" (Lorber, 1994, p. 33). However, gender, race, ethnicity, class, and sexuality should be examined relationally and juxtaposed with power relations in order to better understand the unique experiences within context (Smith, 1992). Athletic trainers and their patients may view health, fitness, and illness differently based on social location, and they may construct different types of meanings in life and career experiences. Therefore, the athletic trainer must understand how one's social location affects one's view of the social world and one's treatment of patients. As a graduate athletic training student wrote, "It makes a big difference knowing your athlete and their social status. . . . It makes a big difference with how the athlete deals with serious injuries and their attitude toward rehabilitation. You want to be able to talk to the athlete [patient] and understand their concerns and questions" (as cited in Biddington, 2007, p. 72).

## Learning Aids

### What Would You Do If . . . ?

1. What if a cross country runner in her first year of high school confides in you, the athletic trainer, that she thinks she might be gay? You are a closeted lesbian.
2. What if you were Korean American and learned from your grandfather that when Japanese forces invaded Korea they decimated your family? You are now an athletic trainer with Japanese American patients.
3. What if during a meeting with colleagues one of the men in the group responds to a comment by saying, "That's so gay"?
4. What if you were the only female traveling with the male basketball team to a game and several team members began telling derogatory stories and jokes about Asian and Pacific Islander women. You are Filipino American.
5. What if a man applies for the position of head strength and conditioning coach at your college? You are an athletic trainer whose religious beliefs are such that you believe homosexuality is a sin, you are on the search committee, and you happen to know that the man is gay.

## Activities

1. Define your social location.
2. Observe your athletic training environment for 2 weeks, then answer the following question: How might your social location affect your practice as an athletic trainer and your ability to provide culturally competent care?

## Key Terms

Define the following key terms found in this chapter:

| | | |
|---|---|---|
| Class | Race | Social location |
| Ethnicity | Religion | Socially constructed |
| Gender | Sexuality | Spirituality |
| Heterosexism | | |

## Questions for Review

1. What is social location?
2. What factors make up an individual's social location?
3. Describe what it means for race, class, gender, and sexuality to be socially constructed.
4. Give several examples of how social locations can affect the treatment of patients in athletic training or other health care situations.
5. Discuss the concepts unpacking and repacking cultural luggage.