In matters of race, silence and evasion have historically ruled literary discourse...the habit of ignoring race is understood to be a graceful, even generous, liberal gesture. To notice is to recognize an already discredited difference. To enforce its invisibility through silence is to allow the black body a shadowless participation in the dominant cultural body. According to this logic, every well-bred instinct argues against noticing and forecloses adult discourse. (Morrison, 1992)

Since the inception of European colonies on the North American continent, America has been a multiracial society with marked social class differences (Bagwell & Bellows, 1998). Africans were here as free persons before they were imported as slaves, and Native Americans preceded all others (Bagwell & Bellows, 1998). By the year 2080, people of color are expected to comprise 45% of the U.S. population (Wattenberg, 1991). Inconsistencies in health care delivery have resulted in racial disparities in access to equal and appropriate health care across populations (Council on Ethical and Judicial Affairs, 1990; Evans, 1992; Martinez & Lillie-Blanton, 1996; Schulman et al., 1999). Similarly, lower socioeconomic status (SES) has been associated with diminished health status and poorer treatment outcomes. Individuals who are members of racial minorities and a lower SES experience social and occupational environments that place them at a heightened risk for health problems and injury (Lillie-Blanton & LaVeist, 1996).
European-American, come from a variety of racial and ethnic groups and social classes. They work with persons of all races and social classes, yet the sociocultural norms of the White middle-class population often are used as models for evaluation of function, contributing to a White middle-class bias in occupational therapy (Evans, 1992; McCormack, 1987; McGruder, 1998; Sanchez, 1964; Skawski, 1987). Cultural sensitivity is imperative to providing effective therapy services (Barney, 1991; McGruder, 1998; Pineda, 1996). Therapists have acknowledged the need to address the racial, ethnic, social, and economic background and context of clients during evaluations, treatment, and discharge planning for effective therapy delivery (Dillard et al., 1992; Dyck, 1989, 1992; Evans, 1992; Kinebéanian & Stomph, 1992; McGruder, 1998; Mirkopoulos & Evert, 1994; Pineda, 1996; Skawski, 1987). Selection of meaningful occupational goals and development of relevant activities depend on both the recognition of historical and cultural influences on the individual and his or her social group and the accurate interpretation of and capacity to understand client motives. Conventions for occupational therapy documentation, however, do not include the labeling of client race, ethnicity, or class (Neistadt & Crepeau, 1998).

The purpose of this study was to investigate the use of markers of race, ethnicity, and social class in case literature, particularly that published in *The American Journal of Occupational Therapy* (AJOT). We believe that silence and evasion of discourse about race is problematic not only in literary discourse, as argued by Morrison (1992) in the epigraph heading this article, but also in health and rehabilitation discourse. We argue that accurate representation of people of color in occupational therapy literature would raise our awareness of the character of our practice and allow us to investigate inequalities of service delivery. Moreover, we see accurate and proportionally adequate representation of minority racial groups as the first step toward ensuring welcoming, empathic, and respectful treatment of all peoples.

Case examples in professional journals reflect the profession’s conventions and rules for discourse on race and class. Evans (1992) problematized existing conventions in occupational therapists’ clinical writing, using the concept of marked and unmarked cases from linguistic anthropology:

The unmarked case is used as the yardstick for all others; it is the norm. The unmarked case is the center, so the marked case is marginalized. That which is other is always marked, as in black American or female pediatrician or male occupational therapist. I have noticed a tendency among occupational therapists and other health professionals to mark the race of nonwhite patients in their clinical writing and reporting but not the race of white patients. This reinforces the idea that the nonwhite recipient of service is somehow other, and other often translates to less than. (p. 680)

To remedy this problem and avoid bias in clinical writing, Evans urged consistent medical writing with parallel race labeling for all. That is, if race is a pertinent variable in health research—and it certainly appears to be—then in all cases, in both majority and minority groups, race should be marked. If the majority group, White, were to remain unmarked, this would have the sociolinguistic effect of reinforcing its dominant position. However, the “Elements of Clinical Documentation” (Neistadt & Crepeau, 1998, p. 902) listed the following components for client identification and background information: name, age, sex, date of admission, treatment diagnosis, and date of onset of current diagnosis. (These conventions for client description were reprinted from standards published by the American Occupational Therapy Association [AOTA, 1995].) Consistent documentation of race, ethnicity, and social class were not addressed. Rather, therapists were given the option to report applicable “cultural and socioeconomic history” if deemed related to “pertinent history that indicates prior level of function and support systems” (Neistadt & Crepeau, 1998, p. 902). However, medical, public health, and nursing scholars have demonstrated that race and class are crucial variables for inclusion in health outcomes research (Harrison, 1997; Jackson, 1993; LaVeist, 1994; Lillie-Blanton & LaVeist, 1996; Martinez & Lillie-Blanton, 1996; Navarro, 1997; Schulman, Rubenstein, Chesley, & Eisenberg, 1995; Williams, 1998).

**Background**

The identifying variables we have chosen to investigate—race, ethnicity, social status or class—are notoriously difficult to define. Social scientists have argued for decades over their proper definition and deployment. The following discussion is brief and primarily concerned with the application of the concepts of race, ethnicity, and class in health research.

**Race and Ethnicity**

Race has been defined as a “biological concept which categorizes humanity by means of sets of phenotypical features that appear to distinguish between varieties of people and are passed on between generations” (Sheldon & Parker, 1992, p. 105). Although Montagu (1964) demonstrated long ago the invalidity of race as a biological classification, race continues as an important socially constructed difference in our society. Montagu preferred the term *ethnicity*...
with its emphasis more on cultural than biological difference. Others have argued, to the contrary, that an emphasis on ethnicity with its connotation of voluntary group affiliation ignores the reality of compelled assignment to a group on the basis of appearance (Harrison, 1997).

Despite difficulties with defining race, consistent documentation of race in health service literature is imperative for assessment of health service delivery and practice trends. Research has revealed race differences in mortality, morbidity, access to health care, and health care treatment among patient populations (Council on Ethical and Judicial Affairs, 1990; Evans, 1992; Lillie-Blanton & LaVeist, 1996; Martinez & Lillie-Blanton, 1996; McCormack, 1987; Nickens, 1995; Schulman et al., 1995; Schulman et al., 1999; Williams, 1998). The magnitude of the disparities has not declined in the past decade. When compared with the White population, three of the four largest U.S. racial minorities (African-American, Hispanic, Native American) experience inferior health outcomes, even among age cohorts less than 45 years old (Lillie-Blanton, Parsons, Gayle, & Dievler, 1996).

Although discrepancies in health care warrant the inclusion of race as a variable in health research to enable evaluation of access to and quality of health care across populations (Bhopal & Donaldson, 1998), European-American health professionals may find overt acknowledgment of race and racial inequalities quite difficult. They may have absorbed the idea from the dominant cultural milieu that to pretend not to see race and to ignore it is a "graceful, even generous, liberal gesture" (Morrison, 1992, p. 9). This gesture, however, "enforces invisibility," denies reality, and destroys the souls of those ignored and denied (Morrison, 1992, p. 10).

Perhaps more relevant to occupational therapists' concerns than Morrison's (1992) observations are similar ideas presented in the nursing literature. Barbee (1993) reasoned that a "color blind perspective" in which race was ignored and treated as a meaningless social category existed in nursing literature because (a) conflicts could be denied as race related; (b) avoidance of mention of race or the influence of race in interactions between individuals eased discomfort; (c) cultural differences could be ignored, distorted, or both; and (d) the need to respond positively to and capitalize on diversity as a resource in educational and service environments was eliminated. Jackson (1993) used the metaphor of "white-out" to comment on the situation in which minority presence and perspectives were excluded; dominant group values were preserved in the culture of nursing; and the responsibility for public health equity was deferred from the societal level to that of the individual.

Social Class

SES, or class, primarily depends on occupation, income, and educational attainment (Nickens, 1995). It is largely the expression of the educational and economic opportunities available in one's social environment and the ability to compete within that environment (Lillie-Blanton & LaVeist, 1996). Occupation in turn largely determines exposure to potential risks associated with using hazardous equipment, materials, and dangerous job-site environments. Income determines access to insurance coverage, prescription medicines, alternative and complementary health care approaches, and transportation. Educational attainment affects comprehension of written information and instructions from physicians and health care facilities (Sheldon & Parker, 1992).

Because minority race and lower SES often co-occur, they are sometimes conflated. When occupational therapists do not understand the economic situation of a minority race client, they risk assuming that differences between minority race clients and the dominant group are entirely cultural (Dyck, 1992). Navarro (1997) demonstrated that race and class are additive factors in predicting morbidity and mortality and has urged that both be taken into account in evaluating health care. Reviewing epidemiological research on racial differences in depression, Brown (1990) argued that studies using social class data to adjust the disparate prevalence rates produced when race alone is taken into account must be interpreted cautiously. Lower SES conveys a definite risk for depression. Although it is possible to separate race and class as independent variables in a large sample via statistical manipulation, Brown warned that African-Americans continue at greater risk for depression because they are more likely to be in the lower SES groups, despite the erasure of race–depression links with statistical controls for income. The possibility of documenting or studying the health of minority populations depends on accurate reporting of both race and social class variables so that the effects of both can be examined.

Although the measurement of social class as a variable is as fraught with difficulty as the labeling of race or ethnicity, occupation has come to be the agreed-on indicator of social class in scales devised over the past 4 decades. According to Crompton (1993), “In contemporary industrial societies, occupation is an extremely powerful indicator of an interrelated network of social advantage” (p. 114). Scales that are based on employment occupation “provide a convenient measure of the broad contours of structured social inequality in late twentieth century capitalism” (p. 75). Yet any scale of social class or social status includes either on the surface or buried assumptions about the nature of groupings in society, the purpose of class divisions,
the processes of class formation, and the means of social mobility (Crompton, 1993). Measures of SES devised in the United States after World War II are associated with models of social order and with the cultural value of different types of employment. They reflect a cherished liberal view of occupational groupings as hierarchically ordered but open to upward mobility by the best qualified, most talented, or hardest working. Scales devised in the United States both reflect and reveal these liberal values (Crompton, 1993). Although the two terms connote different assumptions about the nature of economic groups in society, we will nevertheless use SES and class as synonyms.

Race and Social Class in Occupational Therapy

The observation that occupational therapy is based on the cultural norms of the European and North American White middle class (with emphasis on the values of individual independence and active participation) has been made repeatedly and the ethnocentricity of this approach criticized for more than 35 years in our professional literature (Dyck, 1989, 1992; Kinébanian & Stomph, 1992; Llorens, 1973; McCormack, 1987; Mirkopoulos & Evert, 1994; Sanchez, 1964; Wells, 1993). The occupational roles of persons from different races and sociocultural backgrounds may not resonate with these norms. Awareness of sociocultural influences on human behavior and congruencies of expectations between the therapist and client determine satisfaction with and adherence to occupational therapy treatment (Dyck, 1989; Kinébanian & Stomph, 1992; Levine, 1987). Skawski (1987) surveyed practicing occupational therapists with regard to multicultural competence and found varying levels of cultural awareness and sensitivity among therapists of different racial backgrounds (Black, White, Asian-American). Significantly more Black respondents reported embracing their own culture than White respondents; the group of White therapists was the only one in which fewer than 10% of respondents indicated interest in ethnic or cultural background. Black respondents also reported feeling prepared for the cultural diversity encountered in practice. Moreover, given a forced choice between “enhance” and “interfere,” Black respondents were more likely to see their own cultural backgrounds as enhancing the treatment process, whereas Asian-American respondents saw both the therapists’ and the clients’ backgrounds as more likely to interfere with the therapeutic process. Pineda (1996) repeated and extended Skawski’s study and found a decade later that occupational therapists overall were more likely to state that they viewed cultural difference positively. Interestingly, occupational therapists in Pineda’s multiracial sample showed strong agreement across racial groups on a common set of values and beliefs, yet each group attributed different sets of values to persons of different races.

We perceived a discrepancy between our profession’s valorization of the understanding of the sociocultural context of clients’ lives and the lack of expectation that occupational therapists document race, ethnicity, and class in clinical practice. Therefore, we chose to analyze representations of clients in our professional literature, specifically in case material found in AJOT. A historical review of literature provides the context to interpret current clinical practice and to evaluate professional trends (Portney & Watkins, 1993). The purpose of this study was (a) to examine case material in AJOT for the inclusion of race, ethnicity, and SES identifiers and (b) to determine whether proportional representation of potential client populations has been achieved.

Method

Literature Inclusion Criteria

We selected AJOT for analysis because it appears to be the most widely read journal in our profession. Analysis of articles began with the December 1998 issue and worked backward through January 1975.

We examined every AJOT article, looking for chunks of discourse that described individual persons—what we thought of as “case material.” These representations of clients or participants were drawn from case studies, from case vignettes used as examples in theoretical articles, from qualitative research—in short, from any discourse that represented individuals who were the focus of occupational therapy services or research. Our rationale was that in this kind of case material, occupational therapy writers attempt to construct a brief picture of a whole person and to convey essential elements of that person’s identity. Our question was: Would these word pictures include identifiers of race, ethnicity, and social class as we believed they should?

We purposely did not examine aggregate data in research reports because these tend to include minimal demographics only and are not meant to construct discursive pictures of whole persons. Thus, descriptions of participants in quantitative research studies were typically not analyzed, whereas those in qualitative studies often were. Specifically, representations of persons were analyzed if they included at minimum (a) a description of an adult, including gender, name (or pseudonym), and age, and (b) a diagnosis or other focus of occupational therapy intervention or research. We examined adult case material only because employment occupation was the indicator we used to determine SES. Each case described in AJOT represented one unit in the study. Some articles contained more than one
unit of case material. All case material that met the research criteria was included in the analysis regardless of whether the individual described was a real, composite, fabricated, or hypothetical person because the issue in focus was representation.

Terms and Categories for Analysis

In identifying the race and ethnicity of persons represented in AJOT, we used any reference to race or ethnic background, to phenotypical characteristics, or to primary language spoken. We categorized the cases using race and ethnicity categories derived from the U.S. census, which presents “Hispanic” as a separate ethnic categorization that does not parallel other race categories. That is, the U.S. census structures responses on its questionnaire such that persons who self-identify as Hispanic must also choose a race identifier from the following: White; Black; Indian, Eskimo, or Aleut; Asian or Pacific Islander; or other (U.S. Bureau of the Census, 1990). For the purposes of this study, the U.S. census occupational categorizations were used to determine SES. We acknowledge that the theoretical assumptions inherent in this categorization may lack veracity and that the scale itself is imperfect. Yet the cultural and moral value associated with various kinds of work, or lack thereof, may be an important tacit factor in occupational therapists’ evaluations of clients’ merit as rehabilitation candidates. Speaking more pragmatically, employment status directly determines insurance status, which affects the amount of therapy cost covered by third-party payers. Because the purpose of our study was to describe client representation in a body of literature and not to explain class relations per se, the U.S. census categorization was seen as an adequate, albeit imperfect, tool. The 1990 U.S. census was used for categorization of occupations and for race and ethnicity because the median year for the journals analyzed in this study was 1987.

Six categories were derived from the U.S. census categorization to classify occupations: (a) managerial and professional specialty occupations; (b) technical, sales, and administrative support occupations; (c) service occupations; (d) farming, forestry, and fishing industries; (e) precision production, craft, and repair occupations; and (f) operators, fabricators, and laborers. A seventh category “other” was devised to categorize occupations mentioned by AJOT authors but not included in the census classification (e.g., student, homemaker). References to educational attainment level; insurance; or any other indicator of social class, such as lifestyle or housing situation, also were collected and recorded.

Reliability

The first two authors independently analyzed 14 units of case material to identify indicators of race, ethnicity, and social class with a target agreement of 85%. Initial agreement between the two raters was 86%, which resulted from one rater not noting a mention of ethnicity and disagreement between the raters about the categorization of occupation in one case. These authors continued to discuss and refine categorization of case material by SES, independently examining 25 samples of occupation descriptors and comparing their categorizations of them. Guidelines and criteria for applying the U.S. census categories were discussed while rating these 25 samples until the authors reached 100% agreement.

Data Analysis

Descriptions of persons in case material were categorized by year of publication; age, gender, and diagnosis; descriptors of race or ethnicity, nation of origin, and first language; references to social class; education level; insurance; employment status; and occupation. Labels for these variables were assigned codes. Coded variables were counted and percentages of occurrence calculated. Chi-square goodness-of-fit statistics were used to determine whether case material in 24 years of AJOT reflected or approximated race, ethnicity, and occupational class population demographics from the 1990 U.S. census.

Results

One hundred forty-five articles included case descriptions that met the research criteria for analysis. From these articles, 225 units of case material were gathered. That is, 225 individual adult recipients of occupational therapy attention were represented in the 24 years of AJOT articles reviewed. The category variables of race and ethnicity were analyzed for frequencies and percentage of occurrence among the sample population (see Table 1). Frequencies of occupation (before and after diagnosis) also were calculated and are discussed here. Chi-square goodness-of-fit statistics (alpha level = .05) were calculated for these categories to compare distribution of the population represented in the literature with the actual distribution of the U.S. population. Additional descriptors of race and social class (e.g., primary language spoken, insurance, educational attainment) also were recorded. The null hypothesis was that the population represented in occupational therapy case literature would not be significantly different from U.S. census data for 1990.

Race and Ethnicity

In nearly 85% of the 225 units of case material reviewed, AJOT authors did not report clients’ race or ethnicity. Only 35 case descriptions identified the client’s race or ethnicity.
(see Table 1), making it difficult to compare occupational therapy literature with the U.S. census. Therefore, to examine the goodness-of-fit between cases represented in AJOT and the distribution of race in the U.S. census, we analyzed the data under two assumptions about the missing data, asking the following (see Table 2): (a) How representative of the U.S. census would this case material be if all unmarked cases are assumed to be White as predicted from observations made by Evans (1992) and Jackson (1993)? (b) How representative of the U.S. census would this case material be if we assigned 50% of unmarked cases to White and distributed the rest proportionately to reflect the census distribution in all race and ethnicity categories as predicted from observations made by Morrison (1992) and Barbee (1993)? When the unmarked cases were assumed to be both White and non-Hispanic, as in Assumption A (see Table 2), persons of color and persons of Hispanic origin were significantly underrepresented, χ²(3, 220) = 30.10, p < .001; χ²(1, 225) = 13.44, p < .001. When half were assumed White, as in Assumption B (see Table 2), the underrepresentation of persons of color and Hispanics was not significant, χ²(2, 220) = 7.20, p < .10; χ²(1, 225) = 3.36, p < .10. As noted previously, the U.S. census conventions for reporting demographic statistics on race and Hispanic origin necessitated the separation of these for the chi-square goodness-of-fit analyses.

One case in the 225 examined (.4%) clearly indicated that the therapist was working with a non–English-speaking client. According to the U.S. census, approximately 2.9% of the population has very limited English proficiency. Thus, the case material examined did not reflect the proportion of Americans who have limited English proficiency. Visual inspection of the units of AJOT data over the years indicated no trend across time in reporting race or ethnicity. Data on race and ethnicity appear to be missing as much in recent years as in previous decades.

### Social Class Indicators

Indicators of social class also were reported inconsistently in the literature examined. Only 62 (28%) of the cases reported occupation before the occupational therapy diagnosis, and 13 (6%) reported occupation after diagnosis. This lack of reporting made it difficult to conclude whether cases represented in AJOT reflected the U.S. census reporting in proportion of groups by occupation. Again, more missing data than reported data existed. Comparisons between the U.S. census and identified occupations revealed no significant differences between distribution in the case literature and occupational distribution according to the census.

The census categories most frequently represented as clients’ prediagnosis occupations were technical, sales, and administrative support (n = 16) and operators, fabricators, and laborers (n = 13). Underrepresented categories included managerial and professional (n = 9), service occupations (n = 3), and precision production (n = 5).

Indicators of social class other than occupation were mentioned in 20 cases. These indicators included income status, neighborhood, and mention of receiving federal assistance (see Table 3). Representation of educational attainment was included in 51 cases, with a mean level of 14.6 years of education reported. The median level of education attained in the United States for both genders, 25 years of age and older, is 12.7 years (U.S. Bureau of the Census, 1990). Five cases included clear indications of the client having private insurance.

### Discussion

The importance of considering sociocultural differences during treatment planning and therapist–client interactions has been addressed for more than 35 years in occupational therapy literature (Dyck, 1989; Kinebanian & Stomph, 1992; Llorens, 1973; McCormack, 1987; McGruder, 1998; Mirkopoulos & Evert, 1994; Sanchez, 1964; Wells, 1993). In this study, we examined occupational therapy

### Table 1. Representations of Race and Ethnicity in AJOT Case Descriptions (January 1975–December 1998)

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>20</td>
<td>8.9</td>
</tr>
<tr>
<td>Black</td>
<td>8</td>
<td>3.6</td>
</tr>
<tr>
<td>Hispanic</td>
<td>5</td>
<td>2.2</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>2</td>
<td>0.9</td>
</tr>
<tr>
<td>American Indian</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Not mentioned</td>
<td>190</td>
<td>84.4</td>
</tr>
</tbody>
</table>


### Table 2. Case Descriptors Compared With Census Data Under Two Assumptions About Missing Data

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Assumption</th>
<th>Census</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>210</td>
<td>191</td>
</tr>
<tr>
<td>Black</td>
<td>8</td>
<td>19</td>
</tr>
<tr>
<td>Asian</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>American Indian</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Hispanic origin (any race)</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td>220</td>
<td>212</td>
</tr>
</tbody>
</table>

Note. Assumption A treats unmarked cases as if they were all White and non-Hispanic. Assumption B treats unmarked cases as if 50% were White and non-Hispanic and the other 50% were distributed into the other race and ethnicity categories in proportions that reflect the 1990 U.S. census. Cases in which race or origin were marked retained their labels under both assumptions and were summed with unmarked cases. Column C represents the proportions from the U.S. census applied to a population of 225 (the number of cases analyzed), and these proportions were used as the expected values for chi-square goodness-of-fit tests with columns A and B.

χ²(3, 220) = 30.10, p < .001; χ²(1, 225) = 13.44, p < .001. χ²(3, 220) = 7.20, p < .10; whereas χ² = 7.82 for p < .05. χ²(1, 225) = 3.36, p < .10; whereas χ² = 3.84 for p < .05.
case literature published in AJOT over the past 24 years for representation of race, ethnicity, and SES or social class among clients portrayed as qualitative research participants, as exemplars in discussing theory or treatment, or for other reasons. We found descriptors of race, ethnicity, and SES absent in 82% to 85% of the cases.

The absence of race, ethnicity, and class descriptors in the majority of scholarly writing about clients is problematic because it sets an example for clinical writing. The absence of such descriptors in clinical writing is a problem because without such information it is impossible to ascertain the equity of services or health outcomes across race, ethnic, and class categories. In the case of hypothetical clients constructed as teaching examples or real client cases chosen to illustrate therapy processes, the relative absence of persons identified as minorities or of lower SES may be taken to indicate that such persons are not valued as therapy recipients or that their life situations are seen as too challenging for intervention. The clients whom therapist-scholars decide to report on, select as exemplars, or invent to teach a lesson can be viewed as idealized types. If so, then the idealized recipient of occupational therapy services in our case literature is raceless most often and White most frequently when race is identified.

As researchers, we could not derive from the missing data what motivation underlay the omission of descriptors, from the majority of case material, that we have shown are considered pertinent and important. In sociolinguistic theory, use of the marked case signals that which is unusual, novel, or different from the norm (Eastman, 1990). Conversely, being in the unmarked case indicates dominant group membership. On the basis of sociolinguistic theory and the observations made by Evans (1992) and Jackson (1993), we believe it likely that clients described with no mention of race were White and non-Hispanic; thus, we used Assumption A for the first set of chi-square goodness-of-fit data analyses. If Assumption A is correct, people of color and of Hispanic origin were woefully underrepresented in the case material we examined when their numbers are compared with those of the U.S. census. On the other hand, Barbee’s (1993) observations on the “color blind perspective” and Morrison’s (1992) analysis of American literature allowed us to entertain a different assumption. Because race is an emotionally loaded, difficult difference for Americans to discuss, race may have gone undescribed for both White and non-White clients, leading to a data analysis using Assumption B in which half of the unmarked cases were designated as White and the remainder assigned proportionally to minority groups. If Assumption B is correct, then the profession is closer to having achieved proportional inclusion of people of color in AJOT case literature, although in a way that erases aspects of their social identities. Under Assumption B, people of color remain underrepresented but not significantly so.

**Implications for Occupational Therapy**

Selective reporting of demographic and contextual characterizations poses a threat for potential bias in documentation and research in that we cannot be certain whether minority and poor persons are excluded or their demographics simply not recorded. Consistent and parallel recording of race; ethnicity; and, at minimum, occupation as an indicator of social class in clinical documentation would raise occupational therapists’ awareness of the nature

### Table 3. Other Indicators (Descriptors) of Social Class

<table>
<thead>
<tr>
<th>Category</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower class</td>
<td>Government-subsidized apartment (occurred twice)</td>
</tr>
<tr>
<td></td>
<td>Inner-city apartment</td>
</tr>
<tr>
<td></td>
<td>Federal housing development</td>
</tr>
<tr>
<td></td>
<td>On Social Security</td>
</tr>
<tr>
<td></td>
<td>Family of low income status</td>
</tr>
<tr>
<td></td>
<td>Begging and supported by father</td>
</tr>
<tr>
<td></td>
<td>From a low socioeconomic and educational background</td>
</tr>
<tr>
<td>Middle class</td>
<td>Middle-class family</td>
</tr>
<tr>
<td></td>
<td>Suburban home</td>
</tr>
<tr>
<td></td>
<td>Lives in a quiet upper middle-class neighborhood</td>
</tr>
<tr>
<td></td>
<td>Lower middle-class neighborhood</td>
</tr>
<tr>
<td></td>
<td>Urban house in a middle-class neighborhood</td>
</tr>
<tr>
<td>Upper class</td>
<td>Husband was president of a large chain of stores</td>
</tr>
<tr>
<td></td>
<td>Valedictorian of a prestigious university</td>
</tr>
<tr>
<td></td>
<td>Held a responsible position at a university</td>
</tr>
<tr>
<td></td>
<td>Luckily she has enough money to live</td>
</tr>
<tr>
<td></td>
<td>Well-traveled and well-educated...speaks five different languages</td>
</tr>
<tr>
<td></td>
<td>Ex-wife of a prominent businessman</td>
</tr>
<tr>
<td></td>
<td>Independent, successful, academic woman, who had many friends</td>
</tr>
<tr>
<td></td>
<td>and a rich professional life, who traveled widely</td>
</tr>
</tbody>
</table>

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of our practice. It would allow us to ask and answer difficult questions about whether people of color have equal access to occupational therapy services, whether they receive similar interventions, and whether they experience similar treatment outcomes when compared with Whites. In more general public health research, ample evidence indicates that minority and poor populations do not have equal access to services or equitable health outcomes. We are handicapped from investigating the manifestations of this general public health problem in occupational therapy if we do not begin to acknowledge and name race and SES as factors in our research and clinical practice.

Socioeconomic descriptors such as those presented in Table 3 also may influence attitudes toward client populations served. Information on the economic lives of occupational therapy service recipients is almost as sparse as information on race and ethnicity. Therefore, it appears that we often communicate our knowledge by way of clinical stories that erase the difficulties inherent in living in a classed, racially diverse, and divided society. Moreover, in ignoring the social, we run the risk of focusing all our therapeutic energy at the level of the individual body and mind despite our frequent assertions that we are “holistic” in our practice.

The executive summary of the 1998 report of the Advisory Board to President Clinton’s Initiative on Race includes the following observations and recommendations: Race and ethnicity still have profound impacts on the extent to which a person is fully included in American society and provided the equal opportunity and equal protection promised to all Americans. All of [these racial and ethnic] characteristics continue to affect an individual’s opportunity to receive an education, acquire skills necessary to maintain a good job, have access to adequate health care, and receive equal justice under the law. Americans must improve their understanding of the history of race in this country and the effect this history has on the way many minorities and people of color are treated today....The lesson is...that the absence of both knowledge and understanding about the role race has played in our collective history continues to make it difficult to find solutions that will improve race relations, eliminate disparities and create equal opportunities in all areas of American life....The complexities, challenges and opportunities that arise from our growing diversity point to the need for a new language, one that accurately reflects this diversity. (pp. 2–3)

The present study makes the point that occupational therapists’ language in describing clients in 24 years of AJOT does not reflect our nation’s diversity either because diversity went unreported or because diverse clients and participants were not included for description. The executive summary of the report on the President’s Initiative on Race asserts that a “new” language that reflects diversity is necessary for efforts to eliminate discrimination in health care and other areas of American life (Advisory Board to the President’s Initiative on Race, 1998).

Occupational therapists can join the effort to alleviate barriers to equal and adequate health care delivery across populations by adopting writing conventions that include consistent reporting of race, ethnicity, and social class or status. The use of new writing conventions would enable future researchers to examine such questions as: (a) Is apparent underrepresentation of clients of color in our literature a reflection of their less frequent treatment by our health care system, lower rate of referral for occupational therapy services, neglect or undervaluing of such clients, or merely a sign that report writers have declined to label race? (b) If certain racial minorities have a higher incidence of health problems that occupational therapists commonly treat (e.g., African-Americans and cerebrovascular accidents), why are they not represented in the literature in greater proportion than their percentage in the census? (c) Do clients of color with mental illness typically receive less occupational therapy than White clients as found by Flaherty and Meagher (1980)?

The executive summary of the report on the President’s Initiative on Race also notes the necessary complexity of discussions on race partly because of increases in interracial marriage (Advisory Board to the President’s Initiative on Race, 1998). Although we are advocating that therapists record client race in clinical and academic writing, we are not recommending that therapists impose or invent race and ethnicity labels based on their own perceptions but, rather, that they elicit labels or descriptors from clients themselves. Eliciting clients’ self-labels can be part of a collaborative goal-setting interview and can establish rapport by conveying a respectful acknowledgment of difference. Moreover, the strategy of asking the client how he or she would like race or ethnicity recorded can effectively capture the diversity of the nation’s growing multiracial population.

Directions for Future Research

The findings of this study could be challenged or supported through examination of race, ethnicity, and socioeconomic descriptors in other occupational therapy journals published both within and outside the United States, including non-English occupational therapy journals. The AOTA self-study publications may be a rich source of case material for research that extends our analysis. Our study also could be extended through examination of race and ethnicity markers in case material describing children as we excluded such material from our sample because of our focus on employment as an indicator of social class.
Moreover, photographic representations of clients and therapists or models portraying them in advertisements in occupational therapy periodicals could be analyzed. Finally, a review of actual medical records would reveal whether therapists record race, ethnicity, and social class data in clinical writing more often than we found in literature models of case description.

Limitations

This study set out to examine representations of race and social class in case material found in AJOT to ascertain whether such representations reflected the diverse American reality. Unfortunately, descriptions of race and class were often absent, so meaningful comparisons were difficult to make.

The kinds of descriptions of clients that exist in AJOT are on a continuum from more detailed to less detailed and from lengthy to brief. Our inclusion criteria, of necessity, marked a boundary that inscribed minimal elements for case material to be analyzed. Perhaps our criteria were too narrow in that some case descriptions were eliminated when age or a name or pseudonym were not provided. A complete list of the 145 articles that yielded 225 units of case material can be obtained from the second author.

The 1990 U.S. census was used for categorization and comparison of occupations and does not reflect the very recent growth in the service occupations economic sector. Service occupations were slightly underrepresented in the case literature we examined.

This study did not examine the rationale that authors may have had for selecting exemplars or describing individuals in case literature in a particular way, nor did it explore the experiences of occupational therapy clients to gauge their reactions to having race and SES data documented or ignored. Those important questions were beyond the scope of this small study but deserve to be explored through qualitative research methods.

Conclusion

The results from the present study indicate that inconsistencies in documentation in occupational therapy case literature published in AJOT exist and handicap the analysis of that literature. Because the data we sought were often missing, we proceeded with one analysis on the assumption that race is most often unmarked when the subject is White and non-Hispanic. If this assumption is correct, the case material from AJOT articles (1975–1998) does not proportionately represent actual racial distributions in the U.S. population, and persons of minority race are significantly underrepresented. Results of this study problematize current conventions in documentation. Race, ethnicity, and class are difficult constructs that are nonetheless necessary to the evaluation of health care access and outcomes across communities of people because they continue to operate in a divisive way that perpetuates inequality in our society. One solution to this problem would be the adoption by our profession of conventions for describing clients that will allow occupational therapy researchers to investigate potential biases in the delivery of occupational therapy services. We see such investigation as a necessary first step to identify and, if present, alleviate inequality in access to quality rehabilitation services.

References


Evans, J. (1992). Nationally Speaking—What occupational ther-
apists can do to eliminate racial barriers to health care access. *American Journal of Occupational Therapy, 46*, 679–683.