Understanding the Experience of Noninclusive Occupational Therapy Clinics: Lesbians’ Perspectives

Jeanne Jackson

Key Words: homosexuality, female • socialization • working conditions

This article presents understandings about how noninclusive occupational therapy environments are developed and maintained. The data are drawn from a study that, in part, explored the experiences of lesbian or bisexual occupational therapists working in a health care system. Ten participants each engaged in two to five in-depth audiotaped interviews. The narrative data were analyzed with a modified form of grounded theory. The data provide insight into how heterosexist occupational therapy work climates are created and maintained through four processes: heterosexual discourse, homophobic comments, assumed heterosexuality, and perceived stereotypes. The way in which heterosexist occupational therapy work climates may impede the professional growth of therapists also is presented. The knowledge gained from this study can help practitioners, professors, and students in their attempts to sustain an inclusive environment with respect to persons who are lesbian, gay, and bisexual.

The American Occupational Therapy Association (AOTA) has adopted a policy of full inclusion: “Full inclusion means that all individuals, regardless of ethnicity, race, age, religion, gender and sexual orientation, or disability, should be able to be a part of the naturally occurring activities of society” (AOTA, 1996, p. 855). In clarifying the nondiscrimination and inclusion policies, the profession “emphasized the need for members of the occupational therapy professional community to understand that these concepts apply to our interaction with one another” (AOTA, 1995, p. 1009).

In other words, an inclusive approach pertains not only to our patients, but also to our colleagues. Although full inclusion is a laudable position, it can be difficult to attain in work environments (i.e., the occupational therapy work environment) because of the subtle beliefs and attitudes that are embedded in many institutions. Judgmental attitudes and beliefs that are subtly unleashed in occupational therapy clinics present a particular problem. Whereas such attitudes often go unnoticed by some persons, they hit at the heart of other persons, who interpret such expressions as a lack of acceptance. It is, however, especially difficult to apprehend and monitor the intangibles or elusive qualities of a work environment that contribute to feelings of exclusion.

The concept of work culture and work climates can help to clarify how beliefs or attitudes can permeate institutions even though they are unrecognized by the workers or recipients of service. Work culture is defined as “broader patterns of an organization’s mores, values and beliefs.”

Jeanne Jackson, PhD, OTR, is Associate Professor, Department of Occupational Science and Occupational Therapy, University of Southern California, 1540 Alcazar Street, CHP-133, Los Angeles, California 90033.

This article was accepted for publication March 7, 1999.
In this sense, the work culture serves as an overall philosophical umbrella that is endorsed and transmitted by the manager of the institution or by formal policies. Within a work culture, multiple work climates may exist. A work climate is defined as the feeling in the air one gets from walking around the company. … The atmosphere that employers perceive is created in their organization by practices, procedures and rewards....[Work climates] are not based on what management, the company newsletter or the annual report proclaim.” (Schneider et al., 1994, p. 18)

Employee perception is perhaps the most important concept in this definition because it is employees’ perceptions about the organization’s vision, practices, and procedures that feed into the work climate.

What becomes problematic is that work cultures and work culture can be invisible to the persons who create and participate in them. Culture becomes encoded in social behavior and attitudes in an almost hidden manner. Certain ideas are embedded in the environment that can marginalize some groups of people while granting privilege to others. The purpose of this article is to address how work climates and work cultures can prevent full inclusion of lesbians, gays, and bisexuals in the work setting. Specifically, I will bring to light the ways in which a heterosexist climate is developed and maintained in some occupational therapy clinics and medical institutions. In doing so, I hope to challenge the boundaries of the heterosexist work climate. As long as the workings of heterosexism remain underground, such attitudes and behaviors will more than likely continue, irrespective of people's good intentions. Once visible, however, people can make choices about whether to participate in or reject heterosexism in the workplace.

Because heterosexuality as a concept is pervasive in social thought, people often see the world from a heterosexist perspective without being aware of it. Regardless of one's sexual orientation, most people, at some time in their lives, experience the world from a heterosexist perspective. Thus, in this article, heterosexist refers to a worldview that anyone can—and at times, does—embrace.

The research reported in this article stems from a larger study that examined broad questions about how lesbians weave their identities into everyday occupations, the nature of experiences of working in a health care system as a lesbian occupational therapist, and the experiences of being a lesbian patient receiving health care; in particular, occupational therapy (Jackson, 1995a). Although identifying the nature of noninclusive environments was not the stated purpose of this study, as often happens with qualitative research, findings emerged that provided insight to this related question. In this case, significant data were found that gave insight to noninclusive environments.

From the outset, it is important to note that I am not implying that a work setting could be labeled as strictly noninclusive or inclusive. Rather, as I stated before, multiple work climates can coexist in one setting. In fact, some of the participants emphasized that they experienced a genuine humanitarian approach toward patients and coworkers that contributed to their overall positive perception of their work site. In addition, experiencing the freedom and sense of safety to disclose information about being lesbian created a pleasant work environment. However, in all situations there were incidents in which noninclusive behaviors occurred. It is those incidents that I am examining in this article.

Method

A qualitative approach, philosophical and methodological, was used to frame the study, collect and analyze data, and interpret findings. In general, qualitative research is concerned with tapping the individual’s experience or the collective experience of a certain phenomenon. The belief that people do not engage in a preset itinerary of activities but rather act out of an interpretive mode underlies the concern, in qualitative research, for accessing both the meaning or subjective interpretations of experiences and the concrete actions of humans (Bogdan & Biklen, 1982). Qualitative research can be viewed as phenomenological in nature because qualitative approaches seek to define how ideologies or meanings are lived out in daily actualities (Polit & Hungler, 1991). Because contexts affect action and interpretation, behavior as it occurs in a particular setting and within the larger social–historical realm is also important.

The specific qualitative approach that I used was analysis of narratives (Polkinghorne, 1995). In the use of analysis of narratives, the database consists of multiple stories rather than discrete pieces of information that answer specific questions. Data analysis “seeks to locate common themes or conceptual manifestations among the stories” (Polkinghorne, 1995, p. 13). To analyze the data, I used a modified form of the “grounded theory” method, which is explained in the following sections.

Data Collection

Data from interviews of 10 occupational therapists, 9 of whom identify as lesbians and 1 of whom identifies as bisexual, are represented in this article. The participants ranged from 29 years to 40 years of age. At the time of the interviews, the participants lived on the west coast in either California or the Pacific Northwest. However, because some participants had migrated from the east coast, experiences from that geographical area were also represented in the data.

Participants were recruited in a number of ways. One thousand letters were sent to female occupational therapists who lived within an approximately 2-hour driving distance from Los Angeles. Ads were also placed in the Lesbian News, a local magazine, and Lesbian Connection, a national magazine. Two participants were referred by friends who knew about the study. One participant was a personal acquaintance.

The women participated in multiple (two to five)
audio-taped in-depth interviews that occurred over a 2-week to 2-month interval. With two informants, one interview sufficed. Participants chose their interview sites. Most chose their homes, whereas two chose lesbian-friendly restaurants. An open-ended interview guideline was used that contained prompts for the major areas of concern. An example of a question on the guidelines was, “Can you recall any instances with patients or other health care providers that relate to you being lesbian or your patients being lesbian?” (If yes, what was the content of the encounter? What was the social/temporal context? Who was involved?) Although I had an interview guideline, it was more common for the interviews to be driven by a participant spinning from one narrative recollection to another.

I recorded field notes (Bogdan & Biklin, 1982) immediately after each interview to capture meaning expressed in body language, comments made after the tape recorder was turned off, the types and significance of home objects, and my own subjective impressions or momentary insights. These field notes became part of the transcriptions that were used in the analysis.

Data Analysis

As is common in qualitative research, data analysis and data collection occur simultaneously, with data analysis informing the direction of subsequent interviews and data collection contributing to the analysis (Strauss, 1989). Furthermore, although data analysis can be described in a stepwise fashion, each procedure is not an independent step but rather occurs in a recursive overlapping fashion.

To analyze the data, I or a hired transcriber transcribed the tapes verbatim. During transcription or re-listening to a transcribed tape, I inserted operational notes (i.e., clarification, personal reflections) and methodological notes (i.e., adjustments in the study procedure).

Throughout the study, the data were coded at three levels, beginning with open coding (Strauss, 1989) during which I named the different phenomena that occurred in the interviews. Examples included jokes about gays, bewildered responses of colleagues, and distancing. Axial coding (Strauss, 1989) followed in which I asked myself questions such as, “Under what conditions were heterosexist comments harmful?” or “When were therapists most vulnerable to heterosexist attitudes?” Selective coding (Charmaz, 1983) entailed fleshing out the core categories that had emerged during the axial coding and analyzing the conditions (i.e., content, context, interactional qualities, temporal qualities) of these categories. One of these core categories was heterosexist environments.

Simultaneously with the coding process, I wrote theoretical memos to record the continual elaboration of ideas that explained selected categories (Charmaz, 1983). In addition, approximately halfway through the analysis process, I read occupational therapy literature about clinical reasoning and rapport between health care professionals and their patients as well as interdisciplinary literature from business, lesbian and gay studies, philosophy, and women’s studies to augment, critique, and support my interpretations.

Credibility of the data is grounded in the researcher’s ability to accurately capture and re-create in written form the realities of the participants’ situations (Lincoln & Guba, 1985). One strategy to ensure credibility is to spend prolonged lengths of time with the participants (Krefting, 1991). For the overall larger study, I chose to engage in multiple individual interviews. Multiple interviews allowed for greater rapport and trust to develop between myself and the women, enhancing the possibility of eliciting information that is sensitive in nature and vital to the findings. Multiple interviews over a time span also give the participant time to reflect on the subject matter, thus evoking stories that may not otherwise have been remembered. This opportunity for reflection is particularly important when the information the researcher is retrieving is not a subject that is frequently discussed. In addition, multiple interviews provide an opportunity for member checks; that is, I was able to clarify and confirm information with participants that I had gained in previous interviews.

Heterosexual Climates: The Background Noise

Conversations, debates, anecdotal stories, jokes, and greetings take place among therapists, staff members, and patients throughout the workday. The content of this everyday work chitchat, or informal talk, to some degree reflects the protocols and policies of the institution as well as the attitudes, values, and interests of the individuals. In other words, people disclose information about their lives and share their opinions with one another even in the minor conversations in which they may engage before a meeting or waiting in line at the cafeteria. For the most part, this sharing does not occur in a calculated, conscious way; rather, an individual’s world view is expressed in an uncensored manner through the content of, and the emotion underlying, his or her comments or stories.

The participants in this study were adept at figuring out the attitudes and agendas of the various hospital personnel and the policies of the institution with respect to homosexuality through the nuances of everyday hospital discourse. For the most part, the participants claimed that heterosexual climates pervaded medical arenas. They implied that heterosexism was a type of background noise or static to the everyday workings of the occupation therapy clinics. Sometimes that noise was overbearing in its presence, grat ing on the therapist’s nerves like the constant scratching of a chalkboard with sharp fingernails. Other times the noise was hardly recognizable, like a low-level hum that remained unnoticed for the most part and, when it did surface to consciousness, it was perceived merely as a gentle annoyance. Irrespective of where heterosexism fell
on that continuum on any one day, the women stated that it was present and well maintained. For the participants, heterosexual climates were maintained through four processes: heterosexual discourse, homophobic comments, assumed heterosexuality, and perceived stereotypes. Although these four processes contributed to the maintenance of a heterosexist environment, each participant's experience varied from a deeply felt pain to a minor aggravation.

**Heterosexual Discourse**

Heterosexual discourse primarily refers to the types of verbal interactions that either state overtly, or imply subtly, one's heterosexuality or that imply one's acceptance of heterosexuality as the natural way of being. The prevalence of heterosexual discourse in occupational therapy departments or medical facilities is, in part, a result of the fact that everyday hospital or clinic talk occurs within a larger social context of pervasive heterosexuality. For the most part, people are not consciously aware of how a heterosexual world view influences their interpretation of everyday situations. For example, when a woman announces her engagement, the question "Who's the lucky man?" comes to mind far more quickly than “Who's the lucky woman?" unless she has prefaced this announcement with the fact that she is lesbian or bisexual. In this example, the common cultural understanding of marriage emerges from a heterosexual consciousness. Bruner (1990) claimed that the “ordinary” nature of such interpretations and conversation can be explained by the fact that they are part of the "canonical world of culture" (p. 52). As individuals go about their day interacting with others in the public and home spheres, their behaviors and conversations, for the most part, appear to be typical, taken-for-granted ways of relating and carrying out business. Such events and interactions do not provoke questions about why they occur because they fit into the person's canonical scheme about human existence (Bruner, 1990).

Wittig (1992) highlighted how a heterosexual consciousness is an inescapable concept that infuses both scientific research and theorizing, therapeutic practices, and the categories of language used in everyday communication. She stated that

> the consequence of this tendency toward universality is that the straight mind cannot conceive of a culture, a society where heterosexuality would not order not only all human relationships but also its very production of concepts and all the processes which escape consciousness as well. (p. 28)

In this quote, Wittig claimed that heterosexual discourse frames the way people think and interpret their worlds. To this end, such discourses become oppressive to homosexuals “in the sense that they prevent us from speaking unless we speak in their terms” (Wittig, 1992, p. 25). There are three parameters of heterosexual discourse that frame interactions in the occupational therapy clinic and thus promote a climate that marginalizes lesbians, gay men, and bisexuals. They include (a) subject matter of work chitchat, (b) emotional expectations associated with work chitchat, and (c) the unspoken in work chitchat.

**Work chitchat—subject matter.** The participants talked about many topics of conversation that arose in the crevices of the workday; that is, during the time between seeing patients, over lunch, in the halls, and while note writing. These topics often express heterosexual world views. Discussions of topics pertaining to boyfriends or girlfriends, marriages, and children constitute a kind of press release about one's heterosexuality, whereas those addressing family vacations, in-laws, home decoration, division of household labor, or gardening embody less obvious heterosexual themes. For example, in some occupational therapy clinics, announcements about approaching marriages were greeted with excitement and discussions about caterers, ceremony rituals, wedding attire, and family opinions. These topics served as one focus of conversation during lunches and breaks in the months before the event. Likewise, pregnancy and birth often evoked at least 6 months of questions from concerned coworkers about the woman's health, the baby's room, or maternity or paternity leaves. Discussions about where and with whom to spend vacations or about the perils and joys of visiting in-laws also evoked concerned responses. I am not saying that these were the only topics of discussion, but because these topics served as a type of press release about a colleague's heterosexuality, for many lesbians, especially those who were closeted, these topics loomed in the forefront of their recollections about work chitchat.

Weston (1991) referred to this kind of discourse when she explained that “while sex may not be an everyday topic of discussion in settings like the workplace, schools, churches and synagogues, references to kinship are omnipresent” (p. 67). As she pointed out, it is in reference to kinship or relationships that heterosexual identity is most often disclosed. Sexual orientation is quite naturally implied in conversations regarding these or similar topics because these subjects ultimately address issues of relationships. In fact, most of the participants admitted that few heterosexual coworkers spoke in ways that did not readily and almost subconsciously disclose their sexual orientation through heterosexual discourse. Although heterosexual discourse served to reveal heterosexual orientation, it also was a signal that heterosexuality was the normal and expected framework from which people would interpret the clinic conversations.

One could accurately argue that topics such as children, marriage, in-laws, and vacations are not exclusively heterosexual. More and more lesbian couples and gay couples are having or adopting children. Formal commitment ceremonies and, in this sense, marriages are being conducted by some synagogues and churches, although they are not legally binding. Consequently, family vacations or in-law visits can be with same-sex partners. Although it is true that
these topics are not exclusively heterosexual in nature, the typical clinic dialogue around these issues stemmed from a heterosexual perspective, contributing to what is called the heterosexual climate. For example, in the process of having children, lesbian couples decide whether to use sperm from sperm banks, a relative of one’s partner, or a gay or straight male friend. Additionally, who will give birth to the child or how to arrange adoption by the second mother become important considerations. Connie and her partner, Pat, talked readily about these questions when discussing their plans for having children during their interview; however, Connie claimed that she refrained from discussing these issues with coworkers because the aspects of childbearing with which she was concerned never seemed to automatically surface in the “ordinary,” “taken for granted” stories that emerged during informal conversations.

These examples are not meant to imply that topics in common, which would bring marriage or childbearing experiences of lesbians and heterosexuals together, do not exist. On the contrary, there are an abundance of shared concerns. These examples suggest that important aspects of marriage and childbearing that relate specifically to lesbians are not found in the “ordinary” stories of marriage and childbearing that emerge around the lunch table or during other informal conversation in occupational therapy clinics. This absence contributes to the sense that a heterosexual perspective is the norm and the respectable option.

Work chitchat—expectation of acceptance. The second parameter of heterosexual discourse concerns the emotional expectations that underly the chitchat, for example, the expectation of acceptance. June expressed this in the state-
al expectations that underly the chitchat, for example, the sexual perspective is the norm and the respectable option.

other informal conversation in occupational therapy clin-

childbearing that emerge around the lunch table or during

marriage and childbearing that relate specifically to lesbians

concerns. These examples suggest that important aspects of

experiences of lesbians and heterosexuals together, do not

common, which would bring marriage or childbearing

issues with coworkers because the aspects of childbearing

with which she was concerned never seemed to automati-
cally surface in the “ordinary,” “taken for granted” stories

that emerged during informal conversations.

In this story it was obvious that Marie’s coworkers did not grasp how her life experience fit theirs. This incongru-

cy, I suspect, stemmed from the fact that Sharon and Peg were talking about stereotypical behaviors that they assumed were inherently male. Marie’s comment pointed to the fact that these behaviors could be and also were enacted by women. Sharon’s and Peg’s bewilderment may have emerged from a collision of heterosexual and homo-

sexual world views. But the story also points to the fact that Sharon and Peg could easily commiserate with each other about similar household problems. They expected a certain degree of mutual understanding between them and the fact that they received it reaffirmed that the anecdotes they were discussing were the kinds of things that were normal and experienced by everybody. Although, in this instance, Marie readily jumped into the conversation by offering her support through a similar incident, she was confronted with the reality that shared understanding did not exist and was left with a reminder that lesbian experiences can be interpreted as not fitting within heterosexual discourse. It was interesting that later in the interview, Marie comment-
ed that when Sharon talked about the fact that her husband helped her through school by proofreading all her papers, she declined to share that Diane had done the same for her.

Work chitchat—the unspoken. Heterosexual discourse was also defined by what was omitted from the clinic con-

versations; that is, topics that were not readily talked about in the clinic because coworkers did not possess the back-

ground knowledge to discuss them. For example, one day Marie was expressing to Sharon, a coworker, her relief that the technology workshop to be held at their facility had been scheduled in early June. Marie stated, “Oh, good, because I may be going to New York in June for the National Gay and Lesbian Health Conference and, you know, they are having the Gay Games and stuff.” Sharon’s response was simply, “I didn’t know they had all that.” When reflecting on the situation, Marie commented, “Well, people can’t even fathom it, I don’t think. National Gay and Lesbian Health Conference….What could that possibly be about?”

If Marie’s coworker had been knowledgeable about les-
bians, gay, or bisexual issues, more than likely the Gay Games, the 1994 Commemorative Celebration of Stonewall, and the National Health Conference would have been recognized as exciting events with historical sig-
nificance. The conversation would probably have flour-

ished around questions about where she was going to stay or which sessions she was going to attend at the conference. Coworkers might have reciprocated, talking about their own experiences when they went to local gay pride parades or the National March on Washington. In Marie’s situ-

ation, none of this occurred. Marie felt comfortable to be out around this coworker, experienced a lot of support from her, and considered her to be a good friend. Regardless of how well-meaning Sharon may have been, it
appeared that she simply did not have the background knowledge to engage Marie in a conversation about the National Gay and Lesbian Health Conference or to ask a question, thereby prompting Marie to further the conversation. It is also possible that she did not understand the symbolic significance of this event in Marie’s life and, thus, did not see it as a particularly important issue to pursue. Regardless of the reason, the discussion around this event, which was imbued with lesbian significance, came to a screeching halt. There was not a place for it in the predominantly heterosexual discourse of this clinic.

Homophobic Comments

The second way in which a heterosexual climate was maintained within the hospital was through homophobic comments. Homophobia refers to “the irrational fear and hatred of those who love and sexually desire those of the same sex” (Pharr, 1988, p. 1). Jokes or derogatory comments about gays, lesbians, and bisexuals were often heard on the wards of the hospitals, in charting rooms, around the nurses stations, or during team meetings. Degrading jokes or comments were perceived by the participants as quite damaging and often a strong indicator of homophobia. The participants also noted that jokes and comments about gay and lesbian patients occasionally occurred in team meetings. On the surface, it appeared that these snickers and side comments were simply to relieve uncomfortable tension among team members; however, they also provided a clear message that making fun of gays and lesbians was tolerated in that group. Monica pointed out that, regardless of the reason, the discussion around this event, which was imbued with lesbian significance, came to a screeching halt. There was not a place for it in the predominantly heterosexual discourse of this clinic.

**Assumed Heterosexuality**

Monica summed up the feelings of most therapists in the study, especially those who were closeted, about the prevalence of assumed heterosexuality in the hospital when she stated, “Yeah, that’s a daily thing. It is just accepted as part of life. I mean, that’s really daily.” In this sense, the occupational therapy workplace is merely a microcosm of society where people are assumed to be heterosexual unless otherwise stated. The following comments exemplify three ways that assumed heterosexuality was expressed in the statements of hospital personnel.

In discussing her coworker’s perceptions of her, Monica commented, “They think my last relationship was with a male. I never denied it, said it was a female, so they think it was a male. You know, people are always trying to fix me up.” Sara also shared,

> Like this week, one of the dietary supervisors comes up, and he goes... “So, you’re not married.” And the activities person that is right there just kind of hones in, and she said, “Can you believe it, she’s single. I can’t believe she’s single.” And I said, “Well if you’re not outwardly married, it doesn’t mean you’re not with someone, you’re not committed.”

Finally, Marie recalled,

> But I went to have my picture taken [for a hospital identification card] and...he said, “Now smile.”...He said, “Pretend like you’re smiling for your boyfriend,” and then he said... “See how that picture came out better when I told you to smile for your boyfriend.”

These statements demonstrate, first, how being coupled is falsely assumed to be universally desired and, second, how being coupled is expected to be heterosexual. Furthermore, as some participants pointed out, although assumed heterosexuality is most potent when a question is pointed directly at their personal lives (the first two examples), it is just as annoying when presented by a stranger in the form of a joke (the third example). Thus, when
assumed heterosexuality occurs within the workplace, it puts therapists who are lesbian, gay, or bisexual in an uncomfortable position. Therapists who are not out and who believe that they cannot respond to such comments are at particular risk for feeling ill at ease.

In two other situations, participants talked about times in which their coworkers confided in them about their discomfort with lesbian and gay lifestyles. One woman nonchalantly stated to Monica, “You know, I don’t mind gay men but that lesbian stuff, I just couldn’t handle it.” Likewise, an employee told Jenna that a good friend of hers was lesbian, and that, quite frankly, she had “trouble understanding that whole lifestyle…. I don’t see how she can do it, what’s in it for her.” Both Jenna and Monica were able to manage these situations. They understood the intentions underlying these comments. Jenna even took the opportunity this interchange offered to educate her friend, stating, “Well, you know, some people get it from being with a guy, other people get it from being with a woman. There’s no right or wrong.” These two events happened because coworkers assumed that Jenna and Monica were heterosexual. It appears that their heterosexual world view did not permit them to question the sexual orientation of Jenna or Monica.

**Perceived Stereotypes**

Stereotyping or negative symbolism, as defined by Blumenfeld (1992), was the fourth factor that contributed to a heterosexist climate in the hospitals. Stereotyping refers to applying standardized conventional ideas about, in this study, lesbian, gays, or bisexuals to all persons. According to Blumenfeld, stereotypes about homosexuals can range “from their alleged predatory appetites, to their appearance, to the possible ‘causes’ of their desires” (p. 8).

Patients and other therapists were most often stereotyped as gay or dykes by their dress, mannerism, single status, and silence about dates, or the friends who came to visit them. As Woods (1994) pointed out, similar behavior is interpreted differently for heterosexuals and homosexuals. The heterosexual who receives flowers at work is teased in an envious manner, indicating that he or she is perceived as special. The gay man who receives flowers at work is stereotypically labeled as flaunting, indicating that his lifestyle is inappropriate.

In summary, it is obvious from the participants’ reports that the private lives of health care professionals, which includes their sexual orientation, enters into many aspects of their hospital work. Lunch table conversations, comments at business meetings, and even the small talk that accompanies the process of acquiring an identification photograph are (hetero)sexualized. The participants were continually bombarded with messages that, in their particular institution, heterosexuality was the normative framework from which people thought and acted. These messages about heterosexual privilege, whether they came in the form of heterosexist discourse, homophbic comments, assumed heterosexuality, or perceived stereotypes, were integral to their work culture and climate. They were also present in more formal and complex ways at team meetings where the physicians who represent leadership presided. And they were present in the informal chats around the nursing stations or in the one-line comments about flowers that sit on a coworker’s desk. To many participants, the messages went unnoticed and at times were meant as humorous jokes to bridge communication between two persons. But in the end, they provided strong indications that heterosexism prevailed in those environments.

**Lunch Table: Therapists’ Talk**

In the previous discussion, I pinpointed specific ways that a heterosexist work climate is maintained. Beyond being painful to the lesbian, gay, or bisexual therapist, I will now analyze how heterosexist work climates could compromise patient care by interrupting the dynamics by which new therapists are mentored into the occupational therapy profession and experienced therapists continue professional growth.

When immersed in heterosexist environments, therapists learn ways to manage their lesbian identities. One strategy that many of the participants had used somewhere in their career was separation. Separation is defined as physically removing oneself from conversations that are potentially threatening, particularly with regard to being outnumbered. In this study, separation was used most often to deal with the dilemmas of lunch table talk.

Shared lunches often occurred around a big table in the
clinical or in the cafeteria. Although lunches were somewhat fluid events—that is, sometimes a couple of persons would go out to a restaurant, at other times someone would work through his or her lunch break, and, on occasion, an educational lecture would take precedence—there seemed to be an unspoken expectation that therapists did eat with the other therapists somewhat regularly. This expectation was particularly important for newcomers.

When glanced at superficially, the lunch table talk appeared to be a curious mixture of frivolous discussions about therapists’ personal lives that provided moments of relief from the more serious discussions of patient care. However, when couched in terms of a bonding ritual, sharing lunchtimes becomes a vital event that socializes new therapists into the occupational therapy clinic culture and continually revitalizes the existing relationships among therapists. These relationships ultimately bear on patient care. Burke (1998) pointed out:

Therapists rely on one another to test their ideas about their patients, to share their frustrations and stuck points, and to boast of their breakthroughs and successes. Therapist talk is a powerful source for learning and sharing information in our culture of occupational therapy. (p. 421)

More specifically, in the book Clinical Reasoning, Mattingly (1994) stated:

We took seriously a part of practice that therapists generally did not notice—their everyday storytelling. Therapists studied often traded stories about patients in the lunch room. This was not gossip. Rather, it turned out to serve two very important functions. It was a method of puzzling out problems….It also served to enlarge each therapist’s fund of practical knowledge through vicariously sharing other therapists’ experience. (p. 18–19)

In the current study, patient problem solving was intermeshed with personal life stories during lunchtime discussions. New or experienced lesbian therapists had to be willing to place themselves in the vulnerable position of publicly managing their personal stories to benefit from this clinical sharing. As the following incidents will demonstrate, the need to manage disclosure about their sexual orientation was most discomforting for some of the participants. However, their decisions to separate themselves from this event ultimately left them at a disadvantage, denying them valuable information about patient care.

For many of the participants, the process of bonding with other therapists through shared lunches was highly unsuccessful. Participants talked about feeling uncomfortable, threatened, and isolated. One stated, “I always felt very alone. Like I wasn’t with anybody that I could identify with….I didn’t feel like I had much to say to them because my life was hidden.” Another commented that at the lunch table, “my contribution about my life is very skewed and oftentimes a lie.” As these quotes indicate, isolation or feeling alone often resulted. Sara expressed this concern more completely in her discussion about lunchtime events. At first, she commented that the conversations were just “silly talk,” and it was not her thing to sit around a big table and have lunch. On further reflection, though, she clarified her thoughts, stating,

Oh well, actually it wasn’t silly talk when I think about it. It was really people sharing their experiences with their loved ones and with their family, or things like that. So, really it’s not silly talk. But…sometimes it was just…not very interesting, but probably because I felt so isolated, and I felt that I needed to keep my distance. I wasn’t sharing my, you know, the wonderful play we went to see, the wonderful lecture we went to see, you know, things that were really interesting and wonderful.

Here, Sara acknowledged that the lunch table talk was important and personal to those who could share. Perhaps the realization that her colleagues were able to share these important things in their lives and that she could not share similar things of importance further deepened her feelings of isolation, contributing to a separation between her and the rest of the staff members.

In response to these feelings of discomfort, some therapists chose not to join the lunch table. In some respects, not eating with others during lunch, under the guise of too much paperwork, can easily be excused in contemporary medical care where one must treat patients about 6 to 7 hours out of an 8-hour day. Jogging, going out to lunch with a few safe friends, or attending a lunchtime seminar were equally excusable.

Marie and Jenna explained in more depth the feelings they had about managing the lunch table ritual by separation and how their coworkers interpreted their actions. Marie recounted a conversation that occurred about 6 months after she was hired:

[One of my colleagues] goes, “Gosh, you know, when you were first here you never used to go out to lunch with us, did you?” And I said, “No.” And she said, “Yeah, why was it, you didn’t like us or you just didn’t know us or what?”…I said, “Probably because I didn’t know you guys.”

As Marie explained in the interview, separation was necessary because she felt threatened by the questions that may have potentially exposed her as a lesbian. She had to manage carefully how much and what she would share about herself to avoid evoking questions that would ultimately point to her sexual orientation. She was constantly alert to picking up clues about whether her colleagues would be accepting of her disclosure. Separation from the lunch table seemed to be the easiest way to manage this discomfort at that time in her career.

Months later, Marie came out to many of her colleagues and started to share lunch with them. In contrast to her initial attitude toward the lunch ritual, she now stated,

See, conversation is always so good at lunch. It’s never threatening. It’s not usually threatening or negative. It’s not threatening to me because I know that I’m OK being a lesbian around them….It is so much nicer to work in a department where people know what is going on in your personal life. I feel so much more comfortable. I feel so much more competent [italics added].

What is important in this last statement is that after Marie began to feel accepted in her work setting and could authentically share her life, she became excited to participate in the lunchtime events. This feeling of security seemed to spill over into patient care, as indicated by her statement that she
felt more competent. For relatively new therapists, competence can be related to overall feelings of self-esteem and the informal feedback about performance that one receives from coworkers. The rather drastic shift in the way Marie experienced her interactions with her coworkers before and after she was out reflects the importance of the bonding that occurs at lunch and the wide-ranging effects that being separated may have on the self-confidence she needs to develop as an occupational therapist. In the lunch table situation, it is because personal life and patient problem solving become so entwined that the technique of separating oneself from the situation becomes particularly damaging. By separating from the other therapists, new therapists miss the opportunities for consulting about patients, and the positive feedback from other coworkers about their treatments may be lost.

During her employment at one facility, Jenna separated from a woman and later married a man. When asked how the difference between being married to a man and being in a relationship with a woman affected her work, she stated,

Well, in my work environment I am now eating lunch more often with my staff. I used to not eat lunch with them too much. And again it was that same thing, talk about kids, talking about stuff that I just had no interest in. Plus I tend to work too much, which isn’t good. But now I find myself taking the time to go have lunch and, you know…we have the kids every other weekend. So, I have things to talk about this kind of fit the rest of the people. And even with my colleagues, you know, they’ll say, “How is your husband doing?” Or “How are you getting along with the kids?” You know, that kind of leaves them more things to ask me about. So I find it easier to have social relationships with them.

Jenna also pointed out that in private practice it is important to be able to relate to other businesspeople in order to get referrals. She stated,

‘Cause in my industry, people that use me, they respect me as an OT but they also like me as a person. And part of that is getting to know me and me getting to know them. You know, so that [it’s] not strictly professional in that sense.

She again demonstrates the importance of being able to connect with fellow workers and with other potential business associates on a personal level. Without those contacts, her private practice could not be maintained. Because she is bisexual, Jenna was in the unique position of experiencing the same work environment while being partnered with a woman and then with a man. Her experiences strongly indicate that her work and business connections were easier to make and maintain when she was in a relationship with a man primarily because she had authentic access to the heterosexual discourse that allowed her to relate to others and that allowed them to more easily relate to her.

Implications for Occupational Therapy

Medicine, as a profession and an institution, is overwhelmingly heterosexist (Bayer, 1987; Eliason, Donelan, & Randall, 1992; Stevens, 1992; Stevens & Hall, 1988). Occupational therapy, when housed in hospitals and medical clinics, becomes part of that institution and cannot escape the heterosexist influence. Even if therapists themselves are sensitive to issues that pertain to their patients’ sexual orientation or wish to create a safe space within occupational therapy clinics, it may be difficult to do so. The participants’ experiences in this study illuminated how heterosexist environments are maintained within occupational therapy clinics themselves, through heterosexual discourse, homophobic comments, assumed heterosexuality, and perceived stereotypes. In addition, the experiences that were recorded provide us with a beginning understanding about how heterosexist attitudes among health care providers can stifle therapists’ performances by disallowing them the resources to mature in their profession.

Knowledge empowers people to make change. This article adds to the line of research and practice that provides knowledge about the experiences of lesbian, gay, and bisexual occupational therapists (e.g., Bailey, 1996; Crepeau, 1998; Hamlin & Tarala, 1995; Jackson, 1995b, 1998; Walsh & Crepeau, 1998). The concrete examples described in this study can provide therapists with specific ideas on how to change their clinics. Therapists who wish to create safe environments may need to be cautious with respect to the homophobic jokes made in clinics, the homophobic references made about patients under the pretense of comic relief, the negative stereotyping about a certain therapist’s or patient’s sexual orientation, or the assumption that all patients are heterosexual. As the therapists in this study demonstrated, the hospital climate is steeped in heterosexual ideologies and actions; thus, these precautions need to be taken during interactions with other health care professionals as well as with patients.

Although this study was conducted in clinical settings, the findings can potentially be used by educators and students. The examples can be used to provide information to people who believe that they have minimal knowledge about heterosexism. Furthermore, the scenarios could be used as case studies to challenge students about how they would respond as future clinicians. Students and professors may also want to evaluate their own classroom environment, exploring what is the acceptable atmosphere and how it is maintained. Finally, this article could be used as an educational tool to encourage discussion of full inclusion that may be difficult to attain for persons of different ethnicities, religions, or disabilities. The ultimate goal, though, is not only to provide therapists, educators, or students with a list of changes they may make within their settings, but also to give them a new lens with which to view their settings so that they might be able to question whether and how their workplace, wherever it may be, may maintain a heterosexist climate.

Acknowledgments

I thank Florence Clark, PhD, OTR, FAOTA, Diane Parham, PhD, OTR, FAOTA, Ruth Zemke PhD, OTR, FAOTA, Barrie Thorne, PhD, and Don Polkinghorne, PhD, for their insightful comments on an earlier draft of this article. I especially thank the 10 occupational therapists who graciously gave their time to tell their experiences so that others may enhance their understanding of heterosexism in the workplace. This arti-
cle is based on material submitted in partial fulfillment of the requirement for a doctoral degree in occupational science at the University of Southern California, Los Angeles.

References


