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Perceived Differences between Male and Female Occupational Therapists’ Treatment and Other Related Gender Issues

Dennis Robert Jones
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PERCEIVED DIFFERENCES BETWEEN MALE AND FEMALE OCCUPATIONAL THERAPISTS' TREATMENT AND OTHER RELATED GENDER ISSUES

by

Dennis Robert Jones

A Thesis Submitted to the Faculty of The Graduate College in partial fulfillment of the requirements for the Degree of Master of Science Department of Occupational Therapy

Western Michigan University Kalamazoo, Michigan December 1997
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Dennis Robert Jones
PERCEIVED DIFFERENCES BETWEEN MALE AND FEMALE OCCUPATIONAL THERAPISTS' TREATMENT AND OTHER RELATED GENDER ISSUES

Dennis Robert Jones, M.S.
Western Michigan University, 1997

This study explored how occupational therapy clients perceive the treatment they receive from male and female occupational therapists. The study was conducted in a qualitative manner. Occupational therapy supervisors who have supervised both female and male occupational therapists were interviewed to gain an initial understanding of the relevant issues. More structured interviews were then conducted with clients who have been treated by both a female and a male occupational therapist. Therapists and clients were also observed during four treatment sessions.

Analysis of the data collected through interviews revealed that supervisors and clients do notice some behavioral differences in male and female occupational therapists which may affect client satisfaction and outcome. Additionally, both groups of stakeholders identified gender related issues and concerns which affect therapists and clients. Few gender differences in treatment behaviors were noticed during observations of treatment sessions.
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CHAPTER I

INTRODUCTION

Background: Occupational Therapy and Gender Roles in the 1900's

Occupational therapy has traditionally been a career which, much like nursing, attracted mostly females. The career requirements of a caring, patient, and empathetic practitioner were often stereotypically thought of as better suited to females. The early 20th century was a time when the roles of men and women were quite divergent. Women were not usually expected to be as career oriented as men. An occupational therapy career was often suspended when a female therapist had a child. Even as late as 1972, only 53.4% of female occupational therapists between the ages of 30 and 44 were employed (Jantzen, 1972). Women were often expected to take on the role of nurturer when it came to child rearing or caring for the sick.

Occupational therapy, as a field, began officially in 1917 when these differing role expectations of men and women were quite strong. Throughout much of the 20th century these role expectations prevailed and it was rare to find a male occupational therapist. Reflecting this reality, much of the literature pertaining to occupational therapists used the feminine pronoun 'she' to identify the therapist. Males were given mixed signals about entering the field of occupational therapy. Dr. W. Anderson Thompson (1942), who spoke at the twenty-fifth annual meeting of the American Occupational Therapy Association, encouraged men to enter the profession but in a limited way. He noted the need for men in mental health settings and in the treatment of male clients. He also quoted the calendar of occupational therapy courses of Columbia
University which welcomed men into its educational program but did not welcome them wholeheartedly:

While occupational therapy is a profession of interest primarily to women, there are certain positions in the field for which it is desirable to have male therapists. For this reason a limited number of men may be admitted to the professional course (Thompson, 1942, p. 168).

Changes in gender roles occurred slowly over this century. Much of this change can be attributed to the women's movement. There were three major women's movements in America over the last two centuries. "Each of the three major periods of feminism in the U. S. (1830-1850, 1890-1920, and 1965 to the present) involved idealistic efforts to redefine the realities and rights of being a woman" (Davidson & Gordon, 1979, p. 187). The women's movement of the 1920's resulted in the right to vote for women in the United States, but little changed in terms of the roles men and women were expected to play at work or at home. These roles did not alter significantly until the 1960's when young Americans began to challenge their society's norms and values. "An analysis of trends in attitudes about women's gender roles over the years 1964 to 1974 shows substantial shifts in attitudes about family roles and working roles of women" (Davidson & Gordon, 1979, p. 200). Beginning on June 30, 1966, the women's movement organized formally into the National Organization for Women (NOW). Its objectives were:

(a) Equal rights constitutional amendment; (b) Enforce laws banning sex discrimination in employment; (c) Maternity-leave rights in employment and in social security benefits; (d) Tax deduction for home and child-care expenses for parents; (e) Child day-care centers; (f) Equal and non segregated education; (g) Equal job training opportunities and allowances for women in poverty; and (h) The right of women to control their reproductive lives (Richardson, 1981, p.254).

Because of political turmoil surrounding the war in Vietnam and the organized women's movement, Americans were again forced to reflect on the roles that women and men were expected to play. The 'tennis match of the decade' between Billy Jean
King and Bobby Riggs was pointed to as proof by many that a woman could be superior to a man even when it came to physical prowess. As the women's movement grew and opportunities open to women expanded, American women expressed greater satisfaction with their positions in society.

In 1953, seventy-five percent of U.S. women (three out of four adult women) said that they would want to be a women if they were born again: (Q: 'If you were to be born again, would you want to be a man or woman?') In 1975-76, a larger proportion, eighty-seven percent, said they would choose to be a woman. There may be more prestige related to being a woman in the 1970's than in 1953 (Davidson & Gorden, 1979, p. 200).

By the 1970's, some men were becoming more accepting of women's desire for economic and social equality. Men also began to question the roles society had expected them to play. They began to realize the stifling nature of these expectations and began to reveal the softer or more nurturing side of their nature. "Much of the ideology of the Men's Liberation Movement is phrased in terms of their deprivation relative to women in such areas as support, nurturant behavior and emotional expressivity" (Richardson, 1981, p. 264). Men were allowed to be more nurturing and caring in public and with their children.

These changes in gender role expectations have resulted in a lessening of the sex-typing of occupations like occupational therapy. Research by Rosen (1989) supported the belief that socialization differences, and resulting differences in occupational aspirations of the genders, have diminished over the decades. "The differences between the way girls and boys are reared, when they are found, are seldom large. Certainly these differences are far smaller than in pre-industrial societies" (p. 64). Over a period of 20 years in the 1960's, 1970's and 1980's, Rosen (1989) conducted gender studies in five countries including the United States. His data suggested that there is "only ambiguous support for the argument that the sexes have different occupational expectations" (p.160). Status expectations and goals influence
what we will become. Rosen's study indicated that females no longer are limiting themselves to certain jobs. Males are also listening to society's messages which tell them it is okay to be in professions which have been predominately female.

The Issue: More Men Becoming Occupational Therapists

In the 1940's, the number of men in the profession of occupational therapy numbered about 50 out of 2,265 total therapists, or 2.2% (Hopkins, 1983, p. 13). The cultural changes mentioned above set the stage for an increase in the number of males entering the field of occupational therapy. It was not considered as taboo for males to be caring, patient, or empathetic. The economic situation also began to make many allied health professions more appealing to men. Federally mandated programs such as Medicare, which began in the 1960's, created a great demand for occupational therapists. Salaries began to rise as demand for occupational therapists outpaced supply. This high demand continues to the present day. Salaries for occupational therapists in the 1980's began to be equal to or greater than those of traditionally male positions such as architect or engineer. The number of males entering the field of occupational therapy continued to slowly increase during the 1970's, 1980's, and 1990's. In 1973 about 4.0% of occupational therapists were male (Acquaviva, 1975, p. 427). By 1994 that figure had grown to 6.1% (AOTA, 1994). This figure will continue to rise based on the fact that 12.1% of occupational therapy students in 1994 were male (AOTA, 1995).

Goal of This Research

The phenomenon of men entering the field of occupational therapy in increasing numbers is a relatively recent one. There is research which looks at gender differences in nonverbal behaviors (Mayo & Henley, 1981) and parental treatment differences for
each gender (Montagu, 1986). There is also literature which examines the effects of biological differences and different environments on men and women and how their behavior is affected (Hoyenga & Hoyenga, 1993). Research has also been done which looks at differences between men and women in perceived personal power (Lipman-Bluman, 1984) and the effects on the individual of a nontraditional job for that gender (Williams, 1989). However, no studies were found which look at the effect these differences have on occupational therapy treatment. That is the goal of this research.

Some research has been done which considered the gender of occupational therapists. One study was found (Rider & Brachear, 1988) which described male occupational therapists. One study (Montegue, 1994) was found which looked closely at opposite gender treatment dyads, specifically a male therapist treating a female client. The purpose of this research was to identify if any differences exist in the way men and women deliver occupational therapy services, as perceived by occupational therapy supervisors and clients.

The literature mentioned above will now be briefly reviewed to give the reader a sense of the breadth of research available on gender differences. It will also become apparent that research needs to be done which examines the effects the gender of the therapist has on occupational therapy treatment. This study has begun to fill the gap in the research.

Much of the literature supports the hypothesis that there is a difference between men and women in areas such as verbal and nonverbal communication styles, touching patterns, and displays of emotion. Some researchers (Mayo & Henley, 1981) have found that the behavioral characteristics stereotypically thought of as masculine are truly found more in men and the characteristics stereotypically thought of as feminine are actually found more in women. They identified numerous differences in the nonverbal behaviors of men versus women. Most of the findings tended to support the idea of
more affiliative and less dominant behaviors by females during interaction. Eye contact, which has been linked to a desire to have greater affiliation with others, seemed to be more common among women than men. Even when instructed to withhold approval, women smiled and nodded more than men. Men were found to be "...generally less affiliative and intimate in interaction than females along a number of nonverbal dimensions" (p. 81).

Much of the difference in the behaviors of the different genders can be attributed to parental treatment. Montagu (1986) identified many differences in the way children of opposite genders are treated by their parents. “Proximal attachment behaviors such as touching and holding were primarily affected by the sex of the infant....Female infants were held a greater amount of the time” (p. 138). He also identified many differences in the behaviors of female and male infants. He found that sex differences in tactile sensibility become apparent very soon after birth. Girls have lower touch and pain thresholds than boys, a difference which remains throughout life. Thus tactile stimulation is more meaningful to females than it is to males. Boys respond less to talking and to touch than girls. Parents may thus find it more rewarding to talk to and touch girls than boys. Within a few months, girls also show more interest in faces than boys.

Hoyenga and Hoyenga (1993) looked at the effects of biology and environment on the behavior of males versus females. They identify hormones as the primary biologic means of influencing behavior.

Emotional reactions seem to co-vary with hormones, at least in some people, as seen in PMS, postpartum depression, the use of anabolic steroids, and the use of replacement hormones after menopause. Food intake and sexual activity also show some evidence of hormone sensitivity, although cultural factors are of even greater importance (p. 203).
They also explained how environmental influences are found to have a great effect on the behaviors of each gender. Males and females are exposed to gendered environments from birth to death. Adults often supply different toys for boys and girls. This surely affects the view the child has of the world and his/her relationship to it. Adults also reinforce different behaviors in boys and girls. Often, a child's behavior such as assertion/aggression is either reinforced, punished, or ignored by peers, parents, and teachers depending on the child's gender. The reaction a child receives from these people will influence whether the child will behave that way again or not.

Historical events such as the women's liberation movement impact the generally accepted gender roles of men and women today. Lipman-Blumen (1984) examined the impact gender roles have on perceived personal power and the strategies men and women use to relate to others. Women often use the strategy of submission to an omnipotent force, an institution, or another powerful individual, and men often use the strategy of taking control over institutions, people, and situations. Historical conditions, institutional arrangements and practices justified by ideology, access to resources, norms, values, and stereotypes all channel men into dominant and women into subordinate positions.

Men and women who challenge the generally accepted gender roles society dictates face challenges not experienced by those who follow gender stereotypes more closely. Williams (1989) examined the impact on the individual of working in a non-traditional job for that gender. She found that female marines were feminine, and male nurses were masculine. Gender identity was found to be maintained even in the most nontraditional occupations. She states, "Military policy makers' great pains to preserve military women's femininity (through makeup classes, femininity testing, the combat exclusionary rules, etc.) can thus be seen as veiled attempts to maintain the men's masculinity" (p. 135). Male nurses also strive to set themselves apart from female
nurses. They have done this by migrating to the most prestigious and better paying specialties within nursing, thus removing themselves from any association with the bedside nurse.

Though there is a plethora of studies which examine gender differences, no studies were discovered that look at the effect these differences have on clinical treatment by male versus female practitioners of occupational therapy. Some research has been done in occupational therapy, however, which takes gender into consideration.

One study has been done to identify characteristics of male occupational therapists (Rider & Brachear, 1988). This study indicated that "as a group, male occupational therapists today are younger, more likely to have advanced degrees, and less likely to be married than their 1969 counterparts" (p. 231). Most of the male occupational therapists in this study had parents who were professionals or skilled workers. These men were more likely than the general population to have attended private schools and most of them were raised in small or mid-sized communities. Rider and Brachear did not survey non occupational therapist males, however, so it is unclear whether or not other characteristics they identified differ from the norm.

Some research has also been done which looks closely at the issue of opposite gender treatment dyads (e.g., male occupational therapist/female client) (Montegue, 1994). The majority of the respondents did not identify major concerns working with female patients. They were able to adapt techniques in treating female patients especially when working with them on activities of daily living. However, most of the respondents were very aware of the caution necessary by male therapists when treating female patients because of intimacy issues and concerns over claims of sexual abuse.
Importance of the Study

This study is important because it helped identify issues which confront an increasingly gender diverse group of occupational therapy practitioners and their clients. It may have implications for how occupational therapists are taught in professional schools and how they practice in clinical settings. Also, as professional attrition rates are very high for male occupational therapists (Posthuma, 1982), this study revealed some reasons for males' dissatisfaction with their occupational therapy careers and ways to decrease this dissatisfaction. The outcomes of this research may also assist occupational therapists in making better clinical decisions.

Scope of the Study

The scope of this study was somewhat narrow as it is one of the first of its kind. The focus is on occupational therapists and geriatric clients in settings in which the elderly are served. This focus evolved in response to the growing population of elderly who will be requiring occupational therapy services in the near future and the length of time therapists spend with this population. Data gathered from elderly occupational therapy clients may differ from that collected from younger clients. This is understandable when considering the social roles of men and women that most elderly experienced in their adult years compared with those experienced by more recent generations. Thus, this research may not be generalizable outside of the current geriatric domain. It should, however, provide a beginning understanding of the experiences of those involved in giving and receiving occupational therapy services in current geriatric settings. It is also informative to those interested in the impact of greater numbers of men entering other allied health professions such as nursing.
CHAPTER II

LITERATURE REVIEW

Introduction

The basic assumption made when this topic of gender differences in treatment by occupational therapists was selected was that there are behavioral differences between men and women. The fact that this topic of gender differences is considered important was substantiated by the vast amount of research on the topic. Oskamp and Costanzo (1993) asserted that there have been 35,000 to 40,000 gender related articles published in social and behavioral science journals since 1967. The assumption that there are gender differences in behavior was substantiated by the majority of the literature reviewed for this study. Some of this literature was identified in the introductory chapter of this study to give the reader firm grounding in this beginning assumption. Additional studies will be reviewed to further substantiate the belief that behavioral differences exist between the genders.

The second part of this literature review will examine more closely the feminine and feminist history of the field of occupational therapy. It is important to understand the reasons why occupational therapy has historically been a female dominated occupation. This historical view will help the reader understand the implications of more men entering the field.

Next, this review will examine the balance between feminine and masculine in the field of occupational therapy. Some authors indicated a need for more of a balance between the masculine and feminine while others promoted the feminine approach as the best for occupational therapy today.
The fourth section of this review will look closely at the phenomenon of more men entering the profession of occupational therapy. The historically difficult job of attracting males to the profession of occupational therapy will be described. Male occupational therapists' demographic information will be reviewed.

This literature review will then examine job satisfaction among men in occupational therapy. Reasons for dissatisfaction will be identified.

Finally, the last section of the literature review will examine specific gender related issues in health care, such as male occupational therapists teaching female clients how to bathe or dress. Issues pertaining to male therapists and female therapists will be discussed.

Male and Female Differences

The issue of similarities and differences between males and females has been considered throughout the world for centuries. It is of interest to both genders because gender roles influence how one relates to another and can influence the way one contributes to society. Much of the literature reviewed here is relatively recent (i.e., post 1970). It was reasoned that literature from the most recent decades would best explain how gender differences and similarities affect the roles of, and outcomes achieved by, currently practicing male and female occupational therapists. This study will focus primarily on male and female gender roles in the United States.

Areas of gender differences examined include verbal behaviors such as amount of talk, intonation, communication styles, apologies, interruptions, compliment behavior, persuasion and social influence. Nonverbal behaviors include smiling, nodding and eye contact. These areas of behavior were examined because it was thought that they have a profound impact on occupational therapy treatment. Literature
on strength and intelligence differences, for example, were not reviewed because they were thought to not be as relevant to occupational therapy treatment.

One area of interest when considering gender differences and similarities is amount of talking. A commonly held belief is that women talk more than men. The literature provides some surprising insights into this belief.

Research by James and Drakich (1993) reviewed 63 studies which looked at gender differences in the amount of talk in adult interaction. These researchers focused on 56 of the studies which examined mixed gender interaction, all done between 1951 and 1991. Twenty-four or 42.9% of the studies found males to talk more than females in mixed sex interactions. Sixteen or 28.6% of the studies found no differences between the sexes overall in amount of talk. Only two of the 56 studies or 3.6% found females to talk more than males.

James and Drakich (1993) explained these surprising results by identifying how important status attainment is when considering amount of talk. In mixed gender groups, status expectations propel men to talk more than women. James and Drakich presented evidence which suggests that men learn from their parents and society that it is important for them to assert status and to appear a leader in interactions, while women learn to concentrate on using talk to establish and maintain harmonious relationships with others. The authors established how important differences in expectations and beliefs about oneself and others can be for behavior.

Oskamp and Costanzo (1993) presented evidence that parents' beliefs have an impact on children's developing self-concepts and on the experiences parents provide for their children in various activity domains. These relationships all contribute to gender role socialization. Higher-status individuals are more willing to contribute to interactions than lower-status individuals. Mayo and Henley (1981) asserted that males, who generally see themselves as leaders, may display more dominance,
independence and assertiveness, while females, who generally don't see themselves as leaders, may display more submissiveness, dependency and emotionality. This may have an impact on the treatment which male and female occupational therapists provide.

The type of talk which the person is involved in will also influence her or his amount of talk, according to James and Drakich (1993). When engaging in informal talk it was found that men speak less. The amount that women talk exceeds the amount that men talk in informal contexts more than in formal task-oriented contexts or other formally structured contexts.

Another interesting difference found in male and female conversational research is the type of intonation they use. Pitch and volume changes both affect how we perceive a speaker. Adult men tend to have larger larynges than adult women and thus their basic instrument for speech is pitched in a somewhat lower register. McConnell-Ginet (1983) stated that men tend also to have more of a monotone voice and that monotonicity detracts from the perception of femaleness and enhances the perception of maleness. The degree of perceived emotion is strongly correlated with pitch range and thus females tend to sound more emotional than males simply because of greater tonal fluctuation in their speech.

Another pertinent area investigated is differences in the ways men and women communicate. Multz and Borker (1982) found that women tend to ask more questions, do more to facilitate the flow of conversation, make more use of positive minimal responses such as "mm hmm," make more use of a "silent protest" after they have been interrupted and "show a greater tendency to use the pronouns 'you' and 'we', which explicitly acknowledge the existence of the other speaker" (pp. 197-198). Men were found to interrupt more, challenge or dispute their partner's utterances more, ignore the comments of the other speaker more, use more mechanisms for controlling the topic of
conversation—including both topic development and the introduction of new topics—than do women. Also, men tend to make more direct declarations of fact or opinion than do women.

Bonanno (1982) identified linguistic differences in the dialogues between male physicians and their patients and female physicians and their patients. The effect these differences have on the interaction between the physician and the patient was also examined. This study was considered important because nearly half of 105 randomly selected patients at Georgetown University Hospital in 1976 who were surveyed were unhappy with the quality of the communication between themselves and their physicians. Bonanno found that there were characteristic differences between male and female physicians in the use of certain linguistic features such as hedges, vague adjectives, tag questions, and euphemisms. While male physicians spent almost twice as much time as the female physicians did with their patients, the female physicians used the four features that were investigated almost twice as often as the males.

The use of these four linguistic features comprised what Bonanno (1982) identified as an indirect style. She found women to use this style more often than men. It would be interesting to see if this indirect style is utilized more by female occupational therapists than male occupational therapists. Unfortunately, no research was found which investigated this phenomenon. Another question raised by this study was: ‘How much does the patient understand the therapists' explanations of the client’s illness or treatment plan when an indirect style versus a direct style is used?’ Use of a more direct style may be more effective in attaining client compliance with treatment; however, an indirect style may encourage client empowerment.

When talking with a physician, it has been found that patients feel more empowered with female physicians than with male physicians (Ainsworth-Vaughn, 1992). This study found that physicians wield much greater interactional power than
patients during a medical discourse and also that male physicians play a more dominant role in the discourse than do women physicians.

Patients generally prefer the indirect and empowering style used by female doctors (Linn, Cope, & Leake, 1984). Linn et al. looked at communication styles of male and female doctors and their patients' satisfaction levels. Their study found that both male and female patients evaluated care from females more favorably than care from males. It was not determined in this study if there were any real gender differences in physician behaviors or whether patients merely perceive and evaluate men and women caregivers differently.

Holmes' (1989) study focused on gender differences and the use of apologies. She identified an apology as something "...to provide a remedy for an offense and restore social equilibrium or harmony" (p. 195). She found that women use significantly more apologies than men and that women tend to use more apology strategies which recognize the claims of the victim. Men tend more than women to use more formal strategies which focus on themselves. Women's apologies are predominantly directed to light offenses whereas men use more apologies for medium-weighted offenses. While both sexes use most apologies to power equals, men often apologize to women of different status, i.e. a female boss or a female subordinate. Women use most apologies to female friends whereas, men use most apologies to socially distant women. Though the most frequent response for both sexes is to accept apologies, men reject apologies more than women do.

Compliments are another speech pattern studied. Herbert (1990) found significant differences in the compliment behaviors of women and men and the rate at which these compliments were accepted by the complimentee. He found that males compliment less frequently than females, and that compliments from males are more likely to be accepted than those from females. Male compliments are not so much
offers of solidarity as actual assertions of praise and admiration. In contrast, female compliments are more often offers of solidarity and tokens of good will, and they occur with greater frequency in discourse.

Gender differences in tendency to be influenced have also been found. Two studies done by Eagly (1978, 1983) found some significant gender difference in likelihood of being persuaded. She found women to be more easily influenced than men. She explained that gender differences “...may occur because experiences with hierarchical social structures in which men have higher status creates expectancies about male and female behavior, and these expectancies affect social interaction in ways that foster behavior that confirms the expectancies” (Eagly, 1983, p.971).

Carli (1989) found gender differences in interaction style and influence. She found that women generally exhibit a greater amount of agreement and other positive social behaviors than men. No differences were found between men and women in the strategies used to influence someone.

Other authors have studied nonverbal interaction. Mayo and Henley (1981) stated that most findings tend to support the idea of more affiliative and less dominant behaviors by females during interaction. Even when instructed to withhold approval, women have been found to smile and nod more than men. Women also spend more time smiling and gazing at a partner than do males. Carli (1989) found women to generally exhibit a greater amount of agreement and other positive social behaviors than men. Men are generally less affiliative in non-intimate social interaction than females along a number of nonverbal dimensions, especially with same-sex partners.

Behavioral differences may be the result of the power inherent in men generally being of a larger physical size (Oskamp & Costanzo, 1993). One could conclude that larger people within each gender may also have an advantage over smaller individuals when these aspects of conversation are observed. Multz and Borker (1982) shaped the
explanation of differences in speech styles of boys and girls, and men and women to fit an anthropological perspective. They reasoned that anthropological differences such as body size may explain the present differences in conversational styles mentioned above.

Other authors have explained some of the differences observed in the behaviors of men and women by identifying cultural differences in expectations placed upon them. Oskamp and Costanzo (1993) focused on the child's gender as one potentially critical social factor and presented data showing how a child's gender might influence parents' perceptions of their children's ability, independent of their actual performance. They found boys may be expected to lead in more situations and may be given parental permission, either expressly or not, to speak more in group settings and be dominant when engaging in conversations, especially with women. Rosen (1989) also identified the importance of parents and family for gender role socialization. She suggested that it is in the family that the child first learns about gender roles. The gender role embodies an important segment of social values, rules, and behavior patterns, whose influence the child can observe in the daily actions of parents and other adults.

We can see from the literature that there are some significant behavioral differences between men and women. Oskamp and Costanzo (1993) indicated that these gender differences in amount of speech, type of intonation, number of interruptions and dominance/submissive behaviors become apparent to people at a very young age. They found that, in terms of gender stereotypes, by the time children are in preschool and kindergarten, they are very good at assigning stereotypic gender labels to toys, activities, and occupations. Rosen (1989) identified one study which identified how the child's gender influenced what toys parents bought for their children. This study of parents choosing presents for their children found that no one bought a scientific toy for a girl and no one bought a doll for a boy. Oskamp and Costanzo stated that there is significant social pressure on people to behave in gender stereotypic
ways, because a behavior that violates gender prescriptions is often negatively evaluated by others.

How do men and women peacefully coexist with all of the differences identified above? Socialization provides the basis for our expectations of people of the same and opposite gender. We use our expectations to predict others' behavior. Mayo and Henley (1981) stated that much of our smooth interaction with others depends on our ability to predict what others will do and to have those predictions confirmed. After we have identified someone as female or male, we call into operation a large set of expectations about how such persons should and will behave.

Although significant behavioral differences have been identified between the genders, it should be remembered that in the last 50 years there have been dramatic changes in the gender role and occupational role expectations of females and males in the United States. Though the majority of literature reviewed found significant differences in the verbal and nonverbal behaviors of women and men who grew up in the middle decades of this century, there is also evidence that socialization differences are diminishing. Rosen (1989) asserted that gender differences in socialization are far smaller than in pre-industrial societies. He concluded that as far as achievement and its related individual traits are concerned, the difference between the sexes has narrowed to a minimal gap in most cases.

Feminine and Feminist History of Occupational Therapy

The discipline of occupational therapy began officially in 1917 as men wounded in World War I began to return home to the United States. The founders of occupational therapy recruited only upper-and middle-class, educated young women who would be willing to endure conflict and hardship and to work long hours (Hamlin, 1992). Hamlin identified the stereotypic traits of young men and women of that era.
Masculine traits such as independence, power and logic were more valued by society than feminine traits such as dependence, weakness and emotional. These stereotypes affected the self image and behaviors of men and women. Oskamp and Costanzo (1993) described how the prescriptive component of a stereotype is composed of the behaviors considered appropriate for the target group. Prescriptions indicate how a member of a target group 'should' behave. For example, the female stereotype might include the following prescriptions: A woman should have good interpersonal skills, she should be passive and docile, and she should cooperate with others.

Feminine and masculine traits have been differentially valued by society in the 20th century. Hamlin (1992) used her gender trait comparison and the fact that the occupational therapy field embraced the characteristics of the stereotypic female to explain why "...the profession is not highly valued" (p. 1032). Oskamp and Costanzo (1993) explained how the power and status of each gender could account for the differential valuing of male stereotypic traits, which they identified as the competency cluster, and the devaluing of the female stereotypic traits, which they identified as the social-emotional cluster.

Despite these authors' assertions that feminine characteristics were less valued by society than male characteristics in 1917, both the male and the female founders of occupational therapy obviously felt that the characteristics of the typical female were more suited to treatment of the ill young men who were returning from the war in Europe. They probably used the example of the nurse as a foundation for the development of occupational therapy. The occupational therapist-like the nurse-would need to be nurturing, motherly, resourceful, enthusiastic, thoughtful, versatile and adaptable. Hamlin (1992) stated, "The traits of caring, cooperation, nurturing and subjectivity are at the heart of occupational therapy" (p. 1032).
It is not surprising, with this emphasis on feminine traits, that the field of occupational therapy did not attract more males. Males, in the early part of this century especially, were socially constrained against acting too feminine. It was expected that they would fight in World War I and that females would care for those wounded men who returned from Europe.

Despite the devaluing effect some authors felt a feminine history has had on occupational therapy, many of them have identified the strengths of this history (Frank, 1992; Hamlin, 1992; Hamlin, Loukas, Froehlich, & MacRae, 1992; Miller, 1992). Hamlin et al. identified the history of occupational therapy as based not only on feminine traits but also on feminist principles. They identified feminism as a "...dynamic, evolving ideology" and as an inclusive principle which not only affects women but allows for "...personal empowerment and social justice for all" (p. 967). They believed that the feminism they embraced supported both women and men in becoming more fully human.

Balancing Feminine With Masculine in Occupational Therapy

Miller (1992) compared female and male action to China's Tao or The Way. "Yin action is contractive, conservative, responsive, cooperative, intuitive and associated with the female principle. Yang action is expansive, demanding, aggressive, competitive, rational, analytic and associated with the masculine principle" (p. 1013). A balance of these different types of energies was identified as the way occupational therapy can both embrace its feminist past and move ahead as an all inclusive profession.

Hamlin (1992) identified problems that still exist today in the form of gender conflicts. She stated that much of the conflict is a result of societal demands on occupational therapists as persons and as professionals. Despite progress made, in
part, by the modern women's movement of the 1960's and 1970's, Hamlin believed societal attitudes remain that allow neither women nor men to be fully human. The way to resolve this gender conflict in ourselves and our profession, in Hamlin's view, is to stop putting differing values on the concepts of femininity and masculinity. Both kinds of 'energy' are necessary to make one fully human. There is a risk inherent in following a holistic, or what she considered to be a feminine, path in occupational therapy. She identified the conflict in occupational therapy as one of holism (feminine) versus the medical model (masculine), between the art of caring (feminine) and the science of occupational therapy (masculine). The risk of returning to holistic practice, she thought, was that society may not value occupational therapists as professionals. Frank (1992) similarly argued that the same socialization that suited women to be occupational therapists worked against them in terms of advancing the profession.

Some of the feminist researchers mentioned above promoted feminine holism rather than what they considered to be masculine identified reductionism. Miller (1992) stated that the philosophy of occupational therapy is more closely linked to yin-like energy and thus this holistic form of living should be embraced and promoted. Frank (1992) recommended that competitive recruiting and retention strategies should be undertaken to attract and retain minorities of all kinds including men, but that occupational therapy should more closely examine and treasure its Progressive Era feminism and politics of social reform. She reasoned that this history can prove invaluable in promoting the needs of people with disabilities and chronic illnesses on the margins of biomedicine, which she considered to be grounded in masculine ideals.

Hamlin (1992) stated how freeing the process of eliminating gender based valuing or devaluing could be. She asserted that when the concepts of femininity and masculinity are no longer assigned different values, and the constraints of gender eliminated, people will be free to be uniquely human, to develop their full capacities.
Hamlin et al. (1992) stated that as society continues to change and become less rigid about gender role expectations, feminist voices can help to underscore the importance of collaboration in composing a vision that values all persons.

Kelly (1996), a male researcher, who also stated how important it is to embrace the feminine principle and the masculine principle in occupational therapy. Interestingly, he is one of few male researchers who has written on the topic of femininity and masculinity in occupational therapy. In his view, holism is the essence of femininity while reductionism is the essence of masculinity, and a blending of values is essential in occupational therapy today. In the balanced viewpoint-which includes both the masculine and feminine principles—occupational therapy is seen not as technique but as process, and the challenge today is to integrate feminine values within masculine standards. What is required, he claims, is a reordering of priorities, and a balance to be affected by including the feminine principle. Any system based upon the feminine principle or the masculine principle alone will not be sufficient. The two principles must merge in the practice of occupational therapy.

Peloquin (1995) recommended that empathy be used for all who want to understand people different from themselves. She stated that empathy also increases respect for differences. Occupational therapists, both male and female, can use empathy not only to understand one another better, but also to emulate the behaviors of therapists of opposite gender in the hope of improving treatment outcomes. She held up empathy as an effective way to unite people. The empathic encounter consists of an expression of being there—a recognition of both likeness and uniqueness. It is an entry into the other's experience, a connection with the other's feelings, a disengagement from that connection, and a personal growth which develops from these actions.
This section of the literature review has identified the need for a balance of femininity and masculinity among occupational therapists. The next section examines the phenomenon of more men entering the profession of occupational therapy.

**Men in Occupational Therapy**

Occupational therapy can be described as a predominantly female field, especially in the early decades of this century. The role of men in the profession was limited in the early years to certain settings, such as the mental hospital, or certain positions, such as director of the department. These were, in fact, the areas to which men gravitated. A survey by Christianson (1970) found that 41% of males surveyed were directors of departments in occupational therapy and 61% were employed in psychiatry.

A speech by Louis Haas, Director of Therapeutic Occupations at the Bloomingdale Hospital in White Plains, NY, to the eighth annual meeting of the American Occupational Therapy Association in 1924, reflected the limited role men were expected to play in the field (Haas, 1925). He identified occupational therapy during the war period as essentially women's work. The public who learned of occupational therapy through the war time press began to think of this as a service which only women could render to the sick and disabled-physically and mentally. Haas found the mental health setting and the male clients in these settings especially, in need of male occupational therapists. He identified this as the primary area in which male occupational therapists could serve. "The boundary of this field appears to be the men's service of the mental and nervous hospital. Here the retraining which is required leads one to pursuits which are distinctly masculine in character" (p. 55). This comment reflects the rigid gender roles some people held in the first decades of this century. Haas also recommended that males pursue directorships in occupational
therapy departments. "The number of men directing departments is very small but there nevertheless have been openings for directors with no candidates available" (p. 55). This comment reflects the role expectations some people had of men in these decades, namely that they functioned best as leaders.

Even though Haas (1925) proposed a relatively limited role for men in occupational therapy, the essence of his speech was to identify a need for men to enter the profession. He concluded by saying,

> This then is the field [mental health] in which the services of men are needed. At the present moment there are few candidates available but as the public realizes this is a sphere for the trained man therapist, candidates will appear. Of course there must be, open to the men, the opportunity to receive training. Some candidates have been told in the past that there were no opportunities for men to have formal occupational therapy training. The recognition of the need for development in this direction and the education of the public to consider that men have a part to play in occupational therapy, is all that is needed to bring about the desired results. (Haas, 1925, p. 56)

From its first days, occupational therapy was considered by the general public who knew of it to be a female profession. It is easy to see why few men entered the profession in the 1920's, 1930's, and 1940's. Given the limited roles open to males, as described by Haas (1925), few men viewed occupational therapy as a profession which welcomed males. The issue of too few men in the profession was not considered important, as reflected by the lack of literature found on this topic before 1950. After Haas (1925) presented his paper, only one other paper was found, pre-1950, which identified the lack of men in the profession of occupational therapy as an important issue. Thirteen years after Haas's speech, at the twenty-fifth annual meeting of the American Occupational Therapy Association in 1941, Dr. W. Anderson Thompson talked on "The Training of the Male Occupational Therapist."

Thompson (1942) talked about a conference which was held earlier in 1941 in Richmond, VA, where a hospital superintendent asked why male therapy workers
could not be obtained. At that conference, the participants—who were hospital superintendents—identified two possible explanations for the lack of male therapists: (1) a lack of financial reward, and (2) a belief that the profession was considered a feminine occupation. Thompson asserted in his speech that the latter explanation was accurate but that the public’s perception was not correct. He stated, "At present because of the preponderance of women in it, it may appear feminine, but the type of work taught by men to male patients would not be" (p. 166). This last comment again reflects the limited role thought suitable for male occupational therapists during the 1940’s: primarily the treatment of male patients.

Thompson (1942) went on during his speech to explain in detail the roles suitable for male occupational therapists and the type of training necessary for them, as identified by 18 superintendents of New York state hospitals in a survey he conducted at the Richmond seminar. He quoted one superintendent’s comment as representative of many of the responses to his survey,

There are many activities of interest to male patients of a mechanical nature that only male therapists are qualified to engage, instruct and supervise in. There are certain lines of activity, both craft and physical education, that need the male worker. (p. 166)

Thompson stated that training for male occupational therapy students was available. He cited the calendar of the occupational therapy courses of Columbia University, which, however, as was mentioned earlier, identified a limited role for men in occupational therapy and which stated a not very enthusiastic acceptance of males into the profession.

By the 1960’s, the opportunities open to men in occupational therapy had increased and more men were entering the profession, though they were a distinct minority. By the 1970’s, perceptions of the ideal occupational therapist may have began to change, much as had the view of the ideal nurse. Minnigerode, Kayser-
Jones, and Garcia (1978) surveyed undergraduate and graduate nursing students to learn of their view of the ideal nurse. Even though nursing is a strongly sex typed profession, the ideal nurse was described as highly feminine and highly masculine, i.e., psychologically androgynous rather than sex-role stereotyped. They found that the ideal nurse was described not as stereotypically feminine, but as someone capable of displaying both characteristics considered feminine (i.e., warmth, understanding, gentleness, helpfulness, kindness) and characteristics considered masculine (i.e., independence, competitiveness, self-confidence, decision making). Though no similar study was found which involved occupational therapy, it is expected that there would be a similar outcome.

Androgynous individuals may be a strength to any health care profession. These individuals, who recognize and accept both the masculine and feminine sides of themselves, will be more able to empathize with clients of the opposite gender. Empathy was identified as a crucial skill (Peloquin, 1995) in helping us understand those different from ourselves. Androgyny also has an impact on self-esteem, which one would think impacts client care. Minnigerode et al. (1978) identified studies demonstrating that psychologically androgynous individuals—those scoring high on both masculinity and femininity scales—possess greater self-esteem than either sex-role-stereotyped individuals or those scoring low on both masculinity and femininity scales.

Are the men who are entering occupational therapy as a profession typical masculine men or are they more psychologically androgynous? Lemkau (1984) surveyed males in typical jobs (engineers, foresters, lawyers, financial officers) and males in atypical jobs (physical and occupational therapists, nurses and dietitians, elementary education teachers and librarians). In terms of their personal histories, males with atypical jobs more frequently reported having had employed mothers,
having had distant relationships with their fathers, and having been positively influenced in their career choices by women. These men had more frequently experienced the death of a parent or sibling, or parental divorce or separation, and often mentioned that these stresses increased their nurturing and emotional capabilities. Lemkau concluded that men who have entered female dominated professions seem to have personality and background factors which differentiate them from men who are more traditionally employed.

A study by Rider and Brashear (1988) looked more specifically at the characteristics of men who enter the field of occupational therapy. 797 male respondents to three surveys (1979, 1982, 1985) provided personal data about themselves, such as extracurricular activities in high school and college, marital status, birth order, education and occupation of parents, type of community they had grown up in and people influencing their career choice.

As for high school and college activities, 97% indicated that they were involved in competitive sports. Football was mentioned most frequently, followed by baseball, basketball, track, volleyball, wrestling, tennis, cricket, hockey, bowling and softball. Sixty-one percent of respondents were married at the time of the survey, but 67.5% were single upon entering an occupational therapy curriculum. As for family background, 31% of the respondents were the first child, 33% a middle child, 28% the last child, and 7% the only child.

The mothers of the respondents were more likely than the fathers of the respondents to have completed high school, but they were slightly less likely to have graduated from college or have advanced college degrees than the fathers. As for the main breadwinner of their family, 74.9% said father, 4.2% said mother, 18.8% said both father and mother and 1.4% said they lived with others than their parents.
Parental occupations were also surveyed. Most fathers of respondents fell into skilled worker, managerial, and professional categories. Most mothers were homemakers. Respondents were almost equally likely to be from rural areas, large towns and cities. Just over half the respondents indicated 'self' when asked who influenced them to enter a profession that was 95% female. No other responses were overwhelmingly selected from the choices of father, mother, other relatives, teacher, employer, counselor, spouse, friend, and other. Unfortunately, no data was collected in this study from non-occupational therapist males to determine if there are any differences between them and male occupational therapists.

Rider and Brashear (1988) also surveyed male and female occupational therapists to determine if they thought there was a need for more men in the profession. Ninety-three percent of mostly female respondents to this unpublished survey of occupational therapists in Kalamazoo, Michigan, believed the number of men in the profession was inadequate. They stated that more male occupational therapists were needed to provide male role models for clients (86%), to provide a balance between male and female views in the profession (64%), to provide activities of daily living training for male clients (57%) and to deal with physically hard-to-manage clients (42%).

Job Satisfaction of Male Occupational Therapists

It is important to determine the degree of job satisfaction of men in occupational therapy because this impacts the efficacy of the treatment they provide. Men in female dominated professions face some difficulties which may affect their job satisfaction and the satisfaction their clients experience with their treatment. Kadushin (1976) described what he labeled 'role strain' for male social workers, who are a minority in that profession also, about 33% in 1976. He stated that the impact of role strain is that the
male social worker has to be more than normally secure in his sexual self-identification to contend with occupational stereotyping without developing feelings of defensiveness and anxiety. Role strain may help to explain the low job satisfaction that has been reported in the literature for male occupational therapists.

Though no studies were found which examined female occupational therapists' satisfaction with their careers, some studies were found which determined male occupational therapists' satisfaction levels. A study done by Posthuma (1983) found that "...28 or 66% [of male respondents, both practicing occupational therapists and students] were dissatisfied with some aspect of occupational therapy as a profession" (p. 134). The reasons for male occupational therapists' dissatisfaction seem, on the surface, to be other than the fact that they are entering, or practicing in, a female dominated profession. The reasons identified were low salaries, little opportunity for advancement and lack of status. Only 3 of the 42 respondents identified the issue of entering, or having entered, a predominantly female profession as a reason for their dissatisfaction. Another, larger survey (n=199) of male occupational therapists in Canada (Brown, 1995) found similar dissatisfaction with the profession and a consequent short duration of an occupational therapy career among these men. In terms of job satisfaction, male occupational therapists indicated that they were relatively dissatisfied with their work, pay, promotional opportunities and supervision. The reasons these therapists identified for their dissatisfaction are indirectly related to the fact that occupational therapy is predominantly female. Lack of status and low salaries are highly correlated with female professions in the United States. Headlee and Elfin (1996) found that in 1992 women earned only 71% of what men earned. Women may have also had fewer opportunities to enter high status jobs such as doctor or lawyer, though this is now changing. Professions women have dominated, such as nursing
and occupational therapy, have thus typically been considered to be of lower status by society.

Another Canadian survey (Turgeon & Hay, 1994) of male occupational therapists (n=55) found males who had just entered the profession to be less satisfied than those males who had been in the profession longer. Less experienced male occupational therapists reported themselves to be less satisfied, more inclined to leave the profession or pursue another profession. Those who felt challenged and who worked in adequate physical facilities felt less isolated and more satisfied. This study described little reported gender discrimination among those surveyed. Other studies however have found feelings of gender discrimination on the part of the male therapist. Male occupational therapists think they are seen as presenting a practical problem for dressing practice with female clients (MacAskill, 1985), while it has not been reported as a problem for female therapists with male clients. Males feel they have been viewed as merely muscle power to carry out heavy work or to restrain aggressive patients (Parish, Carr, Suwinski, & Rees, 1990). They also feel discriminated against through the use of 'she' as the pronoun in occupational therapy related literature (Readman, 1992).

Men who are satisfied with their choice of occupational therapy as a career seem to utilize certain strategies to counteract the role strain which Kadushin (1976) described and to achieve goals such as higher salaries and higher status. Kadushin described the process of choosing a career as one which has two parts. A person first selects a profession and then a particular function within the profession. One strategy utilized by males in occupational therapy to avoid role strain and achieve goals, is to gravitate towards areas within occupational therapy that provide higher status and higher salaries, such as department director, or have more masculine physical requirements, such as the area of psychiatry with its potential need for the restraining of
male clients. The study by Christianson (1970) indicated that many male occupational therapists were working as directors of occupational therapy departments or in the area of psychiatry. Both of these areas of practice may allow the male therapist to experience greater satisfaction with his career choice.

Kadushin (1976) identified other similar “islands of masculinity” in other professions. Male librarians are concentrated in college and university libraries, and male nurses specialize in anesthesiology or urology. He also identified a need for female dominated professions to provide such positions which minimize role strain for men. "Any profession that enrolls a minority of men should make provisions for, and respect the functional necessity of, male enclaves" (p. 444).

Kadushin (1976) explained why status attainment in a career is generally more important for men. Occupational achievement is the principal criterion of gender related success for the male. Alternative roles with high status are not available to men in nonprofessional situations. For example, although motherhood is an alternative high status life occupation for women, full-time fatherhood does not offer the same prestige for men. Higher incomes were desired by males in female dominated professions because, at least in 1976, men typically had a greater number of dependents. Because of this discrepancy in the number of dependents, the disposable income of most male social workers was smaller than that of most female social workers, despite higher male salaries.

Taylor, Madill, and Macnab (1990) identified gender differences in the things which therapists consider most important for job satisfaction. Results showed that males thrived on risk and advancement more than females, while females thrived on social relationships more than males. These findings support those discussed above, which find men more likely to strive for and obtain administrative positions which provide them with greater satisfaction according to role strain theory.
A study by Brown (1995) also found gender differences in an employee's job expectations, career aspirations and what aspects of work he or she found rewarding. Women were most sensitive to the complexity of the job, the number of hours worked, and job income, while men were most affected by closeness of supervision, organizational structure, position in the supervisory hierarchy, and job protection factors including the pension, benefits package, and severance pay options. The things considered important to people of different genders tend to be different. This study supports the theory that people of different genders' needs are met in different ways.

Issues Involving the Gender of Health Care Workers

We have examined male and female gender differences, the feminine history of occupational therapy, the balance of feminine and masculine in the profession, the issue of more males in occupational therapy, and the job satisfaction of male occupational therapists. We will now discuss specific problems or concerns which involve the gender of the therapist or the health care worker. Issues involving male health care workers (Montegue, 1994; Parish, Carr, Suwinski, & Rees, 1990; Wagnild, 1985), and female health care workers (Adams, 1971; Leshan & Leshan, 1952) will be reviewed.

One study titled "The Relationship of Male Occupational Therapists to the Female Patient" (Montegue, 1994) examined closely the issue of the male therapist doing activities of daily living (ADL) training such as dressing, bathing, and toileting with female clients. The method used in the study was a survey of male occupational therapists and occupational therapy assistants in Texas (n=81). 95% of those responding to the study answered positively to the statement "Female OTs are not more nurturing than male OTs". This indicates that most of these males felt comfortable with, and capable of, being nurturing. While considering themselves caring, 10% of
these respondents still felt uncomfortable enough or concerned enough about the female clients' feelings to "Usually or always refer female ADLs to female OTs". A much larger percentage, 78%, felt some degree of discomfort around women disrobing and so they sometimes do activities of daily living without having the client disrobe. 44% answered positively to the statement "At least sometimes feel uncomfortable doing ADL's with females". Much of this discomfort was found to be related to the sexual implications of ADLs with females. 43% answered positively to "At least sometimes think of sexual implications".

Some specific problems were commented on by male therapists who wrote about their experiences related to the ADL issue with female clients (Montegue, 1994). One respondent identified how some female patients "gave in" to ADL training from a male therapist when they realized he was the only occupational therapist at that facility. Another respondent mentioned how a patient's father would not let the male occupational therapist treat his daughter. Another respondent said that he had to omit bathing and toileting training because there was no female therapist available to chaperone.

Despite these difficulties experienced by some of the respondents, 77% agreed with the statement "Appropriate for male OTs to do ADLs with females". Most of the respondents indicated that they were able to adapt techniques when treating female patients. It was found that different techniques and strategies were often used when teaching ADLs to female patients.

Another study done in Britain (Parish et al., 1990) found little concern among the 37 male respondents when they were questioned about treatment of female patients and ADLs. Only 8% of respondents were required to be chaperoned by a female staff member and this requirement was primarily for when the patient was putting on and taking off underwear. Only 15% of respondents had experienced refusal of treatment
by a female patient specifically due to the gender of the therapist. This was primarily experienced when dressing practice was the focus of treatment.

Two thirds felt, however, that they were shielded from certain working areas, such as female ADLs, by their supervisors (Parish et al., 1990). Many respondents wrote that they were placed in masculine environments such as a heavy workshop environment for their entire student fieldwork placement. They indicated that they felt they were singled out to carry out heavy lifting duties or to restrain a violent person, but they did not mind these requests. Some respondents also identified what they considered to be the positive aspects of being a male in a female dominated profession in that they often get "...mothered and smothered by the female members" of the staff (p.69).

One study done by Wagnold (1985) identified the need for nursing staff to convey respect during bathing procedures with residents in a long term care facility. There may be implications here for the optimal behavior of male therapists working with female clients. It was noted in this study how important it was to the resident to establish a one-to-one relationship with the staff member, to have eye contact with the staff member, and to take sufficient time to complete the bathing activity. A deficiency in these areas may lead to depersonalization, withdrawal, low morale, and anxiety in the resident.

Leshan and Leshan (1952) addressed the issue of female occupational therapists treating male clients. They described the psychosocial problems which may occur when the male client is treated by a female therapist. Dependency was the main issue addressed. The authors stated "he [the male patient] is largely dependent on women, just as he was as a little boy" (p. 208). They thought the female therapists generally did not do enough to lessen the male clients' feelings of passivity and helplessness. They recommended that the female occupational therapist reassure the male patient that she
"...is an ally in his fight against dependency and passivity" (p. 209). The authors identified "masculine" activities such as arrowhead making, refurbishing antique pistols and rifles, fly tying and others as the best means of reassuring the male patient's masculine identity.

Many of these recommendations seem blatantly sexist today. In 1952, however, the advice given may have been very helpful. It seems unlikely that there are such stark differences in occupational activities between the two genders today, and the advice given by Leshan and Leshan (1952) may or may not apply as much today.

Another article identifying an issue important to female health care workers is by Adams (1971). The main point was to urge women to assert themselves to overcome the expectation that their primary purpose is to provide tenderness and compassion. Adams stated that through the exercise of traditional feminine traits, women have set themselves up as the exclusive gender for protecting and nurturing others. She asserted that an overemphasis on these characteristics has atrophied a large part of the behavioral makeup of females in general, and limited the occupational and social roles open to them. The author identified those professions which have historically been open to women-such as secretarial work and nursing-and how little prestige and power these professions carry with them.

Adams (1971) applauded the women's liberation movement in its efforts to redefine the perceived abilities and roles of women. She identified two skills that she believed women could use to their benefit in redefining their image in society at that time as flexibility of operation and capacity for intuitive awareness of personal and social phenomena. Adams thought the first skill would help prevent doctrinaire policies coming from the women's liberation movement. She believed that the second skill would enable women to pick up subtle clues which "...can produce a diagnostic assessment of individuals or situations with more penetrating insight than more usual
processes of conscious thought can achieve" (p. 102). The skills she identified as important may serve women well and make them very suitable for careers in occupational therapy.

Summary

This literature review examined gender differences in verbal and nonverbal behaviors which are relevant to occupational therapy treatment. Significant differences between males and females were identified. The feminine and feminist history of occupational therapy was reviewed to help the reader understand the implications of more men entering the profession. Contemporary views on masculinity and femininity in occupational therapy were examined. Literature which described the phenomenon of more men entering the profession and their levels of job satisfaction was then reviewed. Finally, gender related concerns of health care workers, including occupational therapists, were described.
CHAPTER III

METHODOLOGY

Introduction

The methodology chosen for data collection in this study is a qualitative one utilizing the hermeneutic dialectic process. The hermeneutic dialectic process is described in Guba and Lincoln (1989) as follows: "It is hermeneutic because it is interpretive in character, and dialectic because it represents a comparison and contrast of divergent views with a view to achieving a higher-level synthesis of them all, in the Hegelian sense" (p. 149). Thus the main process involved in data collection and analysis is comparison and contrast of interviews of different stakeholders. A qualitative method involving multiple interviews of relatively few stakeholders was preferred over a quantitative survey involving large numbers of stakeholders because the relevant issues as they pertain to occupational therapy were not clearly established in the literature. Gender related issues in occupational therapy needed to be discovered and analyzed.

The goal of this exploratory research was to establish grounded theory which other researchers could use to develop more refined qualitative and quantitative data gathering methods in the future. Grounded theory is the goal of research when there is no existing theory to explain the issue being studied. Strauss and Corbin (1990) stated that "A grounded theory is one that is inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon" (p. 23). Data collection, analysis, and theory stand in reciprocal
relationship with each other. One does not begin with a theory, then prove it. Rather, one begins with a topic of study and what is relevant to that topic is then allowed to emerge.

Two groups of stakeholders were identified from whom rich data could be collected, occupational therapy supervisors who have supervised both male and female occupational therapists and occupational therapy clients who have been treated by both a female and a male occupational therapist. The hermeneutic dialectic process of data gathering was well suited to this plan because the major purpose of this process is not to justify one's own construction or to attack the weaknesses of the construction offered by others, but to form a connection between all stakeholders' viewpoints that allows mutual exploration by all parties.

The main concern of the study was to understand the opinions and feelings of occupational therapy clients towards their male and female occupational therapists. Supervisors, however, were interviewed first, using a semi-structured interview format, to learn of the most important issues surrounding this topic-(Phase I). Once these issues were established, the goal was then to use a more structured interview on the primary stakeholders for this study, the occupational therapy clients-(Phase II). Four treatment sessions were also observed during Phase II (male occupational therapist/male client; male occupational therapist/female client; female occupational therapist/female client; and female occupational therapist/male client) to see if issues raised in interviews could be observed. The occupational therapists observed were not interviewed because this study was interested in the clients' perceptions of differences and similarities in the therapists, not the occupational therapists' views on similarities and differences. Data analysis occurred primarily at the end of the data collection process-(Phase III).
After Western Michigan University Human Subjects Institutional Review Board (HSIRB) approval was granted and informed consent forms signed, initial interviews were conducted with five supervisors: two males and three females. A semi-structured format was used. The researcher asked the supervisors to discuss their views on the differences and similarities of male and female occupational therapists. When the supervisor said everything he or she wanted, the researcher asked questions that referred to issues raised in the literature on gender differences to see if these applied to male and female occupational therapists. Each interview was completed in less than one and a half hours. The information gathered from those agreeing to be audio taped, (four of the five supervisors), was transcribed and the data was coded into 11 categories. The 11 categories were established based on the frequency of mention by the supervisor stakeholders and the importance they placed on these topics. The 11 categories established were: (1) gender differences in therapists' performance outside of treatment; (2) gender differences in therapists' amount of smiling, animation, and talk; (3) perceived gender differences in therapists' caring; (4) perceived gender differences in therapists' competence; (5) perceived gender differences in therapists' authority; (6) gender differences in therapists' methods of motivating clients; (7) gender differences in therapists' amount of permission asked and treatment explained; (8) gender differences in therapists' collaboration with client; (9) gender differences in therapists' treatment approaches; (10) clients' desire to change therapist; and (11) same gender/opposite gender treatment dyads. The data coded for the categories ranged from single sentences to entire paragraphs of dialogue. Data was put on 5x8 index cards and numbered with interviewee code and one of the 11 category numbers. Those who had
not spoken to all 11 categories were later interviewed a second time to allow them to speak to the remaining categories and to respond to others' comments.

During this phase, consideration was given to the trustworthiness of the data collected. Trustworthiness techniques used to establish rigor for the qualitative research as described by Guba and Lincoln (1989) were member checks, prolonged engagement, persistent observation, peer debriefing, negative case analysis, and progressive subjectivity. Also, researcher effects were monitored.

Soon after the interviews, supervisors were given copies of the transcripts and contacted over the phone as a method of member checks to see if the stakeholder wished to amend or add to her or his responses. Initial and subsequent interviews were conducted over a period of four to six months with the supervisors. Prolonged engagement was achieved by this length of contact. Persistent observation was achieved through observation of four treatment sessions involving same and opposite gender treatment dyads. Data collected from these observations added meaning and depth to the data collected through the interviews.

Another trustworthiness technique recommended by Guba and Lincoln (1989) is peer debriefing. This was achieved by the student researcher contacting his faculty readers at frequent stages in the data gathering process. Two females and one male were involved as faculty readers. They provided valuable insight and direction to the student researcher. They met the criteria of being debriefers by being "...disinterested parties with knowledge of the methodology and an understanding of the research question" (Meyers, 1995, p. 108).

Negative case analysis was also used by the student researcher to question the prevailing opinions on the 11 categories. Respondents were told of differing opinions either from other supervisors or from the literature and asked their thoughts on the matter. Supervisor biases, whether they were gender based or setting based, were
considered. Progressive subjectivity was achieved as the student researcher became immersed in the topic. His opinions and preconceptions began to be altered as he learned the finer points of the issues.

Researcher effects were monitored to maintain trustworthiness. The researcher was aware of researcher effects and attempted to interview and code in an unbiased way. Leading questions were avoided and follow up questions were used to clarify misunderstandings of the researcher.

During second and subsequent interviews of the supervisors, they were asked to clarify issues unclear to the researcher and to respond to differing views of other supervisors if such views existed. This was a good way to establish the connection recommended by the hermeneutic dialectic process. After all initial supervisor interviews were completed, the data were re-analyzed and a semi-structured interview form was created for client interviews which would begin Phase II of the study.

Phase II—Data Gathering: Occupational Therapy Client Interviews and Treatment Session Observations

After site approval was received from a long term care facility administrator, occupational therapists were contacted to see: (a) if they were interested in participating (i.e., willing to be observed during a treatment session of one client of the same gender and one client of the opposite gender); and (b) if they knew of any clients who would be interested and capable of participating in this study. Qualified clients were those who had been treated by both male and female occupational therapists, were between the ages of 18 and 90, and were able to communicate verbally. If the occupational therapist knew of any qualified residents of that facility and the resident was interested in participating (i.e., agree to be interviewed at least once and/or agree to be observed once during an occupational therapy treatment session), that occupational therapist
would pass their name and phone number along to the student researcher so he could contact them and obtain informed consent. This procedure insured the clients' confidentiality if they did not wish to participate.

One male occupational therapist and one female occupational therapist were asked to participate in the study and both agreed to do so. After informed consent was received from the therapists, they relayed names and phone numbers of interested clients to the student researcher. Informed consent was obtained from the occupational therapy clients. Appointments were made with the occupational therapist and the client to observe one of their occupational therapy sessions. The interviews of the clients were conducted privately between the researcher and client only. The clients interviewed were not necessarily the same ones that were observed. It was determined that this was not necessary for gathering the desired data.

The client interviews were more structured than the supervisor interviews. The 11 categories of concern were already established, however, the clients were encouraged at the beginning of the interviews to speak to whatever aspect of the topic they wished. The researcher was prepared with specific questions to ask concerning the 11 categories for the interview session. The unstructured nature of the beginning of the interview allowed the clients to raise issues which may not have been noticed by, or important to, the supervisors. Clients were asked their definition of some terms during the interviews. This increased the likelihood that both groups of stakeholders were talking about the same issues. For example, was the clients' understanding of the term 'caring' the same as that of the supervisors? After the client interviews, the audio tapes were transcribed and data coded much like the data received from the occupational therapy supervisors.

The observation of the occupational therapy treatment sessions allowed the student researcher to identify circumstances that were brought up in the supervisor and
client interviews. For example, some supervisors stated that male therapists are less likely to smile than female therapists. Also, one supervisor felt that male therapists tend to use more physically demanding modalities with clients than female occupational therapists. Some clients interviewed felt that females demonstrated more caring. Amount of smiling, treatment methods employed, and displays of caring were some of the things observed during these treatment sessions. As suggested by Bailey (1991), the number of times these behaviors occurred was noted. The researcher observed and took field notes to substantiate or refute observations made by the supervisors and clients. Field notes from the observations and coded data from interviews were analyzed and discussed with faculty readers. A convenient sample of previously interviewed supervisors were interviewed one last time after all client interviews and observations were completed to get their reactions and viewpoints on the data collected from these stakeholders.

Phase III—Data Analysis

Methods of data analysis, identified by Miles and Huberman (1984), to generate meaning and confirm findings were utilized. Noting patterns and themes was the first process undertaken. Agreement and disagreement between stakeholders and groups of stakeholders was noted.

Relationships between variables were noted. The researcher attempted to understand the issues well enough to determine if the relationship of factors was causal or simply correlational. Further literature review was undertaken in areas that had not been sufficiently explored prior to the data collection but had been identified by stakeholders as important. Contrasts and comparisons were made with the data and the meaning of outlying or contradictory data was investigated through literature review and peer debriefing. Rival explanations were considered at all stages of data gathering.
This was done to a great extent at the end of data collection. Negative evidence was looked for in those cases where all stakeholders seemed to agree on an issue. All interviews and field notes were coded and documented so that an audit trail was established.

Limitations

The main limitation of this study is its generalizability. Only a few supervisors were interviewed and most of these had supervised only in long term care facilities with the elderly. The clients interviewed were from only one long term care facility in southwest Michigan. The results thus may not be generalizable to other populations of clients, other regions, or other generations of elderly clients. These clients grew up in the early 1900's when men and womens' roles were quite different from what is expected of each gender today. Though generalizability may be limited, the results of this study may provide valuable insight into the experiences of other populations of occupational therapy clients.

Another limitation is the possibility the supervisors and clients may have been reluctant to discuss how they really felt about occupational therapists they supervised or those who treated them. They may have felt that negative comments about one gender or the other might have negative effects on their relationship with the occupational therapists they work with or who treat them. Also, one supervisor made the comment that she just "...hated to make generalizations based on gender." In our politically correct world, it has become somewhat taboo to set people apart for any reason other than their personality. The supervisors and the clients may not have wanted to appear 'sexist' in any way.
Another issue to consider when identifying limitations is that the student researcher, (the one who conducted the interviews), is male. The stakeholders may have adjusted their comments in order not to offend this researcher.

Summary

The methodology used in this study was qualitative use of interviews and observations of nine stakeholders. The stakeholders interviewed were four occupational therapy supervisors who had supervised both male and female occupational therapists and five occupational therapy clients who had been treated by both male and female occupational therapists. Supervisors were interviewed initially to gain an understanding of the topic. Clients were interviewed subsequently to understand the experiences they have had with male and female occupational therapists. Supervisor stakeholders were interviewed one last time to gain insight into their reactions to data gathered from clients. Data collected from all interviews was coded and analyzed. Observations were made during occupational therapy sessions of same gender and opposite gender treatment dyads of the therapists and some of the clients interviewed. Data collected from these observations was also analyzed.
CHAPTER IV
RESULTS

Introduction

Data collected from the four supervisor stakeholders and five client stakeholders on gender differences in occupational therapy treatment will be examined in this results section. Data was collected from supervisor stakeholders first because they were considered more expert at recognizing issues involving gender and the therapists they supervised. Having collected initial data from supervisors, clients were interviewed next to see if the issues considered important to the supervisors were also considered important to the clients. Eleven categories of data were established, based on the frequency of mention by the stakeholders and the importance they placed on these topics. Supervisor comments and client comments will be discussed in a complementary fashion.

Data from the first category, gender differences in performance outside of treatment, was only collected from supervisor stakeholders because clients did not have a basis on which to discuss this issue. Clients do not have contact with therapists outside of the treatment session and are not qualified to give information on how their therapist got along with coworkers, how well they documented the treatment, or how much they requested treatment resources from the facility. The other 10 categories were discussed by both groups of stakeholders. These categories were: (1) gender differences in amount of animation, smiling, and talk; (2) perceived gender differences in therapists' caring; (3) perceived gender differences in therapists' competence; (4) perceived gender differences in therapists' authority; (5) gender differences in
therapists' methods of motivating; (6) gender differences in amount of permission asked and treatment explained; (7) gender differences in therapists' collaboration with client; (8) gender differences in therapists' treatment approaches; (9) clients' desire to change therapists; and (10) same gender/opposite gender treatment dyads. These categories were considered relevant to the research question which seeks to understand occupational therapy treatment differences based on the gender of the therapist. In addition to discussing data collected from stakeholders' interviews, data which was recorded during researcher observations of selected treatment sessions will be discussed.

Table 1 provides the reader with an initial overview of the nine categories which involve potential gender differences in therapists which may affect treatment. The two categories of: (1) client's desire to change therapist, and (2) same gender/opposite gender treatment dyads were not include in this table. The table identifies whether all, some, or none of the supervisor and client stakeholders found there to be gender differences in these nine characteristics.

Performance Outside of Treatment

Supervisors identified gender differences in occupational therapists' performance outside of treatment. These differences may have an impact on the quality of treatment which is given. Differences between male and female therapists in number of requests for facility resources such as space and equipment, differences in documentation styles, differences in getting along with coworkers, and staff adjustments necessary when a male joined the previously all female rehabilitation department were discussed.
One supervisor with experience in a contract company believed that men are more likely to make demands in terms of space and equipment and, in her experience, "they were much less likely to just say that they would 'just make do' and [were more

Table 1

Stakeholders' Perceptions of Gender Differences in Therapists

<table>
<thead>
<tr>
<th>Category</th>
<th>Supervisor Stakeholders</th>
<th>Client Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
<td>Some</td>
</tr>
<tr>
<td>1) Performance</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Outside of Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Amount of Smiling, Animation, and Talk</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3) Perceived Caring</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>4) Perceived Competence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) Perceived Authority</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>6) Methods of Motivating</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>7) Amount of Permission Asked and Treatment Explained</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>8) Collaboration With Client</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>9) Treatment Approaches</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
likely to sort of push for their rights about what they felt they needed for their clients."
A more aggressive style by men is what is expected based on Maltz and Borker's (1982) findings that men tend to challenge or dispute their conversational partner's discourse more than women. This supervisor thought that these behaviors were successful in getting the clients of these therapists what they needed in terms of equipment. She believed a confrontational position was necessary in this setting because it involved a contract agency which wants to maximize profits and save money. This supervisor thought females were, in general, more adaptable to environmental constraints and less willing to be confrontational.

Documentation style, especially conciseness of documentation, is something which may impact the ability of a therapist to take over for a therapist who is sick or busy. Some supervisors identified gender differences in the conciseness of documentation. One supervisor indicated that the two males she had supervised were more concise in their documentation, one to the point of leaving things out. She also believed the males were much more likely to complain about duplication of paperwork. On the other hand, another supervisor who had experience supervising a greater number of males did not echo this observation that males are more concise in documentation and did not recall them complaining about duplication of paperwork.

As for getting along with coworkers, some of the supervisors found gender differences. This is another aspect of a work environment which can impact client care and client satisfaction. One supervisor recalled a male therapist who didn't get along well with coworkers but she indicated this was less due to his gender than his personality, stating "This person was not a good therapist and not a good team player". This supervisor did remark that males were "...less likely to become involved in that narrative piece of clinical reasoning following treatment sessions". She thought the narrative discussion which takes place between therapists is essential in team treatment
because it can reveal to therapists things they had not known about their client. Another supervisor also noticed an ability in females to be more accommodating in a team setting. The one male supervisor interviewed did not notice a gender difference in therapists' rapport but noticed less support between coworkers in disciplines other than occupational therapy. He thought the "OT [staff] work well with each other in a much more fluid way" than others such as physical therapists. He indicated that occupational therapists were generally willing to be flexible and make adjustments if another therapist needed assistance. One supervisor believed there were no gender differences in the therapists' ability to get along with coworkers. She provided the reasoning that "the men in health care are very well aware and prepared for their situation as far as being in a minority".

Because of the dearth of male occupational therapists, the entry of a male therapist into a rehabilitation department may require adjustments by the female staff. One supervisor mentioned a humorous situation in which an adjustment needed to be made when a male therapist joined a previously all female rehabilitation unit. "We had a coordinator-of-the-day position among the staff and, of course, we called it, ... queen for the day. He [the new male therapist] wasn't too keen on that so ... and so we just had to adjust what we called things". She also stated that the diversity of more minorities, including men, on staff can be beneficial in increasing the staff's sensitivity to minority clients.

Gender Differences in Amount of Animation, Smiling and Talk

The literature identified significant gender differences in animation, smiling, and amount of talk. These behaviors are considered very important to the treatment provided by occupational therapists. Expression of these behaviors leads one to believe someone is friendly and trustworthy. These are traits necessary for a healthy
therapeutic relationship. Some of the supervisor and client stakeholders identified
gender differences in therapists' animation, smiling, and amount of talk. The
supervisors differed significantly in their opinions of which gender does more of these
behaviors, however. Some of the clients noticed a gender difference while others did not.

One female supervisor said she noticed a great deal of difference between the
degree to which male and female therapists exhibit these behaviors. She said she
noticed a difference especially when therapists greeted patients at the beginning of the
treatment session. "Women are more likely to do a stronger facial expression greeting
when the client shows up".

The male supervisor thought that the male occupational therapists he supervised
were more animated than the females he supervised. He attributed this to the concern
he believed female therapists have about being in control and appearing competent. He
also thought males have more latitude in their behavior because the elderly population
of clients view him as someone similar to a doctor. He described the difference as
follows:

I think that piece about not wanting to be perceived as a professional
failure is what I've seen in some women. God forbid they should crack
a smile or appear to be less than competent at any moment. Whereas a
male I think is willing to take that risk. So even if you think I'm an ass,
I can go down the hall and have three other people think I'm a doctor. I
just put a white coat on.

As a result, he believed male therapists also tend to be more complimentary, use more
humor, and talk more outside of the technical aspects of what is going on. His
observation of men being more animated, which contradicts the literature findings, may
be explained by the special environment in which therapists work or by the special
nature of male therapists themselves.
The supervisor who noticed women smiling more during greetings was told of this male supervisor's comments. She indicated that she could recall many female therapists who were playful and lighthearted with their clients, but she did agree with the male supervisor that, in the geriatric setting, males tend to be more playful and joking. However, she believed these behaviors occurred more equally between male and female therapists in other settings where there are younger clients.

The male therapist may be constrained against being too animated, however, because the expectation is that he is somehow like a doctor and is not supposed to act animated or frivolous. Another female supervisor disagreed with the assertion that male therapists are more easygoing with geriatric clients. She believed the impression the male therapist often gives, however unconsciously, that he is more like a doctor than the female therapists, affects how he treats the clients. Because he looks like a doctor she said he is "...gonna kinda go into that role and be that more serious directive, task-oriented person and kind of more serious about that". She also described how male therapists in geriatric settings are working in an area that has a predominantly female clientele. The male therapists may not be sure of how to address some of the concerns of this population and may thus not have as much rapport with the clients. She remembered many times when she had noticed a male therapist being professional and dealing with business rather than being easygoing. She said,

I think most of the females are having more fun enjoying the client, easygoing, dealing with whatever these issues are with the client, and that either the males aren't sure what they're gonna work on with them or how to address those concerns, or don't feel comfortable with the clientele, the age range or approaching them.

Another supervisor who had supervised only one male in an acute care setting agreed that he may not have been as willing to address older women's issues. However, she did find him to be as animated as the female therapists and to talk as much as the rest of the rehabilitation staff with clients. She attributed his high level of
social skills to his theatrical background and described him as a people person. She noted that he was fairly formal with clients but attributed this to his cultural upbringing in the South and not to his gender.

The client stakeholders related how important these behaviors were to their care. When questioned specifically about how much of these behaviors they noticed in each gender, some mentioned a gender difference in smiling, animation, and amount of talk while others did not. One male client stated that he found female therapists to "gripe" more and be less easy to get along with than male therapists. One female client noted that male therapists may not smile as much but she felt the females were using "pasted on smiles" and these smiles were not meaningful to her. Another male client felt that both the male and female therapists who had treated him were friendly but that the female therapist had told him "...a lot of stories about her family." He liked it when she shared these stories with him and he wished the male therapist had done the same.

Other clients did not notice a gender difference in these behaviors but stressed the importance of these behaviors to their treatment. One client noted that both therapists had been pretty good and had "...a smile and a little joke. This makes it easier, you know." Another client also asserted that these smiling and animation behaviors were important to her. She did not notice a gender difference but did notice a difference in the amount of smiling between the acute care setting she had recently come from and the long term care facility she was in at the time of the interview. She noted that the hospital rehabilitation staff had been less personable than the nursing home rehabilitation staff. She stated "I think if they had smiled more and been a little more personable, you know, that heals the soul."

During observations of therapists and clients during four treatment sessions, notes were made on the amount of smiling, animation, and conversation in the interaction. An attempt was made to minimize observer effect by having the observer
watch from as great a distance as possible and having the observer not interact with the therapist or client. The female therapist was very animated with her female client. She smiled frequently, laughed, and engaged in some light conversation. She also discussed with the client the reasons for what the client was doing and reminded her of the percent of repetitions of the exercise she had completed. The female client responded by being very relaxed, smiling a little, and following directions well. With the male client, the female therapist was less animated. This was possibly because of the more serious nature of his condition. She was determining if he could empty his leg bag. Whether he could do this or not would determine what facility he could reside in after the nursing home. She used her hands to explain things to the male client. Most of her conversation involved questions to him about his leg bag. He also smiled, was relaxed, and seemed to understand what the therapist was saying. He didn't always agree, however, with the therapist's view of the situation with his leg bag.

The male therapist was also quite animated with his female client. He smiled often and engaged in a lot of easy going, personable conversation interspersed with occupational therapy related discussions. He joked with the female client by giving her little jibes. The client responded by jokingly giving him a hard time and sometimes challenging him but she also seemed very relaxed and followed directions. With the male client, who was diagnosed with dementia, the male therapist was less animated and didn't smile much though he was personable and relaxed. The male client did not smile but seemed relaxed. He seemed a bit disoriented and sometimes had his own idea of how to do things.

Supervisors and clients appeared to agree on the importance of animation, smiling, and the amount of talk. The observations of the treatment sessions indicated that displays of these behaviors will depend as much on the client and their diagnosis as on the therapist's gender.
The supervisor and client stakeholders discussed gender differences in therapists' caring as perceived by the client. It is clear that caring can mean different things to different people. In this study, stakeholders identified a caring attitude as that which results in positive behaviors. Caring is one of the first attributes identified as necessary by current health care workers who talk to those interested in entering a therapy career. They realize the importance of this attribute for successful treatment. Most of the supervisor stakeholders believed that female occupational therapists would be perceived as more caring than male occupational therapists, especially by older female clients. Most of them also indicated however that both the males and females who go into occupational therapy as a career, tend to be more caring than the general population. The male clients asserted that female therapists were more caring. One female client believed males were more caring while the other female clients thought male and female therapists were equally caring.

One supervisor made a comment which was echoed by the other female supervisors. She stated that elderly clients probably feel more at ease with female therapists and sense more caring from them because female therapists attend "...to some of the emotional needs and psychological needs that they are able to sense." She gave an example of a caring behavior a female therapist would be more likely to exhibit than would a male therapist.

When an older adult comes to the clinic and is very upset over something that just happened with nursing, a female therapist may take the time to find out what happened. Such as, 'What do you need right now?'; 'Do you want to do this in a half hour?'; or 'Do you need some time?'

The other female supervisors mentioned that female therapists were probably better at empathizing with and addressing some of the older women's issues. The acute
care supervisor said she thought the male therapist she supervised wasn't sensitive when dealing with dependent women or "whiners". She believed it was harder for him than for females to "...acknowledge where some of those behaviors were coming from. He saw it as a nuisance and didn't want to deal with that personality." She believed females were more empathetic towards older women; and the difficulty males have empathizing with older females may reduce male therapists' desire to work with them.

The male supervisor was less willing to say that women therapists are perceived as more caring. He stated that caring transcends gender. He has seen caring men and uncaring women in health care occupations. He did agree that female therapists are probably better at dealing with older women's issues, however. He believed that males probably use humor and animation to provide a screen from the emotions of older females and to prevent the client from becoming emotional. On the other hand, he indicated that men entering the profession today are more aware of what they are getting into as far as the necessity to acknowledge others' emotions and the emotional expression required of them. He indicated that it is much more acceptable now for males to display caring than it used to be. He stated that in the past, men were constrained against appearing too caring, "People would look at you, like if you're compassionate and caring, are you effeminate in other ways?" He believed that things have changed, "I think it's becoming more acceptable with the Mr. Mom type of guy that it's much less of a joke now and more a reality." He also noted how important caring is to clients and how well they can perceive this quality in a therapist.

Because it is perceived as a positive quality, therapists may try to exude caring to the point of it no longer benefiting their clients or themselves. They may try too hard to please. Some of the female supervisors noted how female therapists tend to get trapped into being a listening ear more than male therapists and may thus be viewed as more caring. One believed female therapists may not assertively set limits, such as time
limits, with clients and "...may be more likely to ask questions that are going to take a while to answer and the men are less likely to ask those kinds of questions. We trap ourselves."

Another supervisor believed these behaviors of female therapists were consciously chosen by females and formed from habit and training and how "It is good to have that interaction." She felt that male therapists should do more of this kind of interaction.

As for responses from clients on the category of perceived caring, they all identified this characteristic as very important in a therapist. One male client indicated that, to him, a caring therapist would be prompt so he "...wouldn't have to sit waiting patiently for them to take care of me." Another client stated that a sign of caring was that the therapist would smile and ask how the client was and not hurry to turn off the call signal. Another client emphasized the importance of caring and "tough love". "Not that they let you get away with anything, but they care about you as a person." The clients also seemed acutely aware of the difference between fake caring and genuine caring.

The male clients both indicated that women therapists were more caring while the females generally indicated that both genders were equally caring. The males seemed to accept the stereotypic view that women are more caring. One male client stated that females "seem to care more" while the other male indicated that females are more caring because "that's their nature". Only one female indicated a gender preference as far as caring is concerned. She preferred male therapists because "It's just the atmosphere that when the men come in, you feel they're going to do a good job and get to the point and not hurry, or at least not give the impression of hurrying." The others females believed female and male therapists cared equally for them. One stated "I think they both liked me. They cared, you know, how I was coming along." The
differences in the ways the clients defined caring may explain why they had different opinions as to which gender was more caring.

During observations of the participating therapists and clients, it was noted how many compliments the therapists made, as an indication of caring. The general atmosphere of all the treatment sessions was one where the therapists both seemed to care about their clients. The female therapist seemed to do less complimenting of the clients than the male therapist, however. She complimented her female client once and her male client once by telling him that he did a good job emptying his leg bag. The male therapist complimented the female client a couple times by telling her that she did one set of exercises well and that her coordination was getting better. He complimented his male client by telling him that he was pretty flexible, had nice shoes, and that he was doing great getting his prosthesis on. Displays of caring, however, will depend not only on the individuals involved but also on the opportunities that present themselves for expression of caring.

Perceived Gender Differences in Competence

Competence is something which enables the therapist to treat effectively. Gender differences in the competence of the occupational therapist, as perceived by the clients, were discussed by all of the stakeholders. All of the supervisors stated that clients in a geriatric setting would perceive the male therapist to be more competent than the female therapist, especially outside of the activities of daily living or self-care domains. Clients generally did not know how to judge competency and did not indicate that one gender was more competent.

Supervisors were asked not who they thought was most competent but, rather, who they believed clients would identify as most competent. Client confidence in the therapist will be influenced by how competent the client views him or her to be, and
may affect client treatment compliance and outcomes. One supervisor said that she believed both male and female clients view the male therapist as being more competent. She explained the reason for this was maybe that the male therapist uses a more directive approach to treatment instead of collaborating with the client and that, to the clients, this directive approach may suggest knowledge. Another supervisor indicated that males may initially be viewed as more competent because "It's assumed that any man in a white lab coat is a physician." She said she did not think this perception of the male being more competent than the female lasted once the clients figured out what his role was and that he was not a doctor.

Having been raised in a different era, the geriatric population holds views which differ from those of people born in more recent decades. One supervisor indicated that differences in the perception of female and male competence do exist in the geriatric population. She explained the reason for this being the differing roles this generation of people expects of men and women. She explained that expectations are "...different because if the client sees that person [the therapist] more as a doctor that's a very different setup than me being seen as her daughter or her neighbor."

A male therapist may have a difficult time dispelling the geriatric client's belief that he is a doctor and the corresponding inflated expectations they have of him. The male supervisor indicated that even after clarifying to the geriatric client that the male therapist was not a doctor, the client would still perceive the male therapist to be more competent than female therapists. He said they might respond to the male therapist's efforts to clarify his position by saying "'Well you're as good as a doctor', or 'You went to school, didn't you?'" The supervisor spoke of an example of clients perceiving male therapists to be more competent.

If I were accompanying a female therapist on an observation of the patient treatment, and I was physically taking a back seat, I mean I was positioning myself so I was off line, I was not even a primary person
interacting with that patient, the patient could be observed to be deferring to me.

Despite the supervisors' beliefs that the clients would identify the male as more competent, most of the client stakeholders indicated that they felt the male and female therapists were equally competent. The reason for this contradiction may be that clients are not well qualified to judge competence and may confuse caring, conversation, smiling, or being proactive with competence. One female client stated that she did not notice the therapists' competence but that they were "Johnny on the spot, doing what they have to do." Another client also mentioned that she wouldn't know how to judge competence. She said she used the atmosphere that they carry with them rather than assessing their specific skills, to judge the therapist's competence.

Educational background does not seem to matter to most clients in their assessment of competence unless the client graduated from college or achieved a higher degree. One client believed both genders were equally competent and the fact that one, the female therapist, had a master's degree, didn't matter to her. Another client stated that having a master's degree was important to her. She said she had graduated from a good college many years ago and that to her "It means quite a bit to have advanced, good training in your field."

One of the male clients indicated that both his male and female therapists had been competent. He said he became aware of, or judged their competency based on the conversations he had with them. He was aware that his female therapist had a master's degree and was the supervisor of his male therapist but this did not seem to affect his opinion of the male's versus the female's competency. He did state that he felt uncomfortable when his therapist and the therapist's supervisor disagreed on his treatment plan. The other male client indicated a preference for the male therapist and that he judged his competency based on the way the therapists handled him.
Perceived Gender Differences in Authority

Another category which was commented upon by both supervisor and client stakeholders was gender differences in the authority of the therapists as perceived by the clients. A certain amount of authority enables therapists to make requests of clients during treatment and to achieve client compliance. Most of the supervisors indicated that, similar to males being perceived as more competent, male therapists are also perceived to have higher authority than females. Most of the clients, however, did not notice a difference in the authority of the male versus the female therapist.

Males may not have to work as hard as female therapists to gain client respect that accompanies perceived authority. This respect may enable male therapists to get more compliance and effort from clients. One female supervisor stated that clients in a geriatric setting perceive males to be in authority without the male therapists having to prove themselves. She believed the geriatric clients probably respected the male therapists who tended to tell them what to do rather than female therapists who she felt work more collaboratively with clients. Another supervisor stated that a male therapist she supervised often worked with male patients because he could "push them" a little more than the female staff could. She believed he was perceived to be in a more authoritative role than the female therapist.

Authority of both male and female therapists may be assumed by clients, especially geriatric clients, who have learned that staff members control most aspects of their life in a nursing home. One supervisor did not notice a difference in perceived authority between male and female therapists. She believed, however, that both male and female therapists were in positions of authority over the client. She stated "I think there’s always a hierarchy because we come in with our agenda to a patient’s room, which has its pluses and minuses."
One client stakeholder stated the same opinion. Client: “They were over me.”
Interviewer: “So you looked up to them?” Client: “Oh yes. They were the experts.”

Most of the other clients stated that they did not perceive a gender difference in authority of the therapists. One remarked that the male and female worked side by side and complemented one another. One male client, however, recognized the female therapist to have more authority because of her position as a supervisor and because she had a master's degree and the male therapist had a bachelor's degree.

Gender Differences in Therapists’ Methods of Motivating

Gender differences in the therapists' methods of motivating clients to participate in their treatment was discussed by all stakeholders. Motivation is a necessary component of occupational therapy treatment. If the client does not have enough internal motivation, the therapist may need to encourage the client to participate in treatment. The supervisors indicated that there were significant differences in the ways therapists of each gender motivated their clients, while the clients did not mention any significant differences.

Greater perceived authority may make the male therapist's job of motivating clients easier. One female supervisor believed that the two male therapists she supervised used a lot of humor, fun, and jest with the patients. She said that they generally got the patient involved but she was concerned that the male therapists may not have been concerned enough about having the client meet his or her therapeutic goals. She also believed that a female therapist may have a harder time motivating a client. She said the female therapist is more likely to provide options or to consider the patient's emotional state or feelings at the time.

Another female supervisor agreed that a male therapist may have an easier time motivating both female and male clients. The client's perception of the differences in
power or authority of the male therapist versus the female therapist may have an impact. If the client senses the male to be more authoritative, the client may feel more pressured to comply with his requests. Also, she stated that the way the therapist asks the patient to do something will have an impact. She said,

Maybe me or another female therapist approach it more like kind of asking or begging to do something versus just saying you're gonna do it. Some of these things are very personal styles and I hate to put them on male and female from our end. But I think from the client's perspective it is, it ends up being male and female.

The male supervisor who was interviewed also thought there were differences in the techniques male and female therapists use to motivate clients. He believed the male therapists used "...humor, their own energy, their willingness to jump right in there," while the female therapists motivate "...through instruction, through repetition, through refocusing on the task, redefining a goal." He also found that male therapists probably have an easier time motivating elderly clients to participate in an evaluation or treatment. He stated the following example of this point:

If a female goes in at quarter until five in the afternoon to initiate an evaluation that she just got an order on, I think that the patient, the resident, particularly in this population, could blow that person off more easily. If I go in or if another male therapist goes in, I think that it tended to be, and I'm speaking from past experience, there tended to be more of a willingness to comply on the part of the patient, whether the patient was male or female.

Clients are probably not aware of the subtle, nor even the not so subtle, ways their therapists get them to participate in their treatment. Possibly because of this the client stakeholders did not report any differences in the ways their male and female occupational therapists motivated them during their treatments. One client was aware of the verbal directions the therapists used to direct her. "They just said 'okay, we're gonna do this now'." Another said she had not noticed any differences. One of the male clients reported that his therapists both motivated him by example. The other male client stated that his therapists motivated him by asking him to do certain things.
Clients seemed to feel that they had to comply with treatment requirements because of the staff's authority or the client's own desire to get better. They did not view the therapists efforts at motivating them to be necessary. One female client seemed to perceive that she had to follow the therapist's instructions and was motivated by this requirement. She was told by the therapist, "Just do this and move forward and put your foot on my foot."

During the treatment sessions, observations were made of how the therapist motivated the clients to participate in the treatment. The female therapist told the female client the number of sets remaining of a repetitive exercise and the percentage of repetitions she had completed to keep her motivated. With her male client she used statements such as: "Let's have you do this", and questions such as "Can you do this?", "Should we do that?", and "Do you want to stand up?" to get the client to begin an activity. The male therapist used statements and questions such as "Let's go through these exercises today", "At least five, okay?", "Come up to about here", and "Should we review bed exercises?" to motivate his female client to participate. With his male client, the male therapist would use prompts such as "You show me what you need to do", "Do you want to roll this up or no?", and "Why don't you bring this around the inside?". No significant gender differences were noticed during the treatment session observations.

Gender Differences in Permission Requests and Treatment Explanation

The supervisor and client stakeholders also discussed gender differences in the amount of permission asked by the therapists and the way treatment was explained. Asking permission of clients to touch them, for example, is one way of empowering them. One major goal of occupational therapy is to give control of their lives back to the clients to improve their quality of life. Also, treatment needs to be explained to
clients so they can fully understand it and participate in it. The supervisors noted the importance of these behaviors on the part of therapists and some did notice a gender difference. The clients did not report noticing a gender difference in these behaviors.

Asking permission and explaining treatment is a way of conveying respect to a client. In a geriatric setting especially, the client needs to be encouraged to be an equal partner in the therapeutic process and these behaviors encourage this. One of the supervisors reported male and female therapists being “...equally good and equally poor” at asking permission and explaining treatment to clients. She did not notice any significant difference in these behaviors along gender lines. The male supervisor noted the importance of asking permission and explaining treatment not only during the first treatment session but also during subsequent sessions. He said:

I think initially during the evaluation process things are explained to patients but I think we tend to fall short thereafter and an assumption is made that once this relationship, this therapeutic relationship, is established that we have kind of this privilege.

He did not identify any gender difference in these behaviors, however.

Female therapists, if they exhibit more caring behaviors as was reported by some stakeholders, may also ask permission more and explain treatment more. One female supervisor thought that female therapists probably took more time with clients and this probably included asking permission and explaining treatment. She thought female therapists do

...a lot more of that kind of sharing, of allowing the patient to share with you their feelings of approaches on something, how they feel about it, and the therapist kind of trying to work with that versus just trying to go into a treatment session, tell them what you're going to do, and then see if you can get them to do it or not.

Another female supervisor noted how female therapists may be more patient when explaining treatment, especially to a cognitively impaired individual. She stated,

In terms of cognitive deficits, it has been my experience that female occupational therapists have structured their interactions according to a
certain cognitive level modifying their sentences and modifying their instructions; whereas, one situation comes to mind where a male therapist became just really impatient in the case of a cognitively involved client with the communication, understanding, comprehension piece.

Gender differences in these behaviors were not reported in the acute care setting. The supervisor in this setting stated that she didn't think there was a significant gender difference in these behaviors. She did state however that "I'm sure that he [a male therapist] needed to ask more permission when it came to bathing issues and that sort of thing than women did."

The clients indicated that they were more satisfied when the therapist explained treatment, though none of them identified any gender differences. One client explained the verbal cues she had received from her therapists, "They told you what they were gonna do, you know. We're gonna get up now and we're gonna do this now, you know." One of the male clients indicated that he liked it when his therapist explained the treatment to him.

During treatment sessions, the therapists were not seen asking permission to touch the client but, both of the therapists were good at giving thorough explanations of treatment. The female therapist explained to her female client that they were going to work on wheelchair to bed transfers and that they were going to do 10 repetitions of five exercises. She also explained to the female client the purpose of a sock aid. With her male client, she explained thoroughly what he needed to do with his leg bag. The male therapist explained every element of the treatment session to the female client. He explained about energy conservation techniques, the reasons behind the manual muscle testing he did, and the optimal angle to lift something during a repetitive exercise. With his male client he did less explaining because they worked only on activities of daily living with which the patient was already familiar. From these observations, no gender difference in permission requests nor treatment explanation was discovered.
Another category which was discussed by supervisor and client stakeholders was gender differences in the amount of treatment collaboration the therapist does with the client. Collaboration is the primary means of achieving client directed functional outcomes, which should be the main goal of occupational therapy treatment. The female supervisors thought male therapists were more directive and less collaborative with clients than female therapists, while the male supervisor thought that male and female therapists were equally collaborative. The clients did not notice a gender difference in the number of choices given to them during treatment, which was the definition used to describe collaboration.

The characteristics of the typical male, which include ignoring the comments of the other speaker (Maltz & Borker, 1982) more than females, may lead male therapists to be less collaborative than females. One of the female supervisors felt women therapists are more likely to be collaborative while male therapists are more likely to be directive. She said, "Whereas men are more likely to say 'Come on in. I'm going to get you started on this' or 'yell when you're done,' women are more likely to say, 'What would you like to work on today?'" She explained that some of the directive approach used by males may be driven by geriatric clients' learned helplessness.

It is unclear whether or not directiveness on the part of some male therapists can be attributed to gender as much as personality. The supervisor in the acute care setting noted that the male she supervised was a fairly direct person who generally had an agenda with clients. However, she did not attribute this to his gender as much as she attributed it to his personality. Another female supervisor felt that men are probably more apt to take the directive approach. She also noted that from the perspective of a male client versus a female client, the male therapist's directive approach may be seen
by the male client as more collaborative. She said, "Maybe that directive style is easily accepted by that male client as a collaborative approach, and a female might not really feel like you're being collaborative, you're just telling her what to do and she's gonna do it."

The male supervisor stated that he noticed no gender difference in the amount of collaboration of therapists with clients. He believed that this is a crucial component of treatment and said that all occupational therapists working with him are trained to be collaborative with clients. He said,

The males and the females that I've observed have really given the resident or the client as much opportunity to participate as possible. We emphasize that in training them that the treatment planning process needs to be collaborative.

The supervisors differed in how much value they placed on collaboration. Surprisingly, not all of the supervisors considered collaboration to be important or necessary. One of the supervisors indicated that the directive approach, when the client is given little choice in treatment, is the best approach because of the limited time available in the acute care setting. She stated,

Now, with the force we're under to get people out of the hospital, we impose our agenda even more than we might have before because we don't have the time luxury. So we don't give people as many choices. I wouldn't give a client as many options.

It is important to consider when, in the treatment process, collaboration is most necessary. It may be most important when establishing goals but not as important when choosing treatment modalities. One supervisor indicated that collaboration in the initial stages of treatment (i.e., when establishing goals) is most important. She said,

So I guess, I think collaboration [on goals] is such a major point of being a good therapist in order to get any motivation, cooperation, and to end up anywhere functional that you want to be, that I think that maybe it's a style of how you're collaborative, male versus female, and how we use that with different patients, male versus female.
She also noted the importance of being directive rather than collaborative after the goals have been collaboratively established. She stated, "But to handle it as in a directive way to run a treatment session, I think it's very effective, and I would like to say that I work that way because I think asking is a big waste of time."

Clients were probably not aware when the collaboration process was occurring with their therapist. Possibly because of this, the clients were unanimous in their opinion that there was no gender difference in the amount of collaboration their therapists did with them. They also generally indicated no desire to be given a choice during treatment. One woman stated this point very well, "They know what they're doing. I leave it up to them." Another stated "They direct the operation." One of the male clients indicated that he liked it when the therapist told him what to do. Another female client stated, "They know exactly what you need. They know and they care, and so I must abide by the rule and accept my responsibility to cooperate." These statements reflect the learned helplessness and lack of empowerment that pervades long term care residents.

During treatment session observations, the female therapist was observed treating a client whom she had only seen once. The therapist did not seem to collaborate with her on goals or methods. With her male client, the female therapist determined one of the exercises but gave the client a choice of whether he wanted to work on arm exercises or standing exercises. The male therapist was observed collaborating with the female client on what they would do during the treatment session. He asked her if she wanted to review bed exercises and she said she did. With his male client, the male therapist was also collaborative. He asked the client what he needed to do and he asked what he could do to help. He also stated, however, what he wanted to see the client accomplish during the session.
Supervisor and client stakeholders discussed gender differences in therapist's treatment approaches. Treatment approaches are the direct link between the therapist and the client. The use of different approaches or modalities will probably have a great impact on client outcomes. All of the supervisors, except the one who works in an acute care setting, thought there were gender differences in the approaches the therapists use during treatment. The clients generally did not notice any gender differences in the approaches their therapists used to treat them.

Males, by nature of their biology, are generally larger and stronger than females. For this reason, one might expect male therapists to be more comfortable using more physically demanding modalities than females. The male supervisor indicated initially that he thinks male therapists are more physical in their approach, although he said he has also seen female therapists who have been as physical in their approach. He stated,

The male therapists that I've worked with, that I've observed, seem to be more physical in their approach. They will not hesitate to use the mat tables. But on the other side of the coin, I have seen females also that have jumped right in.

In the end, he stated that any differences he noticed were not attributable to gender. He said, "In terms of their thinking, in terms of clinical approach, it really boils down to, in my opinion, to the therapist and it's much less driven by gender."

One of the female supervisors indicated that there was a gender difference in the approaches used during treatment. She believed that male therapists use more physically demanding modalities but she would prefer to see them doing functional activities more. She explained her opinion as follows:

I see the male therapists working more, I won't say they aren't working on the same goals, but [rather] using those other modalities versus really honing in on working on the direct functional task in the bathroom, in
the room, but working on it more indirectly, which is on the mat, strengthening, mobility, on the mat.

She also brought up the issue of treatment differences when male therapists are doing activities of daily living with female clients. She identified behavioral differences between herself and the male therapists when the client is toileting. She said,

I have to tell you how many times I've seen male therapists that I work with [who have] the curtain pulled around the client on the toilet and he [the male therapist] is on the outside. My impression is he initiates that to give a little more privacy for certain parts of the task. I can never tell you a time I would do that. Never. Unless somebody asked me to, and I can't think of that happening. One, I want to know if they can do it themselves, not how they do it. Safety-wise I wouldn’t feel comfortable being over there.

The amount of work accomplished during the treatment session may be affected by the modality chosen and the gender of the therapist. Another of the female supervisors disagreed with the opinion that males use more physically demanding modalities. She believed this was not the case and that female therapists urge their clients to do more. She stated, 'Because of that jovial atmosphere, the male might say, 'OK that's good enough for today.' The female might keep the patient there for the entire treatment session urging them to do more.'

The long term care setting seems unique, in that it allows the therapist more freedom to choose modalities for treatment. The supervisor who works in an acute care setting said she did not see any significant differences in treatment approaches used by male and female therapists. She explained that in that setting, 'I'm not sure we have as many opportunities for choices of modality. And the short length of stay, too. We may have only three or four visits total, so you don't have the luxury.'

Clients are probably not familiar with the vast array of modalities which can be used during occupational therapy treatment. They may also not be highly qualified to notice differences in treatment approaches. The clients generally did not indicate that there were gender differences in treatment approach. The approaches used which they
mentioned included repetitive exercises, client education about different methods of bathing, rearranging of the apartment so it was safer, and education on how to use dressing assistive devices. One of the male clients did speak about subtly different methods used by his male and female therapist. The female therapist had him do things such as walking along the parallel bars while the male had him climbing steps. These differences are not significant enough, however, to indicate a gender difference in treatment modalities.

During the treatment sessions observed, it was found that different treatment approaches were used on the four clients. Since all the clients had different diagnoses, however, it was determined that differences in approach were due to diagnoses rather than the gender of the therapist or the client.

Client Wanting a Different Gender Therapist

The supervisor and client stakeholders all discussed the category of the client wanting a different gender therapist. This category is at the heart of the research question this study hopes to help answer. Will the increasing number of men entering the profession pose problems for clients, therapists, and administrators in facilities which serve geriatric clients? The supervisors generally felt this phenomenon of a client wanting a different gender therapist was common. The clients identified some occasions in which they would want a different gender therapist.

Situations involving a need for more trust are probably those when a client is most likely to ask for a switch to a therapist with whom they feel more comfortable. These situations include bathing and other activities of daily living and transfers of heavy clients. The male supervisor mentioned these two situations in which the clients requested changes. He said that female clients in the geriatric setting often request a female therapist when they are working on activities of daily living. He also mentioned
that having a female therapist or assistant help the male therapist with the female client could help reduce the stress to both the client and the male therapist. The other circumstance he mentioned in which a client requests a change is when a male client is not confident that the smaller female therapist can handle him physically during transfers or treatment. He said,

In thinking about what the etiology of it was, the request [for a male therapist], it frequently hinged on one event. If there was one event that sent the patient to a decreased level of confidence in that therapist, [i.e.,] she almost dropped me. A stiff wind could blow her over. How is she going to get me out of this wheelchair and off that mat? The male [client’s] perception of therapy is frequently a very macho weightlifting, mat tables, gaits, standing, you know, no pain no gain. The John Wayne thing. So they see this puny OT or COTA and it’s like, well she’s sweet, but I got tomato plants bigger than her.

Discomfort can occur on the part of the therapist also. The male supervisor stated that the therapists sometimes initiate a change. He identified two circumstances of when a female therapist requests that a male therapist take over because the client is too heavy or because the male client made some inappropriate comment. He spoke of a specific situation in which a male client was harassing the female therapist and she requested to leave that situation. Another supervisor also stated that therapists sometimes request a different gender therapist to take a client. The most frequent occurrence of this, she stated, was with female therapists working with male clients. She said, "I’ve seen in this setting with the older patient we’ve had semi-regularly inappropriate males, usually because of dementia-type things, and therapists refusing that, female therapists refusing to handle that."

All of the other female supervisors agreed with the male supervisor that there are circumstances when either the client or the therapist requests that an opposite gender therapist take over from the current one. One of the female supervisors stated that the switch generally occurred between female patients and male therapists where the female patient would be uncomfortable having a male therapist assist with dressing, bathing,
and grooming. This supervisor indicated that sometimes the clients actually said they were uncomfortable and sometimes the therapist could sense that the client was uncomfortable and would initiate a change without the client actually saying something. She also said that male clients, in her experience, were comfortable doing activities of daily living with both male and female therapists.

Another supervisor agreed that there are times when the clients and therapists request a change. She identified the circumstance of when a female client would like a female therapist rather than a male therapist. She said that they sometimes make a change and other times they try to work through the situation. She said,

In some cases we've tried to accommodate that or have accommodated, and in other cases it's been something we were able to work through and the client was OK with it. As long as the male therapist wanted to work through it. If he felt uncomfortable and didn't want to work through it then we would switch, but usually we've been able to get the client to go ahead and work with it.

She agreed with the male supervisor that there are times when male clients request to have a male therapist though it does not happen frequently. The reason for this request is usually because of the therapist's small size or because she is pregnant and the male client is afraid either he or the woman will be hurt. This supervisor said she is very conscious of these issues and usually makes assignments of therapists based on her awareness of clients' and therapists' needs.

The supervisor who works in the acute care setting also thought that there are times when a change is requested by the client. She said, "There were times when he [the male therapist] would be rejected by an older female patient. The female patient did that both with OTs and RNs. They didn't feel comfortable."

Clients, even though they are in a vulnerable position, are often able to vocalize their discomfort with a certain gender therapist. The clients mentioned occasions when they would prefer a change in the therapist treating them because of gender. The
females generally said they would prefer a female therapist when working on activities of daily living although one female stated that she was comfortable with men helping her with these activities. Addressing the issue of working with a male therapist one female client said, "If I'd had to, I would have [worked with him]. But I just felt more comfortable to have a lady take me to the shower." Another female client believed that she would prefer a female when doing ADLs because they were very personal activities. One female was very satisfied with the two males who had helped her with ADLs and she said she had never requested a change.

The male clients both indicated that they would prefer women to help them with ADLs though they had never requested a change. One male client said he would prefer a female to help him because "They take an interest in you" and "I just think it's in their nature." (5a.7) The other male client said he preferred a female therapist when doing ADLs because after toileting, she cleans better than the male. He said the male "...doesn't want to get poop on him." He believed that men were uncomfortable doing these things with him.

Advantages/Disadvantages to Same/Opposite Gender Treatment Dyads

The problems mentioned above may signal that there is an ideal treatment dyad in general. Both supervisor and client stakeholders discussed the advantages and disadvantages to same gender and opposite gender treatment dyads. A same gender dyad would be a female client working with a female therapist, for example, while an opposite gender dyad would be a female client working with a male therapist. Some of the supervisors saw advantages to same gender treatment dyads, particularly when working on activities of daily living. Other supervisors felt personality was the key factor and not gender. The clients generally did not voice any preference for working
with a same gender therapist or opposite gender therapist other than in the area of activities of daily living.

The male supervisor believed that there are advantages to same sex dyads in the occupational therapy treatment session but he qualified his remark with:

I think it can only be determined on a case-by-case basis because for every male-male therapeutic relationship that I've seen, someone could say to me, well they could see it working just as well with a female therapist.

He also asserted that the goals which therapists and clients work on are genderless, so the gender of the therapist should not matter. He said, "And those goals are really genderless, if it's bed mobility, or if it's strengthening the upper extremity, or increasing endurance. Those are really genderless goals."

Having both male and female therapists on staff can be beneficial to client treatment according to one supervisor. The female supervisor who works in acute care said she sought to hire a male occupational therapist onto the all female rehabilitation staff because he would provide balance and serve as a role model for adolescent male clients. She said,

It was of interest to me to have the possibility of a male on board because the job that was open was part days working in the adolescent mental health program. And I thought that would be a real appropriate use of a male on our staff to help with the young men that we came into contact with.

She said that male occupational therapists pose a challenge for clients, both male and female, however. Historically, males have been the doctors and females have been the helpers; so having a male therapist requires that "the person receiving the help needs to do a shift of expectations." This shift may not be required when the therapist is a female.
Another supervisor disagreed that men in rehabilitation departments are important as role models for young men. She said, "in an ideal world, seeing women in leadership roles is also a great benefit for adolescent boys."

Another female supervisor felt that same gender dyads are definitely advantageous, especially when working on activities of daily living. She said patient comfort levels during activities of daily living increase when they work with same gender therapists. She also stated that the males who go into occupational therapy are probably different from typical males and that she tries to "...look at them not necessarily as this group of [typical] males, but that they're who they are." While recognizing that male occupational therapists tend to be different from males in the general population, she still indicated that female clients prefer to work with female therapists on intimate activities of daily living skills.

The clients were reluctant to say whether they preferred to work with same gender or opposite gender occupational therapists outside of the ADL arena. One female client said, "Well, I think they're both good in their own rights. I think the male clientele likes both too." She also noted, however, that she would prefer a woman helper when she was bathing or toileting. One of the male clients said, "I have no argument with either." He said he would not be uncomfortable with a male or a female helping him with ADLs. One female client said "You have to, you know, go along with the flow,\". Another female client said she preferred males but did not see any advantage to having a male over a female therapist.
CHAPTER V
DISCUSSION

Review

The fact that more men are entering the profession of occupational therapy is primarily what motivated this study. Occupational therapy positions, like many of the other allied health positions, have historically been filled by females. This is now changing as more men enter these professions. It has been proposed that the reasons for the increase in the number of men becoming occupational therapists include better salaries and a lessening of strict gender typing of occupations. The roles and expectations of men and women have changed throughout the decades of this century. Men and women are now allowed more latitude in their career and lifestyle choices.

What will be the impact on clients, therapists, and supervisors of more men entering the profession of occupational therapy? The initial goal of this study was to determine if occupational therapy treatment provided by male occupational therapists is different from the treatment provided by female therapists. As the study proceeded through the literature review and the data collection process, the domain of concern was expanded to encompass not only treatment differences but also gender related differences in therapists' performance outside of direct treatment, clients' concerns related to the gender of the therapist, and male and female therapists' gender related concerns. It was considered necessary to expand the initial domain of concern to include these other aspects of the topic because they also impact client care and because they help provide one with a greater understanding of gender related treatment differences.
The literature review identified gender differences in verbal and non-verbal behaviors which provided a basis for the question of whether or not there is a difference between the treatment provided by male occupational therapists and that provided by female occupational therapists. Literature reflecting the current controversy in occupational therapy over whether to integrate masculine principles into treatment was discussed. The phenomenon of more men entering the profession of occupational therapy was also described and explained. Job satisfaction of males in the profession was examined. Finally, gender related concerns of male and female health care workers were discussed.

The qualitative method chosen for this study was deemed most appropriate because no literature could be found which examined occupational therapy treatment similarities or differences based on the gender of the therapist. This study sought to establish grounded theory on which future studies could be based. Interviews of supervisor and client stakeholders and observations of four treatment sessions provided data which was presented in the results chapter of this study.

Conclusions

Gender Differences in Therapists' Performance Outside of Treatment

This study revealed that there were some behavioral differences noted by supervisors between male and female therapists. Although the small sample size of this study does not permit generalization, their comments give an indication of topics which should be explored further. Supervisors indicated there were gender differences in number of requests for facility resources, documentation style, and ability to get along with coworkers, and they discussed staff adjustments necessary when a male joined the previously all female rehabilitation department. All of these areas are important to staff
morale and cohesion and, ultimately, to client care. Based on their remarks, men appear to make more demands of the facility, document less, and are less communicative with coworkers than females. Also, when a man joins an all female rehabilitation department, changes on the part of the female staff are sometimes required.

The implications of these results are that occupational therapy educational programs need to include more discussions of these topics in their curriculums and facility supervisors need to orient new therapists to their policies more explicitly. Professional occupational therapy programs are ideal places to discuss these issues and prepare new therapists, both male and female, for what will be expected of them once they enter the workforce. In the workplace, supervisors will play an important role in developing these skills and behaviors in the therapists they supervise. Communication channels need to be open between therapists and their supervisors so that constructive criticism can be given and received. The results indicated that male therapists may need feedback from supervisors in areas different than female therapists. Supervisors may need to pay particular attention to male therapists' performance in the areas of requests for facility resources, documentation, and communication with coworkers. In this study, female therapists do not appear to need as much guidance in these areas as do male therapists.

The last part of this category discussed by supervisors was the adjustment necessary by an all female staff when a male joined the rehabilitation team. Though some changes on the part of the staff were often necessary, it was generally considered a positive thing to have a male join the staff. The presence of a male encouraged an awareness of diversity on the part of other therapists and staff. Sensitivity to the needs of male clients and the needs of minority clients will probably increase on the part of female therapists after a male joins the rehabilitation staff. The implication of this is that
males should be encouraged to enter and remain in the profession of occupational therapy.

Gender Differences in Treatment

The primary focus of this study was to determine if there are differences between the occupational therapy treatment provided by male therapists and that provided by female therapists. The results chapter indicated that some gender differences were identified by both groups of stakeholders. Table 1 (p. 48) shows that the supervisor stakeholders found more gender differences than did the client stakeholders. Supervisors found gender differences in all eight of the treatment related categories while clients identified differences in only four of the eight categories.

Categories in Which Both Groups of Stakeholders Identified Gender Differences

Gender differences were found by some supervisor and client stakeholders in four of the eight treatment categories. Gender differences were identified as amount of smiling, animation, and talk; perceived caring; perceived competence; and perceived authority. These differences will be reviewed in relation to the literature. Implications of the results will be discussed.

Amount of Smiling, Animation, and Talk. The literature generally found women to be more affiliative than men by smiling more, facilitating the flow of conversation more, and complimenting more. The supervisors differed on whether they thought male occupational therapists or female occupational therapists were more animated. One female supervisor thought females were more affiliative by displaying these behaviors more, while another female and the male supervisor thought males were more affiliative. The discrepancy may be because of the different personalities of
the therapists involved. It is also possible that males that go into occupational therapy as a career are more affiliative than males in the general population on whom the literature was based. No significant differences were identified between the male and female therapist in terms of these behaviors during the treatment session observations. It appears that displays of these behaviors will depend as much on the client and his or her diagnosis, and on the personality of the therapist, as on the gender of the therapist.

Clients made it clear that it was important that their therapist smiled and was personable. As one stated, "it heals the soul". Occupational therapists, who should be trying to treat the whole individual-body, mind, and soul-may need to be reminded occasionally by supervisors of the importance of their interpersonal interactions with clients. The technical competence of the therapist is crucial but not enough, without good interpersonal skills, to bring about client satisfaction and good outcomes.

**Caring.** Significant differences in displays of caring by therapists may affect outcomes by influencing the client's attitude and willingness to participate. Caring can be considered more of an attitude than a behavior, though certain behaviors exhibited by the therapist, such as complimenting, can indicate that the therapist is caring. Based on the literature which found females to be more affiliative, a characteristic highly correlated with caring, and to compliment more, one would predict that female therapists would be considered more caring. This was what most stakeholders indicated. Discrepancies in the responses may be due to differences in how one interprets "caring". Some clients may prefer, and perceive as more caring, a therapist who is very vocal and animated, while others may prefer a therapist who is reserved and quiet. Women were generally considered by supervisors to be perceived as more caring than men. During treatment observations, however, the female therapist was observed complimenting less than the male therapist. The results of the observations
may not be generalizable however because of differences in clients, clients' diagnoses, and the number of opportunities for compliments.

Clients seem to believe that males care, just not as much as females. It may be useful, however, to remind all occupational therapy students and therapists of the importance clients place on this quality. Therapists should be encouraged to develop an attitude of genuine caring with clients and should be reminded that these geriatric clients are a vulnerable population who derive much of their self-esteem from their interactions with therapists and staff.

**Competence and Authority.** Some clients and supervisors also identified gender differences in competence and authority. The literature on gender differences in amount of talk explained that men talk more because they perceive themselves, and others perceive them, to have higher status and authority. In the categories of competence and authority, male therapists were considered by supervisor and client stakeholders to have more of these qualities. The supervisors did not think males were more competent than females, but rather, that males were perceived as more competent and authoritative by geriatric clients.

It is unclear how important this quality is to clients, however. None of the clients complained of incompetence and most had the opinion that both the male and female therapists were above them in terms of authority and competence. This view would enable both male and female therapists to gain clients' attention and cooperation during treatment. Also, too much authority was cited by one supervisor as being detrimental to the therapeutic relationship by making clients too passive and uninvolved in their treatment. For this reason, an optimal level of authority and competence needs to be projected by the therapist. Those female and male therapists who display too little authority or confidence, which can be interpreted as lack of competence, as determined
by a supervisor, might be encouraged to attend an assertiveness training class to increase their skills in this area. Those therapists who appear too authoritative and distant might be encouraged to attend a sensitivity training class. Though stakeholders indicated gender differences in these qualities, it cannot be said that all male therapists appear authoritative and competent; while all female therapists appear to have no authority and to lack competence. These qualities need to be monitored by both male and female therapists themselves and by their supervisors to determine on a case by case basis what training or recommendations will best suit that therapist.

**Categories in Which Only Supervisor Stakeholders Identified Gender Differences**

In the four remaining categories of treatment differences commented on by stakeholders-methods of motivating, amount of permission asked and treatment explained, collaboration with client, and treatment approaches-some or all of the supervisors identified gender differences while none of the clients identified any gender differences. The differences in responses between supervisors and clients may again be because they truly have different opinions on these categories or it may be because clients did not notice differences which may exist. The fact that supervisors have observed more occupational therapists and undergone extensive training during their careers to observe people and note behavioral differences, and the fact that clients are generally focusing on their own performance in therapy, leads one to think that clients may not have noticed behavioral differences in therapists which may have been present.

**Methods of Motivating.** Some supervisors indicated that there are gender differences in the methods therapists use to motivate clients while clients did not. Supervisors believed that higher perceived authority enables males to get greater client participation in treatment. The display of more dominance, independence, and
assertiveness by males, as described in the literature may explain the ease with which supervisors believed male therapists motivate clients. The implication of this are that some females may need to learn to be more assertive which would be especially useful with difficult older clients. This might be achieved through an assertiveness class. Of course, some males may also need this training to increase their assertiveness, though it appears that males do not need to demonstrate as much assertiveness as females to achieve the same amount of client compliance. Supervisors should communicate with therapists about this skill of motivating clients and offer new strategies when a therapist is having difficulties.

While supervisors felt there are gender differences in motivational styles, the observations of treatment sessions did not reveal any significant differences. This may be because of the small sample size that was involved, or because of similar training the therapists may have received (they both worked at the same facility), or they may have altered their method of motivating clients because they were being observed by a researcher. In any case, this is one dimension of treatment which needs to be examined more closely in future studies.

Asking Permission and Explaining Treatment. Asking permission of clients and explaining treatment to them are ways of empowering the client and conveying respect. Based on the literature, which found patients of female physicians to feel more empowered than the patients of male physicians, one might conclude that female occupational therapists ask permission more and explain treatment more to clients than male occupational therapists.

The supervisors who identified gender differences in these behaviors believed women do these things more. All therapists should be reminded to communicate with clients as much as possible in the interest of empowering them and helping them feel
more in control. Occupational therapy professional programs might have a class which includes role playing between a ‘therapist’ and a ‘client’ during which interpersonal skills, including asking permission and explaining treatment, are stressed.

Observations of treatment sessions did not reveal any significant gender differences, however, which may again be due to the small sample size. One noticeable aspect of the treatment sessions observed was that neither of the therapists asked permission to touch the client. This may be due to the high comfort level of their therapeutic relationships, however, this is one behavior which may need to be exhibited more, especially with new clients. Supervisors should be aware of this aspect of treatment and make recommendations when necessary.

Collaboration With the Client. Collaboration of the therapist with the client is another activity which involves communication. The characteristics of the typical male which were described in the literature as including ‘ignoring the comments of the other speaker’ may lead one to believe that females are more collaborative than males. This is what the female supervisors reported.

Collaboration is necessary in order to achieve the functional goals which the client hopes to achieve. It was surprising to hear supervisors say that, in some cases, they believed being directive was better than being collaborative. One supervisor indicated that, in an acute care setting, they did not have time to get clients to participate in establishing goals. Another supervisor believed in trying to get client’s input on goals but not on the actual treatment plan. It is crucial that goals be collaboratively established to increase the client’s investment in the treatment.

Based on supervisors comments, male therapists may need to be reminded more than females to listen to the client to learn what goals are important to them. Clients,
who often develop a learned helplessness attitude, may need to be encouraged by the therapist to contribute their opinions on treatment goals.

Observations of treatment sessions revealed that the female therapist collaborated less than the male therapist on modalities during the treatment session. It is not as important that each treatment session be collaboratively planned, however, because clients will not have enough technical skills to determine the best methods and modalities to use. Since the first treatment sessions were not observed, it could not be determined if she collaborated on goals.

Treatment Approaches. In terms of gender differences in occupational therapy treatment approaches, no literature was found on this topic and no implications could be drawn from the other literature on gender differences. One supervisor said that a male she supervised used the mat table a lot for strengthening rather than working with the client in the bathroom or kitchen. Therapists may need to be reminded that the closer the treatment setting is to the actual setting of the goal, the better. Male therapists may need to be encouraged more than females to do these activities in the setting they will be performed, i.e., the bathroom or kitchen. If the reason for this avoidance of the bathroom is discomfort on the part of the male therapist or the female client when working on intimate activities of daily living, this problem needs to be discussed and strategies need to be negotiated. Different treatment approaches were noticed during treatment sessions, however, it was determined that this was due mostly to the diagnoses of the clients, which were all different.

Client Concerns Related to the Gender of the Therapist

One concern which clients revealed in the categories 'client's desire to change therapist' and 'same gender/opposite gender treatment dyads' centered around intimate
activities of daily living. Female clients expressed that they were sometimes uncomfortable working with males on intimate activities of daily living such as bathing, dressing, or toileting. This may pose staffing problems in geriatric rehabilitation departments as more men enter the profession. Alternatives may need to be developed when only a male therapist is available. Alternatives mentioned in the literature and by supervisors included: (a) having a female aide present during intimate activities of daily living, (b) increasing rapport with the female client to increase her comfort level, or (c) allowing the female client more privacy when possible. These alternatives may provide an adequate solution to the problem.

Another concern of clients was described by supervisors. They told of male clients who were uncomfortable having small or pregnant female therapists help them, especially during transfers. They were sometimes afraid they were too big for the therapist to handle effectively and safely. To increase these males' confidence and their willingness to participate in treatment, it may be necessary for small female or male therapists to discuss this issue with clients before doing transfers. If the client is afraid, the therapist should ask for assistance from another therapist or aide when transferring this client.

**Female and Male Therapists' Gender Related Concerns**

The main concerns for female therapists indicated in the literature and results were: (a) dealing with inappropriate male clients, and (b) being trapped into spending excessive amounts of time with clients who do not realize therapists have other responsibilities. Training may be useful in helping female therapists deal with these situations. Assertiveness training for both females and males, as was mentioned earlier, may be a useful addition to professional training programs. All therapists, men as well as women, could use additional training on how to maintain their emotional and
physical boundaries with clients. Because female therapists are probably expected by geriatric clients to be more patient and empathetic, it is especially important that they be reminded of how to gently put limits on the demanding client. This will help the therapist maintain a sense of structure and control.

Concerns for male therapists were also identified in the literature review and results. Low job satisfaction was identified as one concern. The male therapist may have low job satisfaction (Posthuma, 1983) partly because of his involvement in occupational roles which he considers feminine. The need for men in predominantly female professions to establish themselves in a masculine niche within their profession, in order to minimize gender role strain, was identified. This phenomenon has not been studied explicitly in occupational therapy. Men in occupational therapy have gravitated traditionally towards directorships of rehabilitation departments and psychiatry positions (Christianson, 1970) which they may have done to minimize gender role strain. Specializing in what he considers to be a more masculine specialty may be the best way for the male therapist to achieve greater job satisfaction and be a better therapist.

Networking with other male therapists or rehabilitation staff may be an excellent way for male therapists to express their hopes, dreams, and frustrations to others males who can empathize, and to minimize the negative effect frustrations and minority status have on their job satisfaction and performance. The American Occupational Therapy Association or state organizations could publish quarterly newsletters which focus on issues of special importance to male therapists. These organizations might also set up social activities which would bring together men in the profession. Male therapist social and professional organizations would aid in the achievement of the goal of networking to alleviate the sense of isolation (when one is the only man in the
department) and encourage brainstorming to identify new ways of dealing with problems specific to male therapists.

Summary

Though some significant gender differences in therapists' behavior and treatment were identified by the participants in this study, these differences can probably be diminished through training and education of therapists. Diversity of occupational therapy staff is increasing as more men enter the workforce. This phenomenon offers opportunities and risks. Diversity in the rehabilitation workplace will tend to sensitize all staff to the needs of different types of clients. However, supervisors may need to change their style of supervising by paying attention to different aspects of the male therapist's behavior and treatment than those behaviors and treatment provided by female therapists. Also professional programs may need to adjust their curriculums somewhat to account for male and female differences.

Significant concerns of clients and therapists were identified which also need to be taken into consideration. By discussing the issues involving gender and occupational therapy, all parties involved can become more consciously aware of them and more able to fix problems that might occur. The enthusiasm of the supervisor stakeholders especially for this topic revealed a keen interest on their part in trying to identify problem areas and ways of rectifying them. Clients were also honest and straightforward about the circumstances in which they experienced difficulties related to the gender of the therapist. The goal of this research was to learn of gender differences in occupational therapy treatment and to learn of other gender related issues of importance to clients and therapists in the hope of improving clients' satisfaction and outcomes. Future studies can now be done which build on the information provided in this study.
Recommendations for Further Research

Because of the nature of this qualitative study, with its small sample size, generalizability is limited. In order to increase confidence that the results in this study are applicable to geriatric clients and their therapists in general, a qualitative study involving more stakeholders needs to be done which examines the issues introduced in this study. A survey of nursing home residents also seems like an ideal follow-up to this study. A quantitative study using a survey might be utilized to determine if the concerns raised, and observations made, by the limited number of stakeholders in this study are also identified by a larger group of participants. One additional piece of information which would be helpful in gaining an understanding of this topic is what aspects of a therapist's behavior and treatment the client considers most important. A simple ranking of the qualities examined in this study could be done by clients to gain this knowledge.

Observations of more treatment sessions given by many male and female therapists at a few different geriatric settings is recommended. These observations should try to limit other variables such as diagnosis of client, and age, degree, and experience of the therapist. A quantitative assessment of relevant behaviors of the therapists should be done in order to increase the objectivity of the data collected.

Though this study focused on geriatric settings, other settings were mentioned during data collection by stakeholders. Some of the issues raised during this study may be relevant to other settings and other groups of clients. Further qualitative and quantitative research needs to be done to establish what gender related issues clients, therapists, and supervisors face in other occupational therapy settings.
Appendix A

Protocol Clearance From the Human Subjects Institutional Review Board
To:    Dr. Susan Meyers
       Mr. Dennis Jones

From: Richard A. Wright, Chair
      Human Subjects Institutional Review Board

Subject: HSIRB Project # 96-10-05

Date: October 9, 1996

This is to inform you that your project entitled “OT Clients’ Impressions of the Similarities and Differences Between Male and Female Ot’s’ Treatment,” has been approved under the expedited category of research. This approval is based upon your proposal as presented to the HSIRB, and you may utilize human subjects only in accord with this approved proposal.

Your project is approved for a period of one year from the above date. If you should revise any procedures relative to human subjects or materials, you must resubmit those changes for review in order to retain approval. Should any untoward incidents or unanticipated adverse reactions occur with the subjects in the process of this study, you must suspend the study and notify me immediately. The HSIRB will then determine whether or not the study may continue.

Please be reminded that all research involving human subjects must be accomplished in full accord with the policies and procedures of Western Michigan University, as well as all applicable local, state, and federal laws and regulations. Any deviation from those policies, procedures, laws or regulations may cause immediate termination of approval for this project.

Thank you for your cooperation. If you have any questions, please do not hesitate to contact me.

Project Expiration Date: October 9, 1997
Appendix B

Consent Forms
I have been invited to participate in a research project entitled "OT Clients' Impressions of the Similarities and Differences Between Male and Female OT Treatment." I understand that this research is intended to study the similarities and differences in the way male and female OTs deliver OT services. I further understand that this project is Dennis Jones' Masters Thesis.

My consent to participate in this project indicates that I will be asked to attend one to three private interview sessions lasting between one and two hours with Dennis Jones. I will be asked to meet Dennis for the first session at a location most convenient and comfortable for me. The first session will involve a structured interview in which I will be asked questions relating to my perceptions of the similarities and differences between the treatment styles of the male and female OTs that treat(ed) me. A few weeks later, I may be asked to meet with Dennis again or speak to him over
the phone for second and third interviews to answer clarifying questions. The sessions will be audio taped if I consent to this. An OT treatment session of mine may also be observed by Dennis if I agree to participate in this project.

As in all research, there may be unforeseen risks to the participant. If an accidental injury occurs, appropriate measures will be taken; however, no compensation or additional treatment will be made available to the subject except as otherwise stated in this consent form. I understand that one potential risk of my participation is that some emotional discomfort may occur as a result of discussing with the interviewer my perceptions of my OTs.

One way I may benefit from this verbal dialog is that I may gain a better conscious insight into the treatment that I received/am receiving.

I understand that all the information collected from me is confidential. That means that my name will not appear on any papers on which this information is recorded. The forms will all be coded, and Dennis Jones will keep a separate master list with the names of participants and the corresponding code numbers. Once the data are collected and analyzed, the master list will be destroyed and the audio tapes erased. All other forms will be retained for three years in a locked file in the principal investigator’s office.
I understand that I may refuse to participate or quit at any time during the study without prejudice or penalty. If I have any questions or concerns about this study, I may contact Susan Meyers at (616)387-3854 or Dennis Jones at (616)373-6559. I may also contact the Chair of Human Subjects Institutional Review Board at (616)387-8293 or the Vice President for Research at (616)387-8298 with any concerns that I have. My signature below indicates that I understand the purpose and requirements of the study and that I agree to participate.

________________________  _______________________
Signature                      Date

I give permission to be audio taped during this(these) interviews.

________________________  _______________________
Signature                      Date

I do not give permission for audio taping of this(these) interviews.

________________________  _______________________
Signature                      Date
Therapist Consent Form

Western Michigan University
Department of Occupational Therapy

"OT Clients' Impressions of the Similarities and Differences Between Male and Female OT Treatment."
Principal Investigator: Susan Meyers
Research Associate: Dennis Jones

I have been invited to participate in a research project entitled "OT Clients' Impressions of the Similarities and Differences Between Male and Female OT Treatment." I understand that this research is intended to study the similarities and differences in the way male and female OTs deliver OT services. I further understand that this project is Dennis Jones' Masters Thesis.

My consent to participate in this project indicates that I will be asked to contact a few eligible clients to see if they are interested in participating in this study. If they say yes, I will pass their name and phone number along to Dennis Jones. I will also be observed during treatment sessions with selected clients. I will not be video taped or audio taped during the sessions.

As in all research, there may be unforeseen risks to the participant. If an accidental injury occurs, appropriate measures will be taken; however, no compensation or additional treatment will be
made available to the subject except as otherwise stated in this consent form.

One way I may benefit from this participation is that I may gain more conscious insight into the ways I therapeutically treat clients.

I understand that all the information collected from me is confidential. That means that my name will not appear on any papers on which this information is recorded. The forms will all be coded, and Dennis Jones will keep a separate master list with the names of participants and the corresponding code numbers. Once the data are collected and analyzed, the master list will be destroyed and the audio tapes erased. All other forms will be retained for three years in a locked file in the principal investigator's office.

I understand that I may refuse to participate or quit at any time during the study without prejudice or penalty. If I have any questions or concerns about this study, I may contact Susan Meyers at (616)387-3854 or Dennis Jones at (616)373-6559. I may also contact the Chair of Human Subjects Institutional Review Board at (616)387-8293 or the Vice President for Research at (616)387-8298 with any concerns that I have. My signature below indicates that I understand the purpose and requirements of the study and that I agree to participate.

____________________________  ____________________
Signature                                  Date
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My consent to participate in this project indicates that I will be asked to attend one to three private interview sessions lasting between one and two hours with Dennis Jones. I will be asked to meet Dennis for the first session at a location most convenient and comfortable for me. The remaining sessions may be held in person or over the phone. The first session will involve a relatively unstructured interview in which I will be asked my perceptions of the similarities and differences between the treatment styles of the male and female OTs I supervise. A few weeks later, I may be asked
to meet with Dennis again or speak to him over the phone for more structured interviews. The sessions will be audio taped if I consent. After completion of all the interviews I will be asked to contact clients that I know have been treated by both the male and female OTs that I supervise. I will ask these clients for permission to pass their name and phone number along to Dennis Jones so he can contact them to see if they are interested in participating in the study.

As in all research, there may be unforeseen risks to the participant. If an accidental injury occurs, appropriate measures will be taken: however, no compensation or additional treatment will be made available to the subject except as otherwise stated in this consent form. I understand that one potential risk of my participation is that some emotional discomfort may occur as a result of discussing with the interviewer my perceptions of the OTs I supervise.

One way I may benefit from this verbal dialog is that I may gain a better conscious insight into the strengths of the OTs I supervise.

I understand that all the information collected from me is confidential. That means that my name will not appear on any papers on which this information is recorded. The forms will all be coded, and Dennis Jones will keep a separate master list with the names of participants and the corresponding code numbers. Once the
data are collected and analyzed, the master list will be destroyed and the audio tapes erased. All other forms will be retained for three years in a locked file in the principal investigator's office.

I understand that I may refuse to participate or quit at any time during the study without prejudice or penalty. If I have any questions or concerns about this study, I may contact Susan Meyers at (616)387-3854 or Dennis Jones at (616)373-6559. I may also contact the Chair of Human Subjects Institutional Review Board at (616)387-8293 or the Vice President for Research at (616)387-8298 with any concerns that I have. My signature below indicates that I understand the purpose and requirements of the study and that I agree to participate.

____________________  ______________
Signature             Date

I give permission to be audio taped during this(these) interviews.

____________________  ______________
Signature             Date

I do not give permission for audio taping of this(these) interviews.

____________________  ______________
Signature             Date
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