Practice in rural schools is one area of occupational therapy that has received minimal attention in the literature and has almost no research base. Personnel shortages in rural schools and related issues in recruitment, retention, and training have been identified as a priority of the U.S. Department of Education, Office of Special Education ("Special Education Personnel Development and Parent Training," 1991), and is of great concern to states with large rural areas, such as those in the Midwest. The purpose of this study was to gain an understanding of the experiences of occupational therapists who work in rural schools and to explore their perceptions of their roles in rural schools. Educators can use this information to prepare occupational therapy students for practice in rural schools and to develop continuing education opportunities for rural-school-based therapists.

Issues Related to Personnel Shortages in Rural Special Education

Although rural districts tend to serve small numbers of students with special needs, the proportion of students eligible for special education is actually higher than that of urban districts (Helge, 1984b; Zeph, 1991). At the same time, the resources available to these students tend to be more limited than those in urban areas. Funding difficulties for school systems in rural areas are more prominent than for systems in urban areas because of a combination of smaller tax bases and overall higher educational costs. The costs of services and resources are often more expensive for rural schools because of transportation and access issues. In addition to the low funding base, rural school systems face shortages of qualified personnel, including special education teachers and related personnel such as occupational therapists (Berkeley & Ludlow, 1991; Helge, 1984b; U.S. Department of Education, 1994).

Shortages of occupational therapists in rural schools are associated with the following: (a) inadequate preparation for the diverse demands of these school settings (Dunn, Hughes, & Gray, 1990; Kanny & Crowe, 1991); (b) unequal distribution of training sites between urban and rural areas (those who train in urban areas tend to remain in urban settings [Gupta & Konrad, 1992]); and (c) few recruitment strategies to draw students from rural areas into occupational therapy educational programs.

Challenges Incurred and Skills Needed to Work in Rural Schools

A number of problems influence service delivery in rural schools. Some of these, such as limited personnel and equipment resources, are also common in urban schools;
however, the problems are more exaggerated in rural schools. Helge (1984a) listed the following variables to be considered in planning rural school services:

1. Access to external resources, such as the state agencies
2. Density of the population within the district (distances between schools)
3. Geographic barriers
4. Climatic barriers
5. Language spoken in the community
6. Cultural diversity
7. Economic lifestyles of the community
8. Types and severity levels of disabilities
9. History of special education services
10. Expertise and attitudes of available personnel.

She suggested that a variety of intervention strategies are needed to deal with these variables. Consultation services, statewide interdisciplinary treatment teams, and advanced technologies, such as satellite communication, are examples of strategies to improve services in rural schools (Hurff, Lowe, Ho, & Hoffman, 1990; Strickland, 1993).

Personal adjustments are needed to work in rural areas. Bracciano (1986) and Welch, McKenna, and Bock (1992) noted that occupational therapists considering relocation to a rural area often fear limited social outlets and convenient amenities compared with life in a city. Privacy and a sense of anonymity also may be lost (Cunningham, 1989). Cunningham suggested that because of the smallness of rural communities, therapists are more likely to come in contact with other team members as well as the families they work with outside of the work setting, thereby combining their professional and personal lives. In addition, therapists may be expected to give advice about health-related problems usually addressed by other health professionals because of the family’s limited access to comprehensive health care (Cunningham, 1989). Therapists may also receive calls requesting them to take on non-school clients, such as persons in nursing homes or in home health programs (Rosko, 1991).

Another challenge of working in a rural area can be the lack of peer support from other health professionals, specifically occupational therapists (Struck, 1993). Having daily access to other therapists offers the ability to collaborate, share day-to-day experiences, seek professional advice, gain moral support, and share skills and knowledge. Isolation from other therapists may create particular problems for new and inexperienced therapists (Welch et al., 1992).

In a survey comparing urban and rural school practice, Kanny and Crowe (1991) recommended a possible shift from delivering direct services to delivering consultation and monitoring services. These indirect services are needed to establish occupational therapy programs for students in remote areas. Daily implementation of the occupational therapy program may rely on unsupervised paraprofessionals and assistants. Izutsu and Jaffe (1988) also emphasized the importance of consultation in rural school settings but recognized that therapists often are not specifically trained in consultation to effectively integrate it into the schools.

Preparation for Service Delivery in Rural Schools

Several of the issues identified (e.g., professional isolation and use of indirect service delivery models) underscore the potential benefit of specific preparation for entry into occupational therapy practice in rural schools. Although a high percentage of both urban and rural therapists reported feeling unprepared for their positions in school settings, nearly 15% more rural therapists reported these feelings (Kanny & Crowe, 1991). Dunn and colleagues’ (1990) study to identify the issues and needs of rural occupational therapists in Kansas resulted in a number of recommendations for preservice training. They recommended that educational preparation include alternatives to direct services and practice models to support teachers who have had limited experience with disability. They also recommended that occupational therapists develop problem-solving skills for efficient use of resources.

In addition to the lack of specific educational preparation, continuing education opportunities are scarce for occupational therapists working in rural schools. Kanny and Crowe (1991) found that 47.3% of the 57 rural therapists they surveyed in the Northwest reported that they received no financial support for continuing education (compared with 21.2% of 195 urban therapists). In Kohler and Mayberry’s (1993) study, therapists in the rural Rocky Mountain region ranked a lack of continuing education as one of the most important personal and professional adjustments to the rural setting.

In summary, occupational therapist shortages in rural schools have generated concern about filling these positions. But what specific skills and values are needed to work in rural schools? How do the variables that characterize rural schools, such as those defined by Helge (1984a), affect occupational therapy practice? Benner (1984) and Niehues, Bundy, Mattingly, and Lawlor (1991) suggested that knowledge about practice could be gained by interviewing expert clinicians and analyzing their narrative descriptions. The following questions guided this ethnographic study of the experiences and perceptions of occupational therapists in rural schools: (a) What...
unique variables do occupational therapists identify as directly or indirectly influencing service delivery in rural schools? and (b) How do occupational therapists perceive their practice in rural school settings?

**Method**

**Participants**

Using purposeful sampling, six participants were identified through rural regional special education centers. The criteria for selection were (a) currently lives and works as a school-based therapist in a rural area, as defined by the Census Bureau, within the state of Ohio; (b) had experience working in an urban school setting; and (c) had 5 years or more of working experience as an occupational therapist and 3 years or more in a school system.

The participants were women who represented a variety of geographic areas, types of schools, and types of practice (e.g., private practice, hospital-based practice with contract to school, or school employee) in six separate regions of Ohio (see Table 1). Four of the participants began their work in a school system, one began in a developmental center, and one worked initially with adults. At the time of the study, one participant was employed by a hospital and worked in the surrounding schools through contracts; the others were employed by schools or educational centers. Each participant was a wife and mother in addition to working full time or nearly full time. All the participants expressed overall satisfaction in their roles and enjoyed their work as rural occupational therapists.

**Data Collection**

Each participant was interviewed twice with an open-ended interview guide; the first interview required about 2 hr and the second required 1 hr. Follow-up interviews were completed within 3 1/2 weeks of the first interview and were more structured because the participants were asked to clarify and expound on their first interview.

All interviews were tape recorded and transcribed verbatim. In addition, field notes were written describing the interview setting, key phrases of the responses, and nonverbal behaviors of the participant. These nonverbal behaviors provided information about emotions and affect associated with the dialogue, helping the researchers interpret the transcriptions. Additional data were collected from overt observation of each therapist as she worked with a child and parent(s), teacher(s), or another therapist. Observation time was from 2 hr to 6 hr. These observations were used as checks on the interview data (Patton, 1990). A final follow-up telephone call was conducted with each participant to clarify any necessary information and to allow the participant to share final comments. These final interviews also were tape-recorded and transcribed verbatim.

**Data Analysis**

Initial categories were generated from the data and further refined and validated through constant comparative analysis (Patton, 1990). When the data did not fit any of the categories, the categories were revised or new ones created. In addition, the interview data and field notes and observation notes were organized into case studies to identify individual themes. Through cross review of the case studies and the categorical information, common ideas and themes were identified by the researchers. These themes were verified by a third reviewer. Using these themes, the data were reevaluated for fit to determine whether the themes explained all the data. The resulting themes (discussed in the next section) were only indirectly related to the interview guide, suggesting that they reflected the thoughts and priorities of the participants rather than those of the researchers.

**Results**

The five major themes that emerged from the data describe how the participants coped with their roles in rural schools. The themes include

- *jack-of-all-trades*, which described how the participants viewed themselves as generalists
- *bridging the span between services*, which described the participants' role in coordinating medical and

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**Table 1**

Demographics of Participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Years Experience as an Occupational Therapist</th>
<th>Years Experience in Rural School</th>
<th>Employing Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stacy</td>
<td>17</td>
<td>15</td>
<td>County board of MR/DD</td>
</tr>
<tr>
<td>Mary</td>
<td>13</td>
<td>9</td>
<td>Regional special education center</td>
</tr>
<tr>
<td>Eileen</td>
<td>11</td>
<td>8</td>
<td>County board of education</td>
</tr>
<tr>
<td>Chris</td>
<td>12</td>
<td>12</td>
<td>City hospital contracts with school district</td>
</tr>
<tr>
<td>Laura</td>
<td>19</td>
<td>15</td>
<td>County board of MR/DD</td>
</tr>
<tr>
<td>Marie</td>
<td>8</td>
<td>3</td>
<td>Regional special education center</td>
</tr>
</tbody>
</table>

*Note:* MR/DD = Mental Retardation and Developmental Disability
health-related services
- the world can get kind of lonely out there, which described the sources of support seen as lessening the effect of professional isolation
- trust and teaming, which described the participants' attempts to provide integrated intervention services and the challenges they faced
- I cannot do it all, but I wish I could, which described how participants selected their service delivery models to meet the demands of their practice.

**Jack-of-All-Trades**

All the participants viewed themselves as generalists and expressed that a broad knowledge base was needed to work in rural settings. The field observations, as well as the interview data, revealed a great variety of intervention activities. Being the sole pediatric occupational therapist in their region meant that they were responsible for providing services to students of all ages and diagnoses. All the participants delivered services to students in preschool through high school, and four delivered services to infants (birth to 3 years). Because of the wide variety of students needing occupational therapy services, the participants felt a need to possess a wide range of skills.

Mary: I often say I know a little bit about a lot of things, and sometimes enough to make me a little bit dangerous [laughing] ... I feel like a jack-of-all-trades.

Marie: ... mostly I try to find out what the student's problems are in the classroom, and how we can best help alleviate them. There is very little state-of-the-art work within the rural population because we do not have the equipment, and we do not have enough students with similar needs to warrant purchasing good equipment.

Chris: ... you have to be a jack-of-all-trades and master of none... I do not have another therapist [with whom I can problem solve].

As the only pediatric occupational therapist within a region, each participant had to take on additional roles. For example, Stacy found that she needed to acquire physical therapy skills because the physical therapist delivered services only once a month. Chris believed that she was sometimes placed in the role of a physician because she was the only medical person employed by the school. Marie related this belief as well. Both of them believed that they were often the first and only person to recognize major medical problems, and they often initiated physician referrals to resolve them.

To competently fill the role of jack-of-all-trades, the participants expressed that continuing education was important. However, all found it difficult to attend continuing education courses, primarily because of the long-distance travel involved. Workloads also made it difficult to schedule time off; none of the participants were satisfied with the amount of time available to them for continuing education.

**Bridging the Span Between Services**

The participants described how living in a rural area provided challenges in coordinating comprehensive services for students with special needs. The areas where they worked lacked medical specialists, equipment suppliers, and therapist resources. To fill this void, participants established lines of communication with medical specialists and equipment vendors in the nearest metropolitan areas.

The participants believed that communicating with other professionals who delivered services to their students was an essential part of therapy. Laura described the importance of this communication:

I make a point of going to doctors appointments and to the hospitals with the kids. I went with several for brace adjustments... I tried to make contact with new doctors... so that I could set up some communication... it's a nice bridging of the two environments, and I think it's good for the kids.

Medical services beyond those of a family physician or pediatrician had to be sought in urban settings. Chris described the challenges she encountered when trying to communicate with medical specialists:

If I have a student that I'm worried about, I can make an appointment with the local doctor and go see him or go meet the parent, and we'll go to the doctor together. But if a child goes to a doctor in a distant city, it is difficult for me to go. I can send a report, but he might only read the summary, and Mom isn't going to ask the same questions I would ask.

Several of the participants discussed experiences they had had when attempting to coordinate services between the school personnel and the therapists in the urban hospitals where many of their students received medical services. Often, the hospital therapists would recommend services that were irrelevant to the educational setting or unreasonable for the rural setting (e.g., feeding techniques to be implemented daily by the therapist). The recommended services placed the participants in awkward positions of explaining to the parents and the hospital therapists why the recommendations were not appropriate in school-based therapy. Laura described her experience with this situation when she was employed as a consultant for a special education regional resource center:

... the medical community views the school system as being very reluctant to supply services, and the school [therapists] see the hospital [therapists] as supplying them with very unrealistic demands.
Recognizing that the school and hospital therapists lacked an understanding of each other’s roles, Laura often assumed responsibility for helping the school and hospital therapists to communicate:

It was a miscommunication sometimes...Hospital therapists write evaluations and send them to the school, [but] the school personnel do not understand it [and] cannot interpret what the medical information means for the child in the classroom. [I have become] the mediator, bridging the span between the medical and the educational systems. What the student needs medically is not always something that is appropriate during school hours.

She explained that hospital therapists often do not understand what students need in the classroom and do not understand how the student’s disabilities affect his or her ability to function in the school environment. In one situation where a student was receiving intervention at an urban center and a rural school, the classroom needs were not effectively communicated to the therapists at the center. To improve communication and service coordination between these two environments, Laura videotaped classroom situations in which the child had difficulties so that the center therapists could view the problems directly.

Although all the participants had established working relationships with equipment suppliers, coordinating those services was challenging because all suppliers were located in urban areas. The participants could not always accompany the family to the city for fitting of prostheses or orthotics. One urban-based company created a “mobile technology lab” that traveled to the rural areas and delivered services within the student’s community. Not only did this mobile lab address accessibility, but it also promoted a better coordinated educational program because the participants and teachers accompanied the family members and child, giving the lab’s assistive technology experts input and receiving information about assistive technology for the child.

The World Can Get Kind of Lonely Out There

Relationships with other persons appeared to highly influence the participants’ sense of fulfillment and effectiveness. For them, feeling a sense of support and a sense of being valued appeared to be an important contributing factor for remaining in their positions. As revealed in both the interviews and the field observations, positive relationships with persons in the school seemed to help them deal with other issues such as a lack of resources and heavy caseloads. All the participants expressed a sense of isolation related to being the only pediatric occupational therapist in their region. However, it became clear during the interviews that their relationships with other professionals, as well as with their colleagues and supervisors, lessened the effect of not having ongoing dialogue with other occupational therapists.

The relationships that seemed to provide participants with the most support were those with physical therapists and speech therapists. These other therapists provided the encouragement, comfort in times of frustration, and renewed confidence in the participants’ skills. They also provided tangible support through their carrying over the participants’ occupational therapy goals in their physical or speech therapy treatment sessions.

Because Stacy worked daily in the same center, she had regular contact with other therapists who worked with the students at the same time she did:

...we support each other. I mean it is a joy to come into work....if we [have a problem with one of the students] it is very easy for us to sit down and talk about it and come up with ideas to change it or make things different.

Those participants who traveled from school to school had to arrange time to collaborate with other therapists. After several years of working as the only therapist in a school system, Chris took a position in a hospital setting to have contact with other occupational therapists. Although these other therapists worked with adults, she learned new skills from them that she then applied to her work with children.

Trust and Teaming

All the participants discussed how the teachers’ acceptance of them in the classroom varied. Special education teachers, as compared with regular education teachers, were usually aware of the role of occupational therapists and were typically receptive to working with therapists. The teachers’ general attitudes about their own teaching role, confidence, and perceived ability to manage the classroom, naturally affected their attitudes toward the participants. The teachers’ personalities also influenced how willing they were to accept new ideas or changes in classroom routines. In addition, the teachers’ receptiveness to the participants seemed to be based on their understanding of the role of occupational therapy in the school.

Chris: I think it boils down to whether the teacher understands what I can do for her and for the child. Sometimes I think they take me as an intrusion, and [that I will lessen their control over their students]...that I will change something in their classroom [and that they will not like the change]....Teachers that understand what I do I feel value me more than teachers who do not understand what I do.

Laura: In my experience, teachers who are in special education classrooms are thrilled to have you. The regular education teachers who were assigned the special needs children...are scared....I think those teachers were unprepared for the child, and they feel that they did
not have the professional background to work with the child. Many times they receive the students in their classroom without adequate support from the school system and they are overwhelmed, so they put up this barrier. Some of them say, “Get this kid out of my classroom, he does not belong here.” Others do not say that, but they put a distance between themselves and the child. They are concerned that they are going to hurt the student or that they are not going to be a good teacher for that student. I have some teachers now who are verbalizing... “I am not opposed to having that child in my class, but do not send him in here without adequate support because I have 28 other students, and my whole day cannot revolve around that student.”

All the participants believed that establishing rapport with teachers was essential to acceptance of an integrated model of service delivery. However, the participants often lacked the time needed to establish rapport with the teachers. Those participants who worked in a number of schools separated by great distances were at a disadvantage because their time in the classroom was less flexible and opportunities for informal conversation with the teacher were fewer. The more available a participant was to discuss classroom issues, the more likely she and the teacher could gain ideas for activities to improve the student’s sense of control. The participants believed that maintaining the teachers’ sense of control was essential to establishing rapport and to fostering cooperation with the therapy programs to be carried out in the classroom.

When asked about the service delivery models used, all the participants described that service delivery had evolved from a multidisciplinary approach to a transdisciplinary approach.

Eileen: I think group therapy is useful for the students that I have on IEPs [individualized education programs], but I think it is useful for the other students also.

Eileen stated that it was part of her role to give teachers ideas for activities to implement with the students with disabilities. The participants also described how they made a point of asking the teachers what problems they were experiencing with the students and what teachers wanted them to emphasize with the students. Asking for their input seemed to increase the teachers’ sense of control. The participants believed that maintaining the teachers’ sense of control was essential to establishing rapport and to fostering cooperation with the therapy programs to be carried out in the classroom.

The participants expressed that the types of services delivered often related to meeting the needs of the teacher as much as the direct needs of the student. For example, providing group therapy that included students who were not on the participants’ caseload helped to establish rapport with the teachers. By observing the group sessions, the teachers could gain ideas for activities to improve sensorimotor skills.

Marie: ... there are many children in the class who need extra help, who are not officially receiving occupational therapy. Including these children makes our students with disabilities feel less singular out when they do an activity with the entire class. We give the teacher some ideas on how she can help her students, which helps build rapport.

The participants found that helping the teacher with her planned activities and giving ideas about helping the other students improved the teacher’s cooperation and interest in carrying over occupational therapy activities in the classroom.

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Stacy: When I first worked in the school, the teacher’s primary interest was for you to develop a schedule, pull the child out of the classroom, do what you have to do, and then return the student. It was a very singular mind-set. That was when the pull-out models were in place...and the idea of a transdisciplinary approach was not well accepted...times have changed, and teachers have changed, and the whole atmosphere has changed...So it has kind of evolved.

Laura: In the mid-’70s, [service delivery relied on pull-out therapy]. We had a therapy department, and we took the students to our room. The teacher wanted the student taken away...now I never take the student from the classroom, everything is done in the classroom.

Eileen: I started in ’86...At that point, we pulled our everybody...we’ve gone from strict pull-out...into the functional programs and writing goals together.

I Cannot Do It All, But I Wish I Could

All the participants expressed a sense of being overwhelmed with their workloads. As the only therapists to provide pediatric services for their regions, the participants were in great demand. Factors such as decentralization, the rapidly growing population of infants and preschoolers needing services, and increasing awareness of parents and schools about the services occupational therapy could offer seemed to have influenced an increase in caseload. Excessive caseloads affected how the participants delivered services.

Stacy faced frustrations with not being able to spend
enough time teaming with the teachers and parents, although she believed that she had good rapport with many of them. Although the teachers made home visits, she did not routinely accompany them on these visits. She wished that she had more time to communicate with the parents, “but there’s a time element.” She believed that if the district had an additional occupational therapist, she could provide more in-service instruction and could spend more time collaborating with teachers and parents.

Marie and Mary struggled with not being able to serve all of the students they knew needed intervention and wished that they spent less time driving from school to school.

Marie: I find it frustrating to spend more time on the road than I do working with the students, and when I do work with them, needed equipment is not available. The equipment is divided among the schools, so there is not enough in any one place to do the kind of therapy you want to do....Inclusion is good (but makes service delivery hard because we divide ourselves among multiple schools).

Mary: I could see more students if I did not have to do all the driving....I feel guilty sometimes because I am not being able to serve all the students that I think we should be serving. Some of them will probably survive without us, but they would survive better if they did receive services.

Chris found it difficult to not be able to optimally fulfill requests of schools and parents for her services. She had 12 children on a waiting list and was frustrated that she could not see students more than once a week.

Because of the heavy caseloads, several of the participants used alternative methods of delivering services to provide them more efficiently. Their explanations of alternative methods revealed that changes were necessary to effectively use time and meet the needs of the students. Students received monitoring and consultation when they were good candidates for direct services. To serve more students with less time, the participants worked with students in small groups and trained teachers’ aides and assistants to provide the occupational therapy activities in the classroom.

Therapy in small groups provided direct services to more children and at the same time allowed the participant to address individualized goals for each child. Marie described her use of the group model:

1 prefer the individual [model], but last year when I was given a half an hour to be in a building...I worked with a group of children at one time, because that’s the only way it could be done. I learned to use the group model. There’s a lot you can do with it if you work on it...You can use the same activities for the whole group and vary it [for different children].

Stacy desired to have more time to work with the teachers and the parents to improve the integration of the students’ programs. To be able to spend time with the students and better observe their progress, she ran small groups outside the classrooms in addition to providing therapy within the classrooms. The administrators and teachers supported this schedule, which allowed her to see the students twice a week.

To integrate the occupational therapy programs into students’ everyday activities, the participants also used classroom aides and assistants to carry out the therapy programs that they had designed. By training others, they could affect the child’s educational program beyond their once-a-week direct contact with the student. Participants found the aides useful in the classrooms and capable of providing activities that addressed IEP goals.

In spite of their frustrations with not being able to meet all the needs of the students in their caseloads, the participants found positive aspects of their jobs. Eileen stated that she had “come to grips” with her workload and did not feel pessimistic about it. When she became frustrated with what she could not accomplish, she reminded herself, “I am going to try to do what I think I can do with these students in the time I have allotted.”

Marie reduced her frustration by setting less ambitious goals that were realistic and achievable for her students:

There is a lot of juggling for time and space, and then usually what you have isn’t optimal....I learned through experience not to expect a lot. I write IEP goals that do not [suggest] that much will be accomplished, if I [write ambitious goals], I feel [unsuccessful], and parents are upset...[therefore I write small goals]...what I think we can achieve given the conditions.

Discussion

This research revealed the perceptions and roles of occupational therapists who work in rural schools. The first three themes (jack-of-all-trades, bridging the span between services, and the world can get a little lonely out there) seem to reflect unique aspects of rural school practice; the remaining two themes (trust and teaming and I cannot do it all, but I wish I could) seem to generalize to all school-based practice as described in the literature.

Themes Unique to Rural School Practice

Jack-of-all-trades. The finding that the participants were generalists matches the stated need in the literature for therapists working in rural areas to possess generalist skills (Bracciano, 1986; Correa, 1992; Helge, 1984b). This generalist orientation was fostered because the participants were the only pediatric occupational therapists in
their regions. Usually their caseloads included students of all ages. Dunn et al. (1990) found that urban therapists were more likely to specialize with a particular age group (e.g., work solely with preschoolers or with adolescents).

The participants were asked to intervene in a variety of situations, and they used a variety of intervention solutions. Many of these solutions involved changing the student’s environment (Dunn, 1989). Their recommendations included changes to the student’s social environment (e.g., how the student is perceived by others), the physical environment (e.g., desk and chair arrangement, classroom and playground accessibility), or the curriculum (e.g., written assignments). The participants’ skills in identifying and recommending comprehensive environmental adaptations for individual students suggested the need for generalist skills.

Dunn et al. (1990) stated that rural therapists must have access to a broad range of current information to update their skills to meet the range of needs that characterize their practice. Although many therapists in rural schools may feel the need to develop generalist skills, urban therapists may have easier access to resources and information to help them develop skills in a variety of areas. Accessing continuing education was a problem with the participants. According to Welch et al. (1992) and Cunningham (1989), limited opportunities for continuing education are a major problem for rural therapists. Peer support groups are one means for obtaining resources and new ideas (DuBois & Dorando-Unklle, 1993). Several of the participants had taken part in either peer support groups or study groups.

**Bridging the span between services.** Another important role of rural therapists is that of service coordinator. In this role, the participants invested time and energy in coordinating the student’s services between urban medical specialists and rural educational personnel. Problems with coordinating the acquisition of equipment were a concern both of the participants in this study and of rural therapists in other studies (Kohler & Mayberry, 1993; Welch et al., 1992). The participants believed that maintaining contact with and providing information to the medical specialists in urban areas and the medical professionals within their rural communities were essential parts of their jobs. Service coordination is an increasingly important and valid role for the occupational therapist (Case-Smith, 1991; Hinojosa, 1992).

Helping their students access needed services and coordinating these services required that the participants develop leadership and advocacy skills. According to Marrs (1984), leadership skills are critical to service delivery in rural schools. The participants’ leadership roles in coordinating medical care and educational programs involved self-initiative and effective communication skills, both of which Cunningham (1989) identified as important to rural-school–based practitioners.

**The world can get a little lonely out there.** Isolation is a characteristic of working in rural areas, yet in studies by Dunn et al. (1990) and Kohler and Mayberry (1993), issues related to isolation and lack of peer relationships were not ranked as major concerns. These results paralleled the beliefs of the study participants. Although isolated from other occupational therapists, the participants had formed positive relationships with colleagues in similar professions. Collaboration was valued, and the participants made time for meeting with other therapists a priority in their schedules. They also devoted nonwork time to meeting with other occupational therapists in informal study groups. As a result of these initiatives, the participants were coping well with situations of potential professional isolation.

**Themes That Generalize to All School-Based Practice**

**Trust and teaming.** Niehues et al. (1991) described the importance of teaming to the therapist’s success. In their ethnographic study, success was “a time when the teaming worked well and...[there] was a good working relationship...between the therapist and teacher” (p. 205). The participants in the Niehues et al. study and in the current study indicated that successful intervention was related to establishing a collaborative relationship with the teachers, and intervention was unsuccessful when collaboration was not achieved. The participants had made specific efforts to collaborate with teachers and other therapists despite their busy schedules and heavy caseloads. As Benson (1993) explained, team relationships develop gradually, and having time to work together is a key component of successful collaboration. The participants viewed their roles as more than providing therapy for specific children, but of providing support to teachers and at times helping to carry out teacher-planned activities. The participants supported teachers by providing recommendations for group activities, assisting in implementing classroom activities, and providing specific information about the students who received occupational therapy services. Rainforth, York, and MacDonald (1992) described three types of support that team members provide one another: (a) resources support (e.g., materials, physical help), (b) moral support (e.g., listening, encouraging), and (c) technical support (e.g., specific and individualized strategies and adaptations). The participants in the cur-
rent study provided each of these supports to teachers. I cannot do it all, but I wish I could. Although the participants had heavy caseloads and hectic schedules, they all described ways in which they were successfully coping with their situations. Through identification of personal resources and positive aspects of their jobs, the participants shared what they valued in their work. They tended to use internal strategies (e.g., their own ability to change a situation) rather than external coping mechanisms (e.g., relying on others for help or support). They expressed satisfaction in managing high levels of responsibility and in finding solutions to managing their caseloads. Identifying the positive aspects of a role helps to sustain a person’s performance in that role (Arnsten, 1990). Master clinicians define problems so that they are resolvable, make seemingly impossible situations possible, and see the gestalt of difficult situations (DePoy, 1990).

One coping strategy the participants used included changing how services were delivered, such as rearranging a schedule to permit more time with the teachers and with other therapists. Mitchell and Kampfe (1990) found that problem-focused strategies, which involved managing sources of stress, ranked the highest among coping strategies used by fieldwork students. In a study by Kanny and Crowe (1991), a portion of their survey was directed at personal attributes therapists believed they needed for rural practice. The top-ranked items were self-reliance and independence, confidence in self and profession, and creativity and flexibility. These same attributes were listed by DePoy (1990) as characteristics of master clinicians. The participants described these attributes as sources of strength to cope with the difficult aspects of their work in rural schools.

Limitations
The sample was limited to the state of Ohio and further limited by its small size, making the results not generalizable. However the similarity of our findings to those of Kanny and Crowe (1991) supports the validity of our descriptions of rural-based practice. Although multiple contacts were made with each participant and interview and observation time ranged from 5 hr to 9 hr, the amount of time in which to complete the data collection was limited. More interviewing time might have provided more comprehensive information because in qualitative, naturalistic design, one does not predict results or predict what additional information would be provided.

Another limitation was lack of clear differentiation between rural and urban school practice. All the participants had difficulty distinguishing how their rural practice would differ from urban practice. On the basis of the literature, we suggested that certain themes applied to practice in any school setting, and others applied primarily to rural schools (Dunn, 1989; Dunn et al., 1990; Niehues et al., 1991).

Conclusion
Occupational therapy education programs might use the information in this study to help prepare students for practice in rural schools. Generalist skills, flexibility and adaptability, willingness to take on nontraditional roles, and skills in communication and collaboration seem to be critical to successful occupational therapy practice in rural schools. ▲

References


