so willing to adopt the methods that are most unique to physical therapy or others but feel so threatened when the American Physical Therapy Association suggests that physical therapists are able to adopt ours? Horowitz and I may have some difference of opinion or some misunderstandings, but what is clear to me is that both feel a concern for the future of our profession and the well-being of our clients. My hope is that my Eleanor Clarke Slagle lecture will help us all to regain respect for our unique role in health care and our recognition as a valuable profession.

Anne G. Fisher, ScD, OTR, FAOTA
Denver, Colorado

References

Both Sides of the Story

I applaud the American Occupational Therapy Association (AOTA) for issuing its statement on "Occupational Therapy for Individuals With Learning Disabilities" (AJOT, 52, 874–880). With the continued emphasis on the need for role delineation, clear practice guidelines are greatly needed. In addition, this statement is a valuable resource for non-occupational therapists for a clear and concise definition of occupational therapy and learning disability terms and description of the occupational therapist's role across the life span of a person with a disability.

The statement describes the three common occupational therapy techniques for treating children with learning disabilities. The theory and application of skill building, sensory integration, and compensatory strategy training are given.

Regarding this statement, I am concerned that AOTA did not mention any information that disputes the use of sensory integration when treating children with learning disabilities. Where is the other side of the story? There is a vast amount of research refuting sensory integration treatment's effectiveness.

Several recent occupational therapy research articles conclude that sensory integration treatment has a statistically insignificant positive effect on the academic achievement of school-age children with learning disabilities. The studies also suggest that sensory integration is not unique in its effectiveness and that perceptual-motor training is equally effective (Humphries, Snider, McDougall, 1993; Polatajko, Kaplan, & Wilson, 1992; Polatajko, Law, Miller, Schaffer, & Macnab, 1991; Schaffer, Law, Polatajko, & Miller, 1989; Wilson, Kaplan, Fellowes, Gruchy, & Faris, 1992). In the past decade, the Committee of Children with Disabilities, Canada, has published statements disputing sensory integration as an accepted treatment method for students with learning disabilities. Hoehn and Baumeister (1994) reported that sensory integration therapy has no effect on improving academic function in persons with learning disabilities.

The purpose of this letter is not to refute sensory integration as a treatment modality, but to encourage AOTA to include the "whole picture" in future statements about sensory integration and learning disabilities. In my opinion, the statement did not stress enough the importance of using a varied treatment approach. Many occupational therapists continue to use sensory integration as the primary or singular treatment method when treating children with learning disabilities (Schaffer et al., 1989).

One amazing aspect of our profession is the ability to choose from a vast number of frames of reference to guide each individual treatment. As occupational therapists, we pick the frame of reference that is the best fit for our patients. However, the responsibility is on us to make educated decisions regarding treatment modalities. As Principle 3 of the Occupational Therapy Code of Ethics states, our duties must be performed "on the basis of accurate and current information" (AOTA, 1996, p. 653). It is a well-known fact that children are in sensory integration therapy for many years with great cost to their parents and schools. I am fearful that this AOTA statement may be used to mislead parents into thinking that sensory integration is guaranteed to work. With this in mind, I implore those in the pediatric practice area not to practice sensory integration because that is what everyone else does. Practice sensory integration after reviewing all the research critically and concluding that sensory integration is the best treatment modality for your patients.

N. Anna Rotenberg
Baltimore, Maryland

References
Different treatment approaches are commonly combined with each other to meet the child's unique needs" (p. 877).

I wholeheartedly support Ms. Rotenberg's closing comment that stresses the importance of therapists choosing a frame of reference or treatment approach "after reviewing all the research critically." Official statements can raise awareness for practitioners about aspects or issues in practice, but each therapist has the professional responsibility to base his or her decisions on a critical review of literature and research. Decisions about interventions need to be evidence based in order to provide the highest quality of service to the persons we serve.

Mary Jane Youngstrom, MS, OTR
Chairperson,
Commission on Practice

Adults With TBI

Research into the efficacy of occupational therapy with persons with brain injury is difficult (Giles, 1989). Tromby, Radomski, and Davis (AJOT, 52, 810–818) sought to determine whether persons with traumatic brain injury (TBI) who received outpatient occupational therapy services achieved self-identified goals related to tasks of daily living. Their article demonstrated that the participants believed that they had improved. Unfortunately, the participants were largely so early postinjury that spontaneous recovery (the natural process of recovery after brain injury) is a more parsimonious account of their improvement than the effects of occupational therapy. The authors chose not to use any of the methods established in the literature to control for spontaneous recovery, so it is hard to interpret the findings as saying anything except that if one provides occupational therapy to persons who are improving anyway, one will not disrupt their recovery. Although the authors claim to show only coincidental improvement and are clear that causation cannot be inferred, a number of their statements are open to interpretation.

Despite the large number of problems with the study, I want to limit this commentary to a few general comments followed by an examination of the problems Tromby et al. have in accounting for spontaneous recovery. I will end with some recommendations about how further research might demonstrate the efficacy of occupational therapy with persons with TBI.

The information provided about the frequency of brain injury is contradictory and, I can only assume, resulted from typographical error. The majority of persons with brain injury have a minor brain injury, get better, and are able to perform daily activities and return to work. Therefore, to claim, as the authors do, that a central issue for an occupational therapist to consider is whether persons with brain injury can recover independence in basic activities of daily living is absurd (p. 811). Of course they can, and the majority do, many with no therapeutic intervention whatsoever (Dombovy & Olek, 1996).

The fact that most persons with brain injury (who do not die) get better presents a major confounding variable for attempts to show that rehabilitation is effective (Giles, 1989, 1994). The research design most able to control for the effects of maturation (spontaneous recovery in TBI) is the randomized control trial (Campbell & Stanley, 1966). Such a trial is unfortunately difficult to mount because of the large financial resources required, the size of the subject pool needed, and ethical and other considerations.

There are, however, a number of viable alternative designs, such as randomized treatment comparison groups (Gladman, 1991). The comparison group design has been used in both brain injury and stroke rehabilitation studies (e.g., see Kalra & Eade, 1995; Ruff et al., 1989). Another method used to control for the effect of spontaneous recovery is to provide treatment after spontaneous recovery has slowed or stopped. Our group has adopted this method in a number of published reports (e.g., Giles & Clark-Wilson, 1988, 1993; Giles, Ridley, Dill, & Frye, 1997). In the Tromby et al. study, 9 of 16 participants were treated 6 months or less after injury, and 12 were treated 1 year or less after injury. Although the participants are reported to be an average of 22 months postinjury, this average is only due to 1 participant being more than 18 years posttrauma. With the exclusion of this participant, the average months postinjury is 8 (median = 5,