The return to a crafts emphasis is impractical. Those authors that support increased use of crafts state that they feel remote from clinical practice. It would be interesting to see whether practicing therapists perceive the lack of crafts to be a problem, and whether they feel they are overspeaking the bounds of occupational therapy by supervising productive activity and exercise that do not use crafts.

Our profession obviously faces a severe identity crisis. The reigning ambiguity has a negative effect not only on practicing therapists but also on other health care groups (physicians, physical therapists, third-party payers). It is enough of a dilemma for the practitioner to convince the patient, physician, and administration of the credibility of occupational therapy as a medically oriented discipline, rather than as the traditional diversional orientation, without feeling that the AOTA is divided on the scope of our practice. How about AOTA supporting the advancement of occupational therapy as a well-defined treatment to improve patients' daily life skills, rather than encouraging a regressive step toward crafts therapy?

Julie K. Walker, OTR
Bettie Lumpkin, OTR
Toni RePowderly, OTR
Sydney Pratt, OTR
Lisa Stevens, OTR
Sandra Wente, OTR
Karen Whitney, OTR
Occupational therapy staff of a 650-bed acute care/rehabilitation center
St. Louis, Missouri

To Whom Does Biofeedback Belong?

Huss must be commended for her article “From Kinesiology to Adaptation” (September AJOT), in which she identifies the areas of differences between occupational therapy and physical therapy. I concur with her primary premise that all treatment modalities used in occupational therapy must be activity directed; however, I differ with her opinion that biofeedback is a physical therapy modality and that “biofeedback is not a natural extension of our body of knowledge, but sensory integration is.”

The term biofeedback has come into widespread use to designate the means of monitoring “physiological processes of which the individual is not normally aware and which may be brought under voluntary control through the use of direct observation and/or monitored instrumentation” (1, p 8). As proposed by Gaardner and Montgomery, a more precise term would perhaps be external psychophysiological feedback (2, p 9).

In my opinion, biofeedback does not belong to physical therapists, nor to occupational therapists; it is a treatment modality, just as is the “Hussenfarber” techniques of facilitation and inhibition. However, the way in which biofeedback is used by the occupational therapist and the way in which it is used by the physical therapist differs. Biofeedback, when integrated with purposeful activity, can be used as an adjunct to ongoing conventional treatment methods and consequently, accentuate the treatment of specific problems of certain clients seen in occupational therapy. The potential use of this treatment modality, as well as other current neurotherapy approaches used in occupational therapy, remains to be further investigated through research and thus I feel that Huss’ critical evaluation of biofeedback is somewhat precipocious.

Biofeedback should not be viewed solely as a treatment modality, but rather, it “should be viewed more broadly to reflect a general conceptual approach to intervention and evaluation” (3, p 275). I believe that the concept of feedback, which underlies biofeedback, is part of our body of knowledge in occupational therapy and, in this manner, biofeedback is a natural extension of this body of knowledge.

Rhoda Weiss-Lambrou,
M.Sc., O.T. Reg. (C)
Montreal, Quebec

REFERENCES

Advocates No-Nonsense Modality Use

Although I am in agreement with A. Joy Huss about the basic premise behind occupational therapy, I take exception to her position with regard to the use of modalities by present-day therapists. (See “From Kinesiology to Adaptation.” September AJOT.)

Our increased knowledge of the basic sciences to which she refers