BABO NEWS

Newsletter of the

Baltimore Academy for Behavioral Optometry

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A Few Reminders

There are still some people who have not made note of the fact that we have moved. It has been a year now that we have been in our new office so our mail will no longer be forwarded. So please make a note of our new address: **110 Old Padonia Road, Suite 300, Cockeysville MD 21030.** The phone and fax numbers remain the same.

Please remember, when you fax a case for consultation, fax it to the BABO office, 410 252 1719 and **include your name, phone number and a time when we can reach you**. We are getting more and more cases for consultation, which is good, but we are wasting a lot of time playing phone tag. Our instructors really enjoy the consultations and helping you broaden your skills, but they would rather spend the time talking with you about the case instead of playing phone tag. Please help us help you by providing this necessary information.

If you have not given your e mail address to Theresa, please remember to do so as soon as possible. We will be using e mail to send out this newsletter and to notify you of any changes to the web site you should be aware of. Please either call or e mail Theresa with your e mail address. Theresa's e mail address is: 110240.254@compuserve.com.

We have had requests from several people about taking courses over after they have already been completed. We allow anyone who has completed a course to audit that course for a fee of $495, on a space available basis. If you would like to audit a course, just call Theresa and she can let you know if there is space available.

Theresa is trying to do a more thorough study of course evaluations. She is following up on some of the written evaluations with personal phone calls. Since she cannot call everyone, she is just calling a random sample. If there is something that you think she should know about your experience at a course, please call her to discuss this information. We cannot get better or correct problems unless we know about them. Our goal is to make our courses the best education available. We need your help in doing that.

In Europe the four BABO core courses are done over 9 three-day weekends instead of four and five-day total courses as we do them here in the US. This program has been very successful there. The BABO Board was wondering how you feel about this type of presentation here in the US. Please e mail or call Theresa with your feelings on this subject. Her e mail address is 110240.254@compuserve.com, phone 800 447 0370.

All people who attend BABO courses are extended a 15% discount at Bernell on all items coded with a B-C. There is a 5% discount on all other items except software. **When ordering this equipment, please use the code GE 201.**

Book Reviews

By: Paul A. Harris, O.D.

Touching the Rock – An Experience of Blindness. Hull, John M., Vintage Books, June 1992. ISBN 0-679-73547-X This was the incredible story of a man losing his sight over an extended period of time and describing in detail his personal experiences through each significant part of this time period. Early on he kept a diary, a log of all the events he considered critical. This was later edited and compiled into this fantastic voyage into darkness.

The book takes us from the summer of 1983 when Hull begin "sinking" into darkness, through the summer of 1986 when he touches the rock of absolute blindness. Oliver Sacks has written about blindness and about many other conditions, but he himself is not blind. Here the feelings, the emotions, and the insights into what vision means and what the loss of it over time means to this devout educator, husband, and father are vividly evoked. Hull's journey is very special and I suggest that each of you take the journey, even if only vicariously. It certainly caused me to stop and think many times and to try to imagine what he must have gone through. Here are few of his insights:

June 1983: "On the whole, my experience has been that, if I have a bad habit, it causes me some inconvenience of inefficiency in my movement, and is naturally corrected in the effort to move more freely. In other words, blindness itself imposes an iron law upon the user of the white cane. Lampposts, curbs, and stairways are the best teachers."

April 1984: In a section on time and space he states, "Perhaps all severe disabilities lead to a decrease in space and an increase in time. When I had sight, I would have worked with feverish haste, correcting forty footnotes in a single morning. Now I am happy if, with the help of a sighted reader, by the end of the morning I have corrected ten. Sighted people can bend time. For sighted people, time is sometimes slow and sometimes rapid. They can make up for being lazy by rushing later on. Modern technology seeks to expand human space and compress human time. The disabled person, on the other hand, finds that space is contracted and time is expanded. It is because of the space-time coordinates within which the blind person lives that his life becomes gradually different from the lives of sighted people."

In the same section, he talks of how sounds help him understand his world. "The acoustic world stays the same whichever way I turn my head. This is not true of the perceptible world. It changes as I turn my head. New things come into view. The view looking that way is quite different from the view looking this way. It is not like that with sound. New noises do not come to my attention as I turn my head around. The acoustic world is mainly independent of my movement. This heightens the sense of passivity. Acoustic space is a world of revelation."

July 1984: "When I am walking along this, my most familiar route, I have in my mind a screen with a sort of map of the area, and my own presence, like a pinpoint of light, moving along it. I continually refer to this to check up on my position. Here I am, coming along this portion of my route, having crossed the road, being about to cross that road, knowing that around the next corner there will be the traffic lights. I must never forget my position. That would be as if the light went out. I am continually verifying my position on this map by taking into account all sorts of little, familiar features. On this corner, the curb is slightly higher. The curvature of the footpath is slightly more pronounced at this point. The road surface here is not quite the same as it was there. Here comes that little smooth patch. There are certain points along my route where I actually have to count the steps in order to avoid the lampposts. All of this requires constant attention. If I

allow my concentration to lapse for a moment, I may get slightly out of position, I might walk into something, I might stray on to a busy road. I cannot do any of this and have a conversation at the same time."

September 1984: John is a father and has young children while becoming blind. Throughout he talks about the changes in how his children understand his blindness and how it affects their relationship. "Over this weekend, I have become sharply aware of how much sighted children live in a visual world. Their play, their humor, their dressing-up and their tumbling around, everything is in the context of sight. It is by way of contrast with this that I developed a sense that am not in the presence of these sighted children. I am, of course, an object in their visual field, but the world of common experience, the world which we know together, the world before which we stand in a sort of mutuality of presence, that is so fragmented by blindness."

Throughout he talks of what happens to stored visual images and visualizations when he encounters that person or place again. Until that time they are held as they were when sight was lost, but at the moment he encounters these people or places again the old image fades and is gone forever.

The book is a quick read, but for the reader who allows him or herself to become fully engaged, is very powerful.

Questions and Answers

By: Rob Lewis, O.D.

We recently had some questions about a two and a half-year-old with a turned eye. When I got the exam information, there was little near testing. When I asked the doctor about that, he said that he had only looked at how she saw at far and that it had not occurred to him to look at how the young person used her eyes up close.

It is funny how we always go back to our roots when confronted with something that looks scary. He was prescribing a near lens for her, yet did the entire exam at distance. The basic principle that a vision problem begins at near and spreads to distance was lost because of the scary looking turned eye.

The problem is still that of a young person who gave up centering to maintain identification and reduce confusion. Even a scary frightening thing like a cross-eyed toddler, is really just an essentially normal response to a problem that has been taken to an extreme.

There are two basic principles of vision that need to be taken into account with this patient. They are:

1. Vision problems begin at near and spread to distance.
2. Vision problems are the result of a normal visual process applied in an inefficient or inappropriate way.

There is a principle of therapy that also applies:

If you can find out why the person put the eyes there, you can show them how to put them where they need to be.

In almost all cases of convergent strabismus, the problem is identification. The young person chooses to maintain identification at the cost of centering. If an eye is turned out of the way, there is no conflicting image to process, but a great deal of the "where-is-it?" Information is lost.

If strabismus was an accommodative/convergence problem, the appropriate lenses would always work to "cure the turned eye". They don't. In most cases the use of the appropriate plus lens assists in reducing the reason for the turned eye, but it is rare for the lenses to effect an acceptable match between centering and identification. In fact, the use of maximum plus for full time wear can actually decrease the chances of the person ever learning to compute space in the same way using each eye.

When the maximum plus is prescribed for full time wear at near distances, the person will often become more farsighted in order to regain the habitual relationship between centering and identification. In those cases, all we have done with the plus lens is to shift the eyes towards alignment similar to the results expected with surgery. Sometimes we hit the home run (straight eyes) and with a little practice (VT 1) in using the eyes, the job is done, but in most cases we need an extensive program to help the person solve the problem of using two eyes together in order to develop a fully functioning visual system.

Consultation Corner

Lat month we had a case on which we asked for your response. Here are some responses:

Thanks to Dr Alan Sikes who responded to the case of the 7yr old in the last newsletter. He recommended visual hygiene, nutritional consultation and +0.37DS lenses. He chose that amount based upon the feeling that the +0.50 would blur the distance too much and that the +0.37 would give a “balance” at near. His clinical experience has shown him that if unembedded she would return in two months with 20/20 distance VA and improved near point findings. He would then use a plano/+0.75 “dual focus” lenses for long-term stabilization. He also interpreted his prescription options to be lens options only and stated he would “of course” offer VT if further workup showed it was needed. Thanks Alan. I hope I paraphrased your response accurately.

Response from Bob Hohendorf, O.D.

I think the history, acuities refraction and notations of which tests could not be done are big clues. The question asked was; is there something more I can do to try to help her or should I send her somewhere else? No prescription options were stated with the data and question.

The first question I would look at was; is she a myope? Unaided 20/40, Monocular refraction OD –0.25, OS plano? Retinoscopy OD +0.25, OS plano, Subjective OD –0.25, OS plano! In my way of looking she appears to have an accommodative problem probably secondary to an eye movement (fixation or saccadic fixation) problem if you look closely at her history.

The second question that begs attention was; does she have a vision related learning problem (VRLP) or a learning related vision problem (LRVP) or both? ASIDE: Paul Harris prefers to avoid the VRLP moniker for linguistic and political reasons. He and I agree we don’t train learning problems, we train vision problems. He believes VRLP doesn’t say that but LRVP does. Bob Kraskin, in LensPower in Action, states there are two kinds of vision problems. Developmental (don’t got it, never did) and stress induced (don’t got it because of an adaptation). I believe LRVP is Kraskin’s stress induced and Developmental problems are VRLP. For linguistics sake we will lose this differentiation if we only use LRVP. The only other alternative would be to find new terminology that works for both sides of the debate.

Now, back to the current case. Without performance testing or test data I can only speculate. With the information provided I could say we at least have a LRVP. My alternatives of care would be:

Compensatory: -0.25 Dioptor spheres OU Prognosis: progressive myopia

Lens Alternative: Plano sphere combined with a +0.75 add OU.
Prognosis: increased far visual acuity over time.
Partial compensation for an eye movement problem (due to stress relief and magnification), which may clear up her LRVP questions.
VT plus a lens alternative: Plano sphere combined with +0.75 add OU plus VT.
Prognosis: Normalize visual acuity and improve (sustain) academic Performance.

VT1 or VT2 is the only remaining question. King Devick Eye Movement, Grofman Visual Tracing, and/or Visagraph test results will be necessary to answer this question. These tests with and without low plus lenses may also be very revealing as to which treatment options I would favor.

Here's Another Case for Your Response

The Optometrist's question was: What are the lens alternatives I have?

Patient: Third grade 10-year-old male.

History: Diplopia at near, rubs eyes, eyes hurt, blinks excessively (and forcefully)
Current Medications: Adderol
Last visual exam: Two years ago
Medical: Eyes, family and current health negative for problems
Academic History: Likes to read, (but loses place) dislikes spelling
Findings: Visual Acuity: 20/25 - 2 OD, OS; unaided at far, 0.37m OD; OS at near (read slow skipped letters)
Cover: 15 P.D. Right exotropia at far
10 P.D. Right exotropia at near (occasional aligned appearance)
Motilities: Fair accuracy, mild head movement, no body movement, without limitations
Worth 4 dot: Far 5 Near 4 +/- 2.00: with +2 got 3, with -2 got 4 (repeatable)
Stereopsis: 0/10
Color: 7/8 OD& OS
Stress Point: +1.50
Ocular Health: Within Normal Limits
Retinoscopy (#4): - 0.25 OU Refraction OD -50, 20/25 OS pl 20/20
Phorias at far (#3) 12 exo (#8) 12 exo
Plano Control-equilibrium BO (#9#10) 24BO "it's moving" – no diplopia BI (#11) X/24/8
Fused cross cylinder at near (#14B) +0.75
Phoria through above: (#15B) 16 exo
Equilibrium: (through +0.75)(BO) (#16) 14BO it's moving – no diplopia (BI) (#17) X/34/16
Positive Relative Accommodation (#20) -0.25
Negative Relative Accommodation (#21) +1.50
Vertical Phorias: Far (#12) 2 Base Down OS
Near (#18) 2 Base Down OS
Poor response consistency for all phoropter testing

What would your recommendations be? E mail Theresa ***110240.254@compuserve.com.*** See Next Newsletter for our response.

Accommodation Anonymous

Presented by Robert Hohendorf, O.D.

In a BVC course in Grand Rapids, several O.D.'s from Indiana, South Carolina, and I developed a humorous reference to Alcoholics Anonymous we turned it to "Accommodation Anonymous". With some help and time, I developed an irreverent set of 12 steps. I hope this does not offend anyone who suffers from a physical addiction; it is meant solely as a spoof of many optometrist's thinking.

The 12 Steps

Step 1: We admitted that we were powerless over accommodative convergence thinking. That our professional judgment had overwhelmed our clinical observations.

Step 2: Come to believe that a model greater then accommodation/convergence could restore us to be more aware of the whole visual process.

Step 3: Made a decision to turn our practices and our thinking over to the care of spatial concepts as we understood them.

Step 4: Made a serious and open inventory of our testing and diagnostic protocols.

Step 5: Admitted to ourselves and to another optometrist the exact nature of our previous errors in thinking.

Step 6: Were entirely ready to remove all these limitations of past training.

Step 7: Humbly work to remove our shortcomings imposed by accommodative convergence thinking.

Step 8: Made a list of all the case types we had harmed, and becoming willing not to repeat these errors.

Steps 9: Made direct amends to such people wherever possible, except when to do so would injure them or others.

Step 10: Continued to take personal inventory and when we begin accommodative/ convergence thinking to promptly recognize it.

Step 11: Sought through seminars and reading to improve our conscious awareness of spatial thinking as we understand it, using our new knowledge for our patients and the management skills to carry that out.

Step 12: HAVING HAD A SPATIAL AWAKENING as the last of theses steps, we tried to carry this thinking to other optometrist's and to promote these principles in all our professional affairs.

Take Note – New Course

Essentials of Behavioral Vision Care is a BVC course for therapists and office staff. This course provides the basic theory and principles of behavioral vision care as well as the theory of how function can alter structure over time. Terms will be fully defined to include: embeddedness, prevention and stress, to name just a few. There will be an explanation of the analytical so that the therapists and staff members can see how their doctor gets information concerning the patient. There will also be a section on behavioral optics and the use of lenses. The development of refractive conditions including myopia, hyperopia and astigmatism will be covered. The therapists and staff members will be able to learn what an optometrist looks for during the evaluation and subsequent progress exams. This course will help therapists and staff communicate with their optometrist and help support his or her treatment plans for the patient. The Essentials Course will be held October 6-7, 2001 in Baltimore. This is the perfect course to train your front desk staff, as well as your therapy staff, so they will be better able to answer questions about your program.