

BABO NEWS

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Book Reviews

By: Paul A. Harris, O.D.

Endless Journey – A Head-Trauma Victim’s Remarkable Rehabilitation. Stumbo, Dr. Janet A., OEP Foundation 1998 ISBN 0-943599-26-1. This was one of those books that I had for at least two years before it came up on my to-read stack. It surfaced a few times and got put down to wait its turn. I am sorry now that I did not read it sooner.

It is a book written in the first person by Dr. Stumbo, a veterinarian who, while living in Australia, was involved in an accident that caused a severe head injury. The book takes you through her painstaking and often frustrating journey from doctor to doctor, through a divorce, through her many attempts to return to being a veterinary surgeon, to her finally deciding that maybe she should change and become a writer.

The role of vision therapy and her optometrists in her recovery is very prominent in the book. Dr. Stumbo worked with behavioral vision care optometrists in Australia and in two places in the United States. Many optometrists have been using books by Dave Cook with cases of learning related visual problems to help communicate what our profession has to offer. This book might be valuable to offer to the families of head-injured patients to help them be supportive of their loved one during the recovery period. I highly recommend this book.

Tool Box Analogy

By: Paul Harris, OD

For many years I have used the toolbox analogy as a way to share with others one way of viewing the relationship between the services offered by a behavioral vision care optometrist and education. I share the analogy here with the purpose of facilitating an understanding of how the services of both professions are needed in order to serve the needs of many of the children who are failing to perform in the educational system.

Imagine that we have delivered to a plot of land all of the necessary raw materials needed to build a house. Piles of wood, nails, screws, drywall, cinder blocks, plumbing supplies, electrical supplies, cabinets, doors, windows, roofing materials, etc. are all present in abundance. The child brings to that

work site each day their toolbox. The tools in that toolbox have been acquired over the years based on the life experiences that child has had. Some children enter the worksite with a rather complete set of tools to cover most needs, while others have only the essentials or may in fact be missing even a core or fundamental tool. Fundamental or required tools might be considered to be a hammer, a saw, a screwdriver or a tape measure.

In general, schools assume two things. The first is that most children enter with the set of tools that will carry them through their academic career and that the fundamental set of tools that a child brings to school is fairly set or immutable. The child is placed into a series of courses such as Carpentry 101, Plumbing 101, and Electrical Systems 101. In Carpentry 101 they may begin with the simple tasks of measuring and marking lumber to be cut to length, how to start, drive, and set a nail, and making a cross-cut saw cut safely, accurately, and square. To a child coming to the workplace with a basic framing hammer, a handheld crosscut saw, and a Stanley 25 foot tape measure these beginning classes may come rather easily. To a child missing one or more of these basic tools, failure to achieve basic “educational” goals may become evident rather early on.

Generally in the education system a child comes to the attention of their teacher before testing for a problem is initiated. To qualify for services their performance must have fallen a certain measurable amount. Many resourceful and smart children who are missing fundamental tools may find ways to get the job done although they are not using the proper tool. They might find a rock to use as a hammer or they might use a monkey wrench to hammer in the nails. The job gets done but it takes longer, the job isn't done as well and there may be some wear and tear on the child that would not have been present had the child used the proper tool for the job. However, the child, due to a lack of the appropriate developmental experiences is/was lacking the tool. This degree of compensating can often serve to mask the discovery of a missing fundamental tool for quite a while in a resourceful child.

Once the teacher realizes the child is having a problem, the school system will initiate a series of tests to identify the problems. Psychological educational testing often correctly identifies the general category of the problems, such as carpentry or plumbing but may fail to recognize that the lack of a tool may be the problem. Here is where a false assumption dooms the child to an intervention program that will actually work to embed the problem even more. How?

A hammerless child is labeled as “hammerless” or “hammer compromised”. The system then looks for special education materials that have been shown to be able to be mastered by those without hammers. The idea has been that the child who does not have a hammer should not be penalized for not having a hammer and we should not ask them to do things that require hammers. Therefore a program has been conceived and produced in, for and by the school, which addresses hammerless children's needs.

The hammerless child will be given activities which will not require them to use a hammer. Either they will now use screws and screw guns for everything or they will switch to learning to assemble prefab home kits. The child will advance through the rest of their courses but a fundamental tool and basic skill necessary to nearly any home building project will be missing, the ability to use a hammer. The false assumption was that once hammerless, forever hammerless.

The education system is not in the business of tools. They are in the business of tool usage. “Missing tool? Oh well you'll just have to learn to accept your hammerless condition and arrange things differently so that you don't encounter hammering demands in school life.” Real life then becomes another matter.

The key factor in behavioral vision care is that our assumption is that the presence of a missing tool is only evidence of not having had the appropriate meaningful experience to have developed or acquired that tool. We are in the business of identifying the missing tools and then putting together treatment protocol.. The purpose of which is to provide the child with the necessary meaningful experiences to acquire the tool.

In essence, we take the child shopping. We know that hardware stores exist. We know the fundamental classes of tools. We know the order which people generally acquire tools. One would not start their saw collection with learning how to use a coping saw or a compound miter saw. One starts with a handheld crosscut saw and learns by cutting basic lumber to length. A rip saw may follow. Then a circular saw, jig saw, table saw, band saw, coping saw etc. each experience being built on the prior knowledge base all which came from the handheld crosscut saw. This process of tool acquisition and attaining fundamental competence in the use of the skill is the domain of optometric behavioral vision care. We turn over to the school system a child who now possesses the correct array of tools to perform the tasks required of them. When the school system moves on to fundamentals of balloon framing houses or the proper method of trussing up a floor the child will have the tools necessary to execute the demands of the class, understand the concepts, and to use the proper tools for the proper job.

Behavioral vision care optometrists do not teach carpentry, plumbing, or wiring. Behavioral vision care optometrists do not teach reading, writing or mathematics. Behavioral vision care optometrists do identify missing tools and take the child shopping to acquire and gain competency with the new tools. Then, and only then, will the school system find a child who is ready to be taught using conventional methods and who will achieve in a variety of educational settings and following a variety of teaching methods.

Treasures From the Vault

This is the first month for “Treasures From the Vault” where we will drag out *oldies but goodies* from past newsletters that are as important now as when they were first printed. From the August 2000 BABO Newsletter comes this treasure:

By: Robin Lewis, OD

Once a patient elects vision therapy as his treatment option, the optometrist will select the BABO curriculum tailored to that patient’s needs. The curriculum selection is based on the results of the performance testing that each prospective vision therapy patient should be doing. Amblyopia, the type of strabismus, and difficulty on the performance testing are keys to the curriculum selection.

VT-1 is designed for those patients who have difficulty with tracking and locating, focusing, and computing space. These patients have sometimes been referred to as “skills cases”. If a patient has the above mentioned problems, has healthy eyes and associated tissues, does well on the performance testing, and does not have amblyopia or strabismus, he or she belongs in VT-1.

VT-2 is a specialized curriculum designed to develop vision in areas most critical for those patients where specific vision problems are interfering with the learning process. This is based on the results of performance testing. For example, a patient who has difficulties with the King-Devic Saccadic Test or the Wold Sentence Copy Test would be more likely to be in curriculum 2 than in curriculum 1.

VT-3 is a specialized curriculum that is designed to eliminate strabismus and amblyopia. If the patient does not have amblyopia and the eyes are aligned most of the time, the patient does not belong in VT-3. If the patient requires vision therapy, and does not have a learning related visual problem, then the intermittent strabismic gets VT-1 and her eyes are trained while they are straight.

In some cases, patients will present with both academically related vision difficulties and amblyopia or strabismus. In those cases either curriculum 2 or 3 can apply, based on the desires of the patient and family. In many cases, the strabismus will be improved or eliminated during the VT-2 program and since most people want improved performance in school first, VT-2 is often done prior to shifting attention to working on the strabismus.

If in doubt about a particular case, write the case up and fax it to us at 1-410-252-1719 for a case consultation with a BABO instructor.

“How To” Using BABO Case Consults; Putting the BABO/OEP courses into action

By: Paul Harris

In the beginning, each of the four core BABO courses was five days in length. Over time material was realigned and the VT-2 and VT-3 courses were streamlined down to the current 4-day length. We recognize a delicate balance between factors such as time out of the office to take the courses, the amount of material to be presented, the amount of supporting research and theory, the amount of practical hands-on in the diagnostic and treatment portions of the course, and the amount of practice needed to really own or embed the new concepts, ideas, and procedures.

The ideal teaching situation would be to work in very small groups over an extended period of time with alternating periods of didactic sessions interspersed with supervised time working with real live patients. Since for most people spending extended periods of time out of their offices is just not possible, what we have done is to fill the course times with massive amounts of knowledge and information as well as a map and a plan for what to strive for in terms of the testing and treatment protocols used in the office. In many case it will take many repetitions until you feel comfortable with doing a procedure as proscribed or actually getting to the point where you stop thinking about the mechanics of the procedure and get to observe fully the behaviors displayed by your patients.

When looking over post-course evaluations we often see comments like: “We need more case examples” or “We need more hands-on time to work with the procedures.” In an ideal circumstance we would be able to satisfy both of these needs. However, I am reminded here of the quote, which I will paraphrase, by the late Bruce Wolff, OD. He stated: For the person who is asking for theory they need to work with patients and get hands-on clinical experience, and for the person asking for procedures, or a cook book, they need theory. His point was that as we come into a field we generally seem to be asking for exactly the opposite of what is needed at the time.

You might be saying, “OK, I get the point, but I still feel lost and feel like I don’t know how to put this all together. How do I get going when it all seems like such a jumble?” The answer: CASE CONSULTS!

Some have said that they don’t even know what to begin to ask. Well, here then is a bit on how to use case consults to implement the knowledge base you have invested in by taking the BABO/OEP courses.

Each of you will come to The Art and Science of Optometry Care – A Behavioral Perspective (BVC) with a routine that, depending on how long you have been out of school, you will have been doing for a while and have probably grown comfortable with. The first step is to begin collecting data in a similar fashion as to how it was demonstrated and talked about in the BVC course. Two of the five days of that course your instructor goes step-by-step through each element of the testing sequence, from the case history through the chair tests through the analytical.

At this point you may have the data in the new form but not yet feel confident in the validity of the numbers you have written down. A good example is a test that is new for many stress point retinoscopy. It may take 50 patients before you feel you have confidence in the validity of your findings on this test. So now you have a new set of numbers taken in a different routine in which you have a degree of uncertainty.

Case Consult to the Rescue

Now is the time for a consult. Get the data onto the BABO exam form and fax the form to us at 1-410-252-1719. Be sure to put your name and office phone number on it, as well as when you will be in the office. Please instruct your staff that a BABO/OEP instructor will be calling and we ask that you take our call rather than starting phone tag. If you are with a patient, let us know at the beginning of the call and if we feel there is a lot to go through, we will schedule a time for an extended conversation.

We will then go through the data, helping you understand the relationship between the data and the patient and their behaviors. Often we will ask some questions that will help us get a sense of the degree to which you have integrated the information from the course. At times we may recommend some readings or suggest we do a follow-up call to get more in depth in some areas. Many times as we begin a sentence about something over the phone we can hear the Ah-Ha go off, signaling the crystallization of a fundamental understanding of some course material. Often, until you have a real live case that is your own that you have tried to look at in this new way, it won't click fully until our phone call. This is what we, the instructors, live for; to facilitate and experience that Ah-Ha with you.

We have witnessed meeting after meeting where cases are presented; 45 to 60 minutes of data is presented. Finally they get to discuss the ins and outs of the case and now the data is down and it's too hard to integrate because there isn't a real person there. When you have a real person that is your patient asking you for help, you invest much more into understanding who they are and what makes them tick. With your data in front of us, we will walk you through, step-by-step, the types of questions and thinking we would use with the same patient. You will walk away with a much greater appreciation for the massive amount of content you were exposed to in the courses and will be aided in moving through the full integration of that knowledge into working with your patients.

On the backside of the exam form there are three sections for writing down each of three treatment options. We would like you to take a stab at writing in a lens formula that would correspond to each approach to caring for your patient. Below each lens formula write out what you think will be the consequence of the patient selecting that option. This will help the instructor who calls you to get a sense of your thinking about the case.

Generally, we expect several cases to come in from each attendee the first week after taking the BVC course. Over time the numbers of calls and the type of calls changes. After a few months you will send in an occasional case with the alternatives all thought out and filled in on the exam form and we will

often call and give you positive feedback that the plans you have are on target. At this point you will know that you will have turned the corner from cook to chef!

Theresa assigns instructors to the case consults so the work load is spread evenly. Even if you develop a preference for working with one instructor, it is to your advantage to work with each of them as the differences in style and presentation between the instructors will tend to illuminate the issues from a broader perspective. Make sure you fax or mail your case consults to Theresa. E-mail cases are harder to deal with because we have become accustomed to looking over the record card where everything is in its place. There is a pattern that appears out of the constellation of data that is harder for us to see if the data is presented in a form with which we are less familiar.

Using the BABO/OEP case consult is the main method whereby many put the information and knowledge they obtained in the courses into action. Don't be shy! Remember, the only dumb question is the question you don't ask!

Consultation Conner

By Robert Hobendorf, O.D.

Patient: AJT **DOB:** 4/93 (Age 8yr 9mos, male) **Occupation:** 3rd grade student + kiddo

Chief Complaint: 1) failed school screening (3 months ago)
2) Blur at far
3) Headaches – Later in the day after bookwork

Maternal comments via case history: (Mom is a teacher)

- 1) Notes tracking problems with reading
- 2) Problems with expressive written work
- 3) Unusually verbally strong at 18 months
- 4) at age 5
Frequent ear infections Right handed, left footed
- 5) Medical history of tonsillectomy age 2-age 5
- 6) Negative allergies and current meds
- 7) Familial eye history: both parents and 2
of 3 siblings myopic

Referral data from another OD:

- 1) Lives one and one half hour from office
- 2) Eye history—first exam 1 month ago, no previous glasses
- 3) Unaided visual acuity OD,OS,OU 20/30 at far
- 4) Refraction OD $-0.25-0.50 \times 180$, OS $-0.25-0.50 \times 180$
Visual Acuity OD and OS 20/25
- 5) Binocular Cross Cylinder: $+0.75-0.50 \times 180$
- 6) Stereopsis: 4 of 9
- 7) Cover test: Far-Orthophoria, Near-Esophoria
- 8) **Internal and external health:** Within normal limits
IOP 12 OU, 0.2 Cup to disc ratio
clear macula with crisp foveal reflexes

CURRENT EXAM

Chairside Tests and History:

- 1) Likes math, does not dislike any school subjects,
Spelling OK (accelerated class), Writing OK (but not great),
Free time: Basketball, Soccer
- 2) Unaided **Visual acuity:** Far OD 20/40, OS 20/60(-2+2), OU 20/25-3
Near: 20/40+1 OD,OS,OU
- 3) **Cover test:** Far-low Exophoria (<4 PD)
Near-moderately low exophoria (6-10PD)
- 4) **Motilities:** No head or body movement, no limitations
Rated as very to excellent (4.5/5)
- 5) **CNP:** To nose
- 6) **Stereopsis:** 1/5, 0/3, 0/8 Alternate Suppression elicited
- 7) **Developmental eye movement test (DEM)**
Vertical score 4th percentile for age 8
Horizontal score 5th percentile for age 8
Accuracy score 20th percentile for age 8
Ratio 16th percentile for age 8
Diagnosis Automaticity and Oculomotor dysfunction

#7 Subjective OD -0.25 sph
OS -0.25 sph
OU 20/30-3

#7A Largest OD -0.75 sph
OS -0.75 sph

#8 dist phoria through plano: 2 exo

Control Indicator : plano

#9/10 x/19/1 **S I L O**

#11 x/7/1

#13B Near Phoria 7 eso (+1=3 exo)

NEAR CONTROL: +1.00

#14A Unfused Cross Cylinder: OD +2.25 sph **G**
OS +1.50 sph **G**
13 exo touch to fuse

#14B Fused Cross Cylinder: OD +1.75 **G**
OS +1.50 **G**

#15B Phoria with 14B: 5 1/2 exo

#16 Near Equilibrium: x/14/5 **S I L O**

#17 x/14/12

#21 PRA/NRA: -3.25 (20/30 letters) **A**
+2.75 (20/30 letters) **A**

What would you recommend? Don't forget use 3 alternatives of care

Forward your comments to BABO, e mail TheresaBABO.OEP@verizon.net, or fax to 410 252 1719.

Mind Candy

Why Add Vision Therapy to an Existing Practice

By: Rob Lewis, O.D.

There are two main reasons why adding vision therapy to a practice is a sound idea. Whether one is more important than the other depends on the outlook of the particular practitioner.

Having therapy as a part of your practice gives a substantial opportunity to meet the needs of patients that might not otherwise be met. The more therapeutic options one has as a doctor, the happier you and your patients can be. This leads to a greater professional satisfaction and a more fulfilling life. I am deeply gratified when I can prevent the trauma of strabismus surgery and assure a better visual result at reduced cost for my patients who are amblyopic or strabismic.

Early on in my career as an optometrist a young woman in her twenties came into my office. She was wearing crooked, pink glasses and her right eye was pointed at her nose. She had moderately high hyperopia, amblyopia, and strabismus even with her glasses in place. At that time our contact lens options were much more limited than they are now. I asked her why she hadn't worn contact lenses and with tears in her eyes she told me that no one would let her. She had asked a number of doctors and no one was interested in helping her. We fit her with +7.00 gas permeable lenses, and she became a different person. People at her work asked who the "new girl" was. After a few sessions of therapy, her eyes were straight and now, fifteen years later, she has essentially normal binocular vision.

Our patients often write success stories describing the positive results of vision therapy for themselves and their family. My personal favorite is when a young person, who originally came in for a learning related vision problem, talks about now enjoying participating in sports for the first time. The grades are good and the young person is having a positive experience in the classroom, maybe for the first time ever; but this is in second place when compared to the simple experience of playing catch with his dad.

Another reason to have therapy as a part of the practice is that therapy provides a substantial income base for the practice. For every ten patients enrolled in therapy, your practice stands to realize about \$3000 profit per month. In our practice, each therapy patient is seen four times per month for six to nine months. During the days following September 11, the number of exam visits we saw dropped. Our therapy patients kept our practice stable and helped us be assured of a paycheck.

In addition, therapy referrals bring in additional examinations and often you will see a whole family rather than only the big sister who has already become a myope because the parents realize the role of prevention in vision care. Parents also appreciate our focus on performance in the classroom and sports rather than an emphasis solely on visual clarity.

The bottom line is that a practice that adopts the behavioral perspective of vision care is more valuable, both in terms of income and in terms of service to the community.