

Harmonious Correspondence

Really “Seeing” Vision Therapy Work

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As I began my fourth year at the Illinois College of Optometry (ICO), I was excited to finally begin working in the specialty areas of optometry and expand my clinical experience beyond the primary care examination. I was especially excited to start working with children and begin my pediatric/binocular vision rotation. I wanted to finally use the concepts of vision therapy that I had learned in my courses and to discover how they work in the real world. As students, we read many cases involving conditions such as Convergence Insufficiency or Accommodative Insufficiency and are told how these diagnoses can be overcome through the practice of vision therapy. Finally, as a fourth year student, I would be able to really see optometric vision therapy work with my own eyes and not just through reading about it in class.

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At ICO we are required to complete four externship rotations for a three month time period in our last year. Each rotation specializes in a different area of optometry and allows you a short ten week glimpse of that specialty area. As I began to start doing therapy on patients in my pediatric/binocular vision rotation, I soon found out that ten weeks was not always enough time to see the resolution of the patient's visual problems. It became frustrating to work with patients week in and week out, only to find that they had progressed but one diopter of minus on their amplitudes of accommodation or only pulled that Brock string in 5 cm more than the week before. Of course, so much of the quicker success stories were seen by clinicians who had patients who were compliant with their home VT and didn't just work on in office therapy once a week. These patients were also the ones who were on time and never missed an appointment. In my somewhat limited experience, not every case was that easy and I really had to find ways to motivate my patients. It became important for me to use my creative side to come up with therapies that were not as conventional, but motivated and excited my patient to a higher level. One of the things I learned in doing therapy, is that it is just as important to get the patient motivated to work as it is to actually see the progress.

I soon discovered that for therapy to be effective you need to conduct a complete review of what has occurred prior to you assuming the care of the patient. As incoming therapists we need to become familiar with our patient's case before diving into a therapy program. By doing this, we can determine what has worked for that patient and what has not. The top questions that need to be answered while reviewing a file are;

- What are our patient's favorite optometric vision therapy procedures?
- What procedures the patients are not particularly fond of?
- Where did they start at the time of diagnosis?
- How far have they come to reaching their goal at the point we are taking over?
- What activities are they going to do when we are not there to coach them through a therapy session?

Finding answers to these questions is critical to actually seeing the success of vision therapy.

A particular patient that I had seen was a great example of success... but only if you took the time to look back at where they started. The patient was a nine year old refractive amblyope that began with visual acuities of only 20/200 in the amblyopic eye. She was lucky to have central fixation and an ortho posture. She had been seen at the clinic for a few years and was, on

average, consistent in coming to her appointments and working at home on her therapy. She had been seen by a number of student clinicians, each taking over from where the last one ended. When I took over the case, she had just taken a break from therapy due to frustration in not achieving “perfect” 20/20 vision and was apprehensive about coming back for more. I was given the challenge of keeping her motivated and changing the therapy from what had been done before my arrival.

Our first session was a challenge. She was very frustrated and didn’t want to be there. When things became difficult for her she would often cry to try to get out of the therapy. If her visual acuities were taken, she would memorize the lines to try to trick me into thinking she was improving. I began to change her therapy and started having her do some new interactive procedures that she enjoyed and even wanted to be challenged by. I made sure that she brought in a record of her home VT to keep track of her efforts. Right in front of my eyes, she perked up at the new therapy procedures and actually enjoyed the struggle of learning new therapy routines. She regained the 20/50 VA that she had had prior to

her break. To my knowledge, she is still working at that level but now with a different attitude.

If I had looked at this case as a 20/50 amblyope that when I left was still the same VA I would have thought VT did not work. However, once I looked at where she came from many years before and looked at where her attitude was before the ten weeks, I was able to see the change. To me this was success. I never personally saw an improvement in the line of Snellen VA, but would not be surprised if by now she is able to gain that goal of 20/40 or better. Her next therapist may look at her possible improvement to 20/40 with a somewhat jaded appreciation of VT had previously accomplished if they do not take the time to review where she started and how much effort she has given to be at the level she is today. For this reason, I did see VT work before my eyes, but not in the way I thought I would. As students and therapists we need to remember to always look at the whole picture that each individual patient presents and to remember that success is not always seeing 20/20 but much, much more.

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