BABO NEWS

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Mind Candy

By: Robin Lewis, O.D.

In the first VT course we discuss the difference between Piaget's concepts of low level learning, high level learning and development. Low level learning is the improper use of a prior strategy to solve a problem. In many cases the low level solution will seem like the easiest, but almost always is really more difficult than a more appropriate scheme. A good example of low level learning in the therapy room is when a young person tries to memorize the Hart charts instead of just reading them. It is easier to just look at the chart than it is to memorize it, but the more difficult strategy is chosen because the young patient has more skill at memorizing the charts than looking at the charts and has not yet discovered the easier way.

High level learning is the appropriate use of an existing scheme to meet a challenge or solve a problem. A good example is writing. Most of us first learn to write with a pencil or marker to put our ideas on paper. Later we learn to use a pen and may learn to use a computer to record our ideas. The process is essentially the same, but we can use any number of ways to record our ideas after selecting the most appropriate available tool.

Development is when we are able to have the Ah Ha! We have a new realization or see a new way to do things. Development is when it all comes together. When vision therapy is at it's best there is a constant parade of Ah Ha's!. This happens because the therapist arranges conditions where the patient is safe and can have the necessary and meaningful experiences for change to take place and vision to develop.

Now comes a critical point. I have noticed there is a tendency of both doctors and therapists to want to "understand" a technique before they experience it fully. The catch is that to understand a therapy technique anyone must first experience it and make it their own. The intellectualization of the technique before the experience is a form of low level learning very similar to memorizing the letters on the Hart charts. Full understanding of any therapy technique comes only from full participation. See it first, than learn the mechanics.

There is also a natural human tendency to shy away from those techniques that are more difficult or affect an area of performance where the therapist is less able. This means that it is much more difficult for a therapist to help a patient in areas of development that are incomplete for the therapist. In fact, it is possible for the therapist to be fooled into thinking the patient has a good grasp and understanding of an aspect of visual performance when this is not true; thus missing out on a critical skill that later visual proficiency depends on.

A very important part of providing consistent high level therapy is "owning" the technique. This means making it your own by fully experiencing it with your own vision. Remember, you can't sell what you don't own.

Book Reviews

By: Robert A. Hohendorf

The Pro's Edge. Dr. Lawrence D. Lampert, published by Saturn press 1998

This is the best specialty sports vision book I have read to date. It is practical, comprehensive and for me a logical approach to a game I enjoy.

Dr. Lampert starts by saying "In golf there is not a lot of movement going on but the game is very visual". He covers the basics of alignment (where am I), visual imagery (motor planning), to targeting (where is it), to judging distance (spatial), and being in the zone without self talk (speech auditory).

He uses eye aiming, head movement effects on judgments, bead jumping, bug on a string, CP saccades, stick in a straw, relaxation, & visualization techniques. He leads the reader in developing consistent practice routines.

I found the best tip for me to be in putting. I've always visualized the line I want so the putt goes into the hole. He takes it one step further to help with distance and the time it takes for the putt to go into the hole. He has you trace the line your putt will go at the speed you expect it to move with your eyes. He suggests you retrace your eyes along the path and at the speed you expect it to move until confident. Using bug on a string technique, so to speak. What a great way to not only stay in line but finish near or in the hole using the **feel** of your eye movement.

The only weak spots are his discussions of spatial effects of phoria's and his simplistic (optical only) look at myopia, hyperopia, and astigmatism.

I highly recommend this book to any of you who golf or for your golfing patients.

By: Paul Harris, O.D.

How to Speak How to Listen. Mortimer J. Adler, A Touchstone Book by Simon and Schuster, 1983 ISBN: 0-684-84647-0.

I found this book to be an excellent next step after his work "How to Read a Book", about which I did a paper a few years ago. This book builds on the earlier work and expands many of the author's concepts about reading to speaking and listening. Speaking and listening can occur between two people or you and groups of all sizes. The art of listening is taken for granted in our society but so much of what we learn about and what we want our patients to learn about comes via the auditory channel.

This book includes many guidelines for improving your abilities in both the areas of listening and speaking. The following are some of the quotes that I felt were particularly significant:

In the section on the "sales talk" he describes three parts to persuasion – *ethos, pathos,* and *logos*. In the first stage, *ethos,* you establish your credibility as a speaker. "You can do it by telling stories about yourself, the effectiveness of which will be heightened if they provoke laughter and the laughter is about you. You can do it more indirectly by underestimating your credentials to speak about the matter at hand, thus allowing the listeners to dismiss your underestimation as undue modesty. You can also do it by suggesting your association with others whom you praise for certain qualities that you hope your listeners will also attribute to you." This is part of what I have called "establishing the legend of who you are". This needs to be done in every situation where you are attempting to persuade another.

In the second step, *pathos,* you, "arouse the passions of the listeners, getting their emotions running in the direction of the action to be taken. *Pathos* is the motivating factor." To be effective in the use of *pathos* you, "must recognize those human desires that they can depend upon as being present and actively motivating forces in almost all human beings – the desire for liberty, for justice, for peace, for pleasure, for worldly goods, for honor, good repute, position, or preference." "Persuaders cannot always count on desires that are generally prevalent in their audiences and ready to be brought into play. Sometimes people have needs or wants that are dormant, needs or wants of which they are not fully aware. These, persuaders must try to awaken and vitalize."

In the margin I wrote, "Do you want your child to be better?" I can recall in particular two instances over the years where the answer to this question was not evident to me. Having a child with a problem was what was defining these particular parents or families. It was a rallying point. The families were being held together by this issue and without it what would these families become? I cannot recall now if I ever asked the question aloud directly but reading this section of the book definitely reminded me of these two cases.

Logos – the marshalling of reasons – comes last. "Reasons and arguments may be used to reinforce the drive of the passions, but reasons and arguments will have no force at all unless your listeners are already disposed emotionally to move in the direction that your reason and arguments try to justify."

In the section on "Uninterrupted Speech" Adler states, "A good lecturer, in short, must have some of the gifts of a good actor. Each time the curtain goes up, no matter how many times it has gone up before for the lecturer, it should always seem like a new performance for the audience. Their sense of novelty should be heightened by the sense that the speaker is discovering for the first time the truths he is expounding. The skill of the lecturer in dramatizing the moments of discovery will draw listeners into the activity of discovering the truths to be learned." When I read this, I felt Adler was talking directly to me. It may be my music background but I certainly see that each time I get up in front of a group, I love the feelings of telling a story and unraveling for them, as if it were the first time, just how I came to see the shred of knowledge about which I am speaking.

Adler continues, "The speaker should be able to make a fairly shrewd guess concerning the general character of the views about the subject chosen that are likely to be prevalent among the listeners. To persuade listeners to change their minds by adopting views contrary to ones they have persistently and, perhaps, obstinately held, it is necessary to undermine their prejudices in a manner that is as firm as it is gentle. Long-standing prejudices are barriers to persuasion. They must be removed before positive persuasion can begin. Removing them opens the mind and renders it receptive to views of a contrary tenor." This is so essential in the case presentation. Find out where your audience is. What are their mental models? What do they think can and should be done? This tells you where you need to begin, by undermining these preconceived beliefs. Therefore, no two case presentations can ever be exactly the same.

Later on Adler states, "Always risk talking over their heads! By the emotional fervor of your speech, by its physical energy and your manifest bodily involvement with materials that are obviously abstract, you should be able to get them to stretch their minds and reach up for insights they did not have before."

In a section entitled "With the Mind's Ear" he states, "Listening is primarily an activity of the mind, not of the ear or the eye. When the mind is not actively involved in the process, it should be called hearing, not listening; seeing, not reading."

There is much more in this work about how to listen, how to take notes, and how to communicate in other varied situations. I highly recommend this book.

Questions and Answers

1. *Can the distance Worth 4-dot be done with the small, hand-held, "flashlight" that is used for the near test, or is it necessary to have the larger wall model such as you have?*

You can use a hand held. The problem is that as you get it further and further away the dots become so small that it may be hard for someone to really see if they have doubled or not. I would recommend the wall unit. However, some projector charts have the distance 4 dot built in. You might want to check that out as well.

2. *I have a fair amount of confusion regarding stress-point retinoscopy! I have listened to the tape and it doesn't get any clearer! Here is my current technique…please advise on whether I am close or not. I set up to the patient with my spot retinoscope at the patient's Harmon distance (which you will recall is essentially the same as the "Myers distance" of ½ arms length). I hold in my other hand the Wolff Wand at 4 inches from the retinoscope. I have the patient hold the lens flippers over their eyes—beginning with the +0.50 and then continue to up the lens power they are looking through until I note a dimming of the retinal reflex.*

   First, am I doing the procedure correctly, and second, which number should be recorded as the finding—the last one to give a bright reflex, or the first one to give the dull reflex?

No! The Wolff wand should start AT the retinoscope. The goal is to see if you can move it from the retinoscope in 4 inches and still have the reflex remain bright. You should not start the target there. I always begin with no lenses at all. I then make a judgment and begin with a lens near where I think the stress point will reveal itself. In the beginning I suggest going very high in plus (+3.00) to see that persons' dark and then work up and down (+0.75 /+ 2.50 / +1.25 / +2.00 …. Etc.) until you bracket the stress point.

3. *The #7 finding (I scare myself trying to use these OEP numbers…but believe it or not, I'm getting more comfortable with them!)—You say that we want the most plus or least minus to get 20/20, or maximum acuity. Is this the point at which the patient reads "all" of the letters, half of the letters, one of the letters…at what point as I am bringing them down do I say, here is my #7?*

All of the letters with ease but with least minus or most plus.

4. *The #7A—you say we want the "Largest" lens…I have found that this is confusing to patients. I understand that we want the lens which gives them maximum acuity without over minusing (under-plussing them), but I find when I ask patients to "tell me through which lens the letters appear the largest", they either say—"What?" or many patients say they all seem the same (no change in size)—how do you word this so that it is not as confusing yet gets the information you are after?*

If they see no size change and do not spontaneously report any other significant change then there is no 7A and I use the 7 as my endpoint. I cannot say that the "largest" lens is a maximum acuity lens without over minusing. Stay with it and don't worry about getting a 7A. I would say that on clearly one-half of the patients I see I only get a 7.

Consultation Corner

Patient: 7 year old female. 1st grader

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.

History: Failed Pediatric screening
Teacher has her moved closer to the board due to slowness in completing work

Mother states: A) Vertical columns no trouble, horizontal stumbles on words
does better with a straight edge for support
B) Hunching over reading material with increased reading time

Patient states: She loves to read

She is an A,B student up to now

Findings: Visual Acuity: OD 20/40 OS 20/40 OU 20/30 at far
JI OD,OS, OU at near
Cover: Far= ortho Near= 5 exophoria
Motilities: no limitations, head or body movement noted, accuracy excellent
Near Point of Convergence: ½ inch, Diplopia reported
Worth 4 dot at near 4, $\pm$ 2.00 also 4
Color Vision: 12/14 OD,OS
Stereopsis: 25 arc sec
Stress Point: +0.50
Retinoscopy OD +0.25 OS pl
Subjective (7) OD –0.25 20/25 OS pl 20/25
(7A): same
Phoria at far (8): 2BI
Phoria at near (13B) 4BI (pl control)
Cross cylinder (14A) no reliable responses – monocular or binocular
Positive Relative Accommodation (20) -2.25
Negative Relative Accommodation (21) +2.00

SEE NEXT NEWSLETTER IN APRIL FOR OUR PRESCRIPTION