

EFFECTIVENESS of VISION THERAPY

AS INFLUENCED BY THE DELIVERY MODE

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Abstract

There are two methods to deliver vision therapy: clinic/office based (CBVT) and home based (HBVT). There is little research comparing the effectiveness of each mode. The files of 50 CBVT and 50 HBVT patients in an Australian private practice were sequentially and retrospectively evaluated along several variables. All patients had completed the vision therapy treatment plan or self-discharged. The purpose was to compare the effectiveness of the two modes of treatment. The results indicate that CBVT produced more successful results, and in a shorter time period.

Key Words

clinic/office based vision therapy (CBVT), compliance, home assistant, home based vision therapy (HBVT), home therapist, train the trainer, vision therapy

INTRODUCTION

The goal of optometric vision therapy (VT) is to develop visual abilities so that the patient can meet the visual demands of variable and complex situations with greater efficiency, endurance and economy of effort. The treatment plan is directed at rehabilitation and enhancement of diagnosed visual inefficiencies. It incorporates activities that seek to ensure the transfer of the enhanced visual abilities into areas of special importance to the patient; be it during learning, earning or play.¹ Although most VT treatment plans are primarily conducted in an optometric office or clinic, there is the option of a system that is primarily conducted in the patient's home.

MODES OF VT DELIVERY CARE Clinic/office based vision therapy (CBVT)

In this system, the major aspects of therapy are primarily delivered in an optometric clinic or office by a trained staff of vision therapists, who act under the supervision and guidance of the optometrist. The optometrist develops a treatment plan with accompanying VT procedures that are applied during a consecutive series of in-office sessions. These sessions are supplemented by planned and supervised home practice sessions, aided by a designated home assistant. The basics of CBVT in my practice are summarized in Appendix A.

Home based vision therapy (HBVT)

The essence of this system is the delegation of VT delivery to a home therapist (usually a parent). The optometrist develops the treatment plan, selects appropriate

procedures, demonstrates and discusses each of the procedures with the child and the home therapist. This is done after the initial VT evaluation and after all succeeding office visits. The office visits are planned to occur at four to five week intervals. The implementation of the therapy then becomes the responsibility of the home therapist. Consequently, the optometrist and vision therapist do not directly supervise or modulate the child's performance.

The optometrist is now mostly dependent on written communication from the daily diary kept by the home therapist. The essentials of HBVT as practiced in my office are summarized in Appendix B.

LITERATURE OVERVIEW

Current opinion, as expressed in a number of optometric VT texts, indicates that CBVT is the delivery mode of choice.²⁻⁹ Additionally, the joint organizational policy statement by the College of Optometrists in Vision Development reflects the choice of CBVT as the treatment modality for VT delivery by most specialist vision therapy practices.¹⁰ One text,¹¹ written for primary care optometrists without facilities for CBVT, details an HBVT management approach for a variety of visual conditions. However, no data regarding the effectiveness of the approach was provided.

In a recent paper which surveyed the treatment modalities used for convergence insufficiency, Scheiman et al¹² noted that many articles indicated that CBVT was an effective treatment modality, he was unable to find reports on the outcomes of HBVT. However there was one pilot study on pencil push-up training