

# EDITORIAL

## *A Rationale and Clinical Model for Collaboration Between Optometry and Occupational Therapy*

Over the past several years there has been a significant increase in the management of common patients by occupational therapists (OT) and optometrists (OD). These patients are principally from one of several populations: the developmentally-disabled, learning-disabled, and traumatic brain-injured. While there had been some degree of clinical interaction between the two professions for at least the past decade, it appears that a certain "critical mass" has more recently been reached. This has been particularly evident by a number of symposia where the speakers and audiences were comprised of members of both professions and at least several articles.<sup>1-4</sup>

These interactions have been almost exclusively between those OTs who are adherents of the Sensory Integration model of Ayres<sup>5</sup> and ODs who practice according to the Behavioral Optometry model first espoused by Skeffington and Associates<sup>6</sup> and later elaborated principally by Getman.<sup>7</sup>

A study of these paradigms and their consequent elaborations goes far to explain why some OTs and ODs increasingly depend on each other in the interest of optimal patient care. One is struck by the overall similarities of these two models.

They both recognize the importance of infancy as a time when the individual utilizes tactile, proprioceptive, kinesthetic, visual and vestibular information to develop a sense of self, or stated differently, an internal space. The purpose of this initial component of development is to serve as an anchor or base point for the construction of a primarily visual world, or external space. Clinically, this mandates evaluation of the intactness and integrity, in developmental terms, of both the motor and visual systems. Early childhood is viewed as a time for the further development and elaboration of this

visual spatial world, and each model emphasizes the neurological connections, particularly between the vestibular and visual systems, during this period. Clinical evaluation during this time primarily encompasses assessment of balance, posture, motor planning ability and investigation of the basic integrity of the oculomotor, accommodative and vergence visual subsystems. Each model recognizes the early school years as a time when this external space is still further elaborated, but most particularly in terms of the more specialized, cognitively-based near visual space. The neurological concomitants of this space are the various cerebral association pathways. The clinical evaluation highlights a determination of whether the visual subsystems cited above are capable of ensuring sustained clear and comfortable single binocular vision, and assessment of the integrity of the auditory-language and visual perceptual processes.

The remarkably common developmental model of human function and behavior that emerges sets the tone for clinical intervention of the patient populations that are served. Be the individual a child with learning disabilities or an adult with traumatic brain injury, optimal patient care requires that all levels of the model are investigated, and that active remediation begins at the lowest level of dysfunction. Both professions have more than a passing interest and experience in all components of the model. However, optimal patient care requires a recognition that each profession is, by dint of education and clinical expertise, more proficient in the evaluation and remediation of some, but not all, areas. Consequently, the model itself and its implementation mandates that in the "best of all worlds," there is active collaboration between optometry and occupational therapy. Clinically, this means that while both professions need to

evaluate the motor, visual, language, perceptual and cognitive functioning of the patient to a greater or lesser degree, definitive diagnosis and therapy should be carried out in each area by the party most qualified.

Recent events have signaled that it is time to begin this process. If it is not done, and done in a timely manner, there is the distinct possibility of turf battling which will benefit neither profession nor the public.

### References

1. McEwen M (ed). Sensory integration. Special interest section newsletter. American Occupational Therapy Assn, 1987; 10(3): 1-8.
2. Applebaum S. Sensory integration: optometric and occupational therapy perspectives. *Optom Extension Prog*, 1988-89; CII, 61: #1-12.
3. Cool S. Behavioral optometry and occupational therapy--an interactive whose time has come. *J Behav Optom*, 1990; 1(2): 31-2.
4. Hellerstein LF, Fishman B. Vision therapy and occupational therapy: an integrated approach. *J Behav Optom*, 1990; 1(5): 122-26.
5. Ayres AJ. Sensory integration and the child. Los Angeles, Calif.: Western Psychological Services, 1981.
6. Skeffington AM, Lesser SK, Barstow R. Near-point optometry. *Optom Extension Prog*, 1947-48 (3); 1948-49 (4); 1949-50 (5).
7. Getman GN. Techniques and diagnostic criteria for the optometric care of children's vision. *Optom Extension Prog*, 1960.



*Irwin B. Suchoff, O.D., D.O.S.*