Visual Perceptual
Therapy That Works!

Visual Perceptual Therapy Case Study

Andrew

A Very Challenging Case

Natoya Rose
Visual Perceptual Therapist

Email: info@visualperceptual.com * Website: www. visualperceptual.com

Case Study – Andrew

Andrew is probably the most challenging traumatic brain injury case I have ever worked with.

Andrew worked as a mini-tanker driver and approximately 4 years previously he had blacked out and fallen face first off an excavator. He had fallen around 3 metres and had broken most of the bones in his face. However, no one had ever mentioned to him the potential for a brain injury, and he hid the true extent of his symptoms for those 4 years. To this day I think Andrew thought he had some sort of mental illness, as he continued to say that he thought this was just him and the way it was going to be.

It was immediately apparent to me that Andrew was in dire straits. He sat turned away from me and did not make eye contact. He was rather aggravated that he had been put off work. He advised that his employer knew that something was not right and had arranged for him to be assessed by an occupational physician, and he had raised the question that Andrew had suffered a traumatic brain injury. It was obvious that the past 4 years had taken an extraordinary toll on Andrew and that he was stressed, distressed, and undoubtedly depressed.

Andrew advised that he had had problems with his eyes since his accident. He had initially been told there was nothing wrong with them, but further investigation revealed that he his eyes were not working well together. He had been prescribed glasses with prisms in them to address this discrepancy, but our therapy sessions quickly revealed that there was much more going on with his eyes than anybody had realised.

Andrew was put on a comprehensive rehabilitation programme, which included both physiotherapy and psychological services, along with occupational therapy for the Visual Perceptual Therapy. A worksite assessment was conducted to determine the demands of Andrew's job, as the goal was to get him back to work. Andrew had advised that he experience a lot of severe headaches and he said that he thought they were related to the physical demands of the job, namely pulling the fuel hose off the tanker, and moving it around.

The physiotherapist gradually began increasing Andrew's activity levels as he had essentially been sitting at home doing nothing. He was initially resistant because he believed so many of his symptoms were caused by physical activity. However, he soon realised that this was not the case and, consequently, became very engaged in his gym programme and began walking up to 8 kilometres a day.

As soon as I began working with Andrew it was apparent that the usual Visual Perceptual Therapy treatment regime was not going to work for him. Andrew's vision was incredibly sensitive to any visual stimulus, and his tolerance for visual loading was only about 45 minutes. He advised that our therapy sessions resulted in him not being able to do anything else for the rest of the day, because of fatigue, visual disturbances, and headaches. Andrew's situation highlights just how important it is to ensure the client has control over how much they do in a therapy session; however, there is usually a period in which the client must increase their awareness of just how much 'enough' is. This was certainly the case with Andrew, as he had developed a habit of 'pushing through' his symptoms and not listening to his body when it said enough was enough.

There is absolutely no value in 'pushing through' neuro-cognitive symptoms. Doing so only maintains a level of reduced performance and increased symptoms, or a see-sawing effect where there is always a significant consequence when the person does too much. Typically, the client will advise of an overall increase in symptoms, particularly symptoms of sensory overload, and that those symptoms only ever compounded over time.

One of the measures used to determine the positive impact of the Visual Perceptual Therapy is that the client will naturally start to do more, without an increase in symptoms. When I work with adults with traumatic brain injury, I require them to stop working, because of this issue. We will utilise a graded return to work process to get them back to work, which allows them to gradually adjust to the sensory demands of their work situation.

The tasks utilised in the Visual Perceptual Therapy are very adaptable, but Andrew's situation challenged me to take this to a new level. I told Andrew several times that he was adding to the Visual Perceptual Therapy, because he would not be the last person I ever saw with such significant visual issues, and that there would be other people who would benefit greatly from the modifications we made to the tasks. A balance needed to be struck between presenting tasks that had a positive impact on Andrew's cognitive performance, without unduly provoking his visual issues. I began seeing Andrew on a weekly basis and for shorter sessions – he could really only tolerate 20 – 30 minutes of the Visual Perceptual Therapy tasks, and then we had to stop.

We discovered that colour, and contrast between light and dark were triggers for Andrew's visual issues, along with the amount of sensory loading he as exposed to. Modifying the tasks I use, allowed him to make significant progress with his cognitive performance; however, Andrew needed to see an optometrist who specialised in working with people with traumatic brain injuries. This was to provide Andrew with the means of screening out some of the visual loading so that his neurology had some the space to adapt and improve around his visual issues.

It was apparent to me that there were two separate issues going on with Andrew. While both were neurologically based, one was an issue of his actual eye function, and the other was within his perception and performance. Both factors interacted with one another where loading his perception caused his vision to fail and, when his vision failed, his cognitive performance also declined. I found myself wending my way through Andrew's triggers so that there was a positive impact on his cognitive performance. The optometrist confirmed my suspicions, and also had to complete her assessment over two sessions, because of how quickly (and with little provocation) Andrew went into sensory overload and his vision failed, to the point where he could no longer engage in the assessment.

I also arranged for Andrew to see a neurologist. There had been no satisfactory explanation for him blacking out prior to him falling and his visual issues were very atypical for a traumatic brain injury and I felt it was critical that any other potential neurological issues were ruled out. There was also the issue that driving fuel tankers is a heavy regulated industry in New Zealand, and a clearance from a neurologist prior to a client returning to work following a traumatic brain injury is a must.

Andrew also had an excellent GP. This GP had a sister who had suffered a traumatic brain injury, so he had carried out a lot of research into these injuries. He carried out a very thorough examination of Andrew and prescribed Escitalopram, an anti-depressant that has a particularly good effect on the anxiety that often arises in conjunction with neuro-cognitive issues.

Andrew did see the neurologist and it later transpired that Andrew had a benign brain tumour and that this may also have been responsible for some of his visual issues.

Andrew's case highlights the importance of clients being thoroughly assessed. While his cognitive performance did resolve, Andrew is still faced with the issues of his brain tumour and its management. This would not have been picked up if he had not been referred to a neurologist and had a brain scan.