



# MAER Newsletter

Association for Education and Rehabilitation of the Blind and Visually Impaired  
Michigan Chapter

August 20, 2009

## President's Message

Kathy Konow

I hope everyone is having a fantastic summer. I know it is going way too fast for me, and before we all know it, school will begin ... and then it will be time for winter break.

... serving as board members or helping on various committees. Your willingness to share your time and talents is what makes us such a great organization.

Our 2009 MAER Spring Conference was a great success. We were concerned that the current economy would hurt our attendance, but actually we were close to last year's attendance and are thankful for each of you who took the time to attend. The evaluation results were very helpful and the MAER Board will use your suggestions in planning for the 2010 conference.

According to comments, those who attended the BREEZE session felt it was very worthwhile. This was the first time an all-day-one-topic session was attempted. We were encouraged by your remarks to include this type of session in our 2010 conference. It will be taken under serious consideration in our planning.

We were especially pleased to see that many of you were interested in becoming more involved in MAER, either by

Again, have a fun, safe and restful August. As always, if you have any questions or concerns, please feel free to contact me or any board member.

## From the Editor

Alicia Li

Following the MAER Annual Conference, this newsletter usually dedicates a good portion to synopses of conference presentations. Two synopses were submitted and are included in this newsletter.

The eye condition featured in this issue, CVI, is a shortened version of a presentation given at the Tri-County Swap Meet in December 2008. This provides a recap for the TCVIs who participated and is a good resource for those who were unable to attend.

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## From the Editor

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In the Parents' Corner, you will find an article by Gwen Botting which will shed some light from a parent's perspective. It has been well documented that successful collaboration between parents and teachers significantly increases the learning of a child with or without disabilities.

The Bulletin Board offers free braille books offered by the Temple Beth El Braille Bindery Volunteer as are great resources for elementary braille readers. If you are interested in the workshop on BrailleNote mPower, please sign up ASAP.

## Eye Conditions: CVI

Alicia Li

Cortical or cerebral visual impairment (CVI), a neurological disorder, is caused by damage to the occipital lobes and /or to the posterior visual pathway. The eyes are structurally intact, but ocular damage may co-exist with CVI. It has become the leading cause of blindness and visual impairment in young children (Spungin, 2008). A large portion of children with brain damage also have visual problems since over 40 percent of the brain is devoted to visual functioning (Dutton, 2006).

The visual system and CVI (Dutton, 2006; Hyvarinen, 2005; Vaughan, Asbury, & Riordan-Eva, 1999): The light reflected off objects enters the eyes and passes through the cornea, aqueous humor, pupil, lens, vitreous humor, and retina, where the light is turned into electrical signals which then travels along the optic nerve path (Watkins, 1989). The optic nerve emerges from the posterior surface of the eyeball through a short, circular opening in the sclera. The nerve joins the opposite optic nerve to form the optic chiasm, just above the pituitary gland. Each bundle of nerves con-

tinues, one along the right, the other the left, to points called the lateral geniculate bodies. Eighty percent of the information goes to the occipital cortex for interpretation and twenty percent goes to the brain stem, which is thought of as the primitive visual brain.

The brain stem, which protects a person from danger and functions subconsciously, detects a peripheral movement and initiates movement before the person has a chance to be truly aware of his/her movement. It appears to be most sensitive to movement at the side and is less sensitive to movement straight ahead. For example, a child may detect a moving spoon if it is coming from the side and open his/her mouth more readily than if the spoon comes from straight ahead. A child may be able to walk around objects to the side in his/her path despite apparently having little detectable vision. However, the system may become fatigued and thus cannot respond as it normally would. As a result, the child's responses may become inconsistent.



It takes about one-tenth of a second for information of the visual scene to go through the above-mentioned visual pathway to reach the occipital lobes. The left occipital lobe sees the right side of the visual scene and the right occipital lobe sees the left side. The bottom of the occipital lobes see the upper part of the scene and the top of the lobes see the bottom part of the scene. Once the information reaches the occipital lobes, it is analyzed in two separate ways during the next tenth of a second, the dorsal stream and the ventral stream.

The dorsal stream: It runs from the occipital lobes to three locations: the posterior parietal lobes, the motor cortex/strip, and the frontal cortex.

The posterior parietal cortex is responsible for handling a lot of information at the same time. If there is damage to this area, the person's ability to handle multiple forms of information at the same time is decreased. A child with such damage sees the world one thing at a time. S/he perceives well when a baby's book is presented where one to two large pictures appear on each page. This also applies to when s/he is doing things such as listening to music, s/he is less aware of other things happening simultaneously.

The motor cortex is responsible for bringing about movement of the body.

The frontal cortex is responsible for making the executive choice of attending to and making movements.

For example, the action of picking up a toy: The picture of the toy is formed in the occipital lobes, then is mapped along with everything else in 3-dimensional space by the posterior parietal cortex. This information is

passed to the frontal lobes, and the action is executed by the motor cortex. The visual and motor systems are interconnected within the dorsal stream. Children with damage to the dorsal stream may have difficulty accurately reaching for things and/or difficulty moving their feet to a correct location in visual space depending on the location of the damage, i.e., the nerve fibers responsible for moving the hands or feet.

Other functions of the frontal cortex include moving the head and the eyes to look at a chosen new location and scanning the information received by the posterior parietal lobes. When the dorsal stream is damaged, following and tracking a moving object can be difficult. Reading can also become difficult because printed information on the same page cannot be seen at the same time and thus impossible to move the head and eyes accurately to a new location to access the information. To cope with this difficulty, the teacher may present small amounts of information (e.g., a few words) at one time, enlarge the materials, and present them sequentially.

The ventral stream: It runs from the occipital lobes to the temporal lobes on each side, where the visual library is located. The visual library contains a general store of objects and shapes which enable us to recognize one object from another. The visual library on the right side of the temporal lobe also contains a special store of people's faces and route-finding methods. Children with damage to the ventral stream may have difficulties with differentiating one object from another, recognizing people's faces, and the

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meanings of facial expressions. The route finding can be particularly difficult.

The dorsal stream and ventral stream pathways work in harmony with each other. When brain damage occurs, a specific task for which the damaged parts of the pathways are responsible will be deficient. It can be puzzling why a child with CVI is able to see one thing but not another. For example, a child is able to recognize certain objects and reach out for them whereas s/he does not appear to see or recognize people who may be around her/him on a regular basis.

Possible causes for CVI (APH, 2007; Roman-Lantzy, 2007):

**Asphyxia (A lack of oxygen):** This can result from placenta previa, placental abruption, maternal infection, multiple gestations, precipitous labor (Good et al., 1996).

**Hypoxic-Ischemic Encephalopathy (HIE):** Hypoxia is a condition where too little oxygen is provided, and ischemia means too little blood flow. HIE can result from asphyxia and is a term used to describe abnormal neurological functions resulting from low blood flow to the brain.

**Intraventricular Hemorrhage (IVH):** Bleeding occurs in the germinal matrix and/or ventricles and surrounding tissues of the brain. The germinal matrix is a region of the brain outside the ventricles which functions as the incubator for brain cell production (Volpe, 1987).

IVH is graded I through IV. Grades III and IV IVH may result in seizures, post-hemorrhage hydrocephalus, developmental delay, cerebral palsy, and CVI (Volpe, 1987; Vaucher, 1988; Lantzy & Roman, 2002-2007).

**Periventricular Leukomalacia (PVL):** Injury to or death of the white matter of the brain. It occurs when low blood flow injures the vulnerable cerebral white matter (“leuko” means white) of a premature infant’s brain (Volpe, 1987).

Children with PVL may experience developmental and sensory difficulties, including spastic diplegia, neurologic dysfunction and visual differences consistent with CVI (e.g., difficulties with visual crowding, visuospatial orientation, and interpretation of complex visual patterns such as faces and words) (Brodsky et al., 2002).

**Infection:** Group B streptococcus, E coli, meningitis, TORCH (toxoplasmosis, rubella, cytomegalic virus, and herpes).

**Structural Abnormalities:** The most common types include spinal bifida, microcephaly, lissencephaly (smooth brain syndrome), congenial hydrocephalus, agenesis of the corpus callosum.

**Metabolic Conditions:** CVI has been diagnosed in children who have brain damage due to severe hypoglycemia and kernicterus (extremely high bilirubin levels).



Acquired CVI: Acquired hypoxia (near-drowning, near-SIDS), head injury related to auto accidents, shaken baby syndrome, and tumors or optic radiation damage, childhood infection (encephalitis or meningitis).

Characteristics of CVI (Anthony, 2004; APH, 2007; Roman-Lantzy, 2007. pp. 21-29):

Color preference: Generally speaking, color vision does not seem to be affected. Some colors appear to be “better received” than others, such as red, yellow, and orange. It is important to integrate the child’s preferred color into objects used in his/her daily routines, learning, and leisure. Pictures and objects presented need to be bright and clear with high contrast.

Need for movement: Movement attracts attention in people with and without visual impairment. The majority of children with brain damage are able to see moving targets even if brain damage is severe (Dutton, 2006). Most students with CVI tend to respond more consistently and for longer periods of time to objects that either produce motion, especially in the peripheral fields, or have shiny reflective surfaces that give the illusion of movement (e.g., single-color Mylar pom-poms, balloons, and pin-wheels). When objects are not moving or do not have reflective surfaces, some children with CVI may have better visual responsiveness when they are actually moving (e.g., when riding in a car) as opposed to standing still. Although mirrors are reflective objects, children with CVI may not be able to attend to the details reflected in the mirrors very well because of the complex visual arrays presented. The human face is a

highly complex configuration, and the environment reflected back in the mirror might be complex as well.

Visual latency (delayed responses in looking at objects): Providing sufficient wait time is important because many children with CVI have delayed response in looking at objects. This is particularly true with those who have limited amount of functional vision. In children who have more functional vision, visual latency may be more prolonged when they are tired or overstimulated.

Visual field preferences: Many children with CVI have peripheral field preferences.

Many children may exhibit a mixed-field preference (i.e., the field preferences are different in each eye). A child may notice the position of an object using one eye, then turn his/her head to use the other eye for examination of the object’s details. It is important for professionals working with children to be aware of this pattern, so that seemingly random head turning is actually the child’s intentional attempt to use vision. Children with CVI may have visual field defects due to specific neurological damage.

Difficulties with visual complexity:

Complexity of the target viewed: Children with CVI appear to have better visual responses when objects viewed have simple patterns or colors.

Complexity of the background: Objects that are simple, familiar, or carry the child’s favorite colors may even not be recognizable when presented in a complex background. When an ob-

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ject is placed against a visually complex background, or when objects are placed too close together, Children with CVI may have difficulties sorting one object out from another.

**Complexity of sensory environment:** For some children with CVI, distractions from other sensory stimuli such as touch, voice, or olfactory input may keep them from readily attending to the target with their eyes.

**Light-gazing and nonpurposeful gaze:** Children with CVI may gaze toward light, staring into air without a definite target, or look toward a blank wall when listening to voices, music, or environmental sounds.

**Difficulty with distance viewing:** Distance viewing and complexity are interrelated. Children with CVI may bring objects close to their eyes to fill the entire visual field so non-essential information can be eliminated.

**Absent or atypical visual reflexes (e.g., the reflex to blink in response to an approaching object is impaired):** Many children with CVI have either an absent or a delayed response to an unexpected touch at the bridge of the nose or a perceived threat.

**Difficulty with visual novelty:** A preference for viewing familiar objects over unfamiliar is shown in children with CVI.

**Absence of visually guided reach:** Some children with CVI look away from a target when reaching for it. The integration of looking and reaching may be missing. The child may be able to deal with one sensory input at a time, or the child is using peripheral vision to locate the target prior to reaching for it. Visual performance can be fluctuating. Some days are better than others; or some times are better than others within the same day. Factors that might contribute to the fluctuation include physical status (e.g., fatigue, illness), environments (e.g., noisy, busy, or unfamiliar settings), and contrast between the target and its background viewed.

**Assessment and Intervention** (Anthony, 2004; APH, 2007; Church, n.d.; Erin, 1996; Li, 2003; Roman-Lantzy, 2007):

A functional vision evaluation that each child with low vision receives is also warranted for children with CVI to determine their visual functioning, including ocular reflexes (blink and papillary reflex), distance vision, near vision, visual fields, and ocular motor skills (scanning, tracking, shift attention, and eye-hand coordination). In addition, the CVI Range developed by Christine Roman-Lantzy has become a popular tool that aids in designing a program for children with CVI. The CVI Range, an assessment protocol based on the ten visual & behavioral characteristics delineated above, assesses both the presence of the characteristics and the degree of impact that each characteristic has on a

child (Roman-Lantzy, 2007). The range of the presence of the characteristics is assessed and referred to as Rating I: Across-CVI Characteristics Assessment Method, where a 10-point range is used. The results determine in which phase a child falls. Roman-Lantzy (2007) divided the range of 0 to 10 into three phases:

**Phase I (Range 0-3) Building visual behaviors:** Children in this range are affected most by CVI, and are generally able to use their vision only when there are no visual distracters and when other sensory input is carefully controlled.

**Phase II (Range 4-7) Integrating vision with function:** Children functioned in this phase are able to use their vision when small amount of background visual distracters and low-level of other sensory input is present.

**Phase III (Range 8-10) Resolution of remaining CVI characteristics:** Children at this phase resolved a number of the CVI characteristics, but may still have remaining difficulties with some of the characteristics, such as distance viewing, high levels of complexity, and visual-motor performance.

Following the overview of the overall extent to which the impact of CVI is interfering with the child's use of vision, Rating II: Within-DVI Characteristics Assessment Method examines the specific degree to which each characteristic is affecting the child. A numerical value from 0 to 1 is assigned with 0 being "not resolved" (i.e., the characteristic usually or always a factor affecting visual functioning), and "1" being "resolved" (i.e., the characteristic is not a factor affecting the child's visual functioning).

To ease the use of the CVI Range, the CVI Resolution Chart is an instrument for summarizing the visual behaviors of a child and where s/he falls on the CVI Range for each characteristic. It summarizes all information regarding CVI phases, number ranges, and characteristics. For a complete description of a CVI Range assessment, please refer to pp. 50-112 of Roman-Lantzy's book, *Cortical Visual Impairment: An Approach to Assessment and Intervention*.

Based on the results of the CVI Range assessment, Roman-Lantzy (2007) provided guidelines for developing a child's IFSP/IEP in relation to the three phases identified during assessment. Materials and activities recommended for each phase is also included. Examples are provided as follows:

**Phase I:** The goal for this phase is to build stable and sustained visual behavior. This needs to start with items that can attract the child's attention. The child may begin with brief localization and fixation. In this phase, visual and other sensory input should be carefully monitored and controlled. Some students need auditory input to trigger his/her visual response; others can only "look" when other sensory input is removed.

Activity examples for phase I: Present objects of the child's interest for him/her to look at while s/he is in various positions (e.g., in wheelchair, supported sitting, on a wedge, standing board, etc.). Documenting each child's interest inventory (objects to which the child has attended or likes) is essential. The object may be a shiny Mylar balloon, a piece of red metallic paper, a shiny Pom-Pom.



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Phase II: Children in this phase demonstrate more consistent visual behaviors than those in the first phase. The goal in this phase is to integrate vision with functions. The use of vision is incorporated into daily lives. For example, a fork/spoon is wrapped with a piece of red metallic paper; or a lever or a button that activates a communication board or a cause-effect toy is covered with a gold wrapping paper.

Phase III: Children in this phase are able to functionally use their vision but continue to have difficulties with some of the CVI characteristics such as complexity. The goal of this phase is to facilitate the resolution of the CVI characteristics that remain interfering with the child's visual functioning. Activities that can be done in this phase are as follows: eliminating or reducing the number of objects presented or the amount of sensory input involved for a child who continues to have difficulty with complexity.

For a bank of recommended activities for children in different phases, please refer to Roman-Lantzy's book, pp. 152-172.

While working with children of different phases, parents and teachers need to keep in mind the following principles/strategies:

Present one item at a time with tolerable complexity to determine the child's current level of visual functioning before adding more items and/or increasing complexity. Eliminate unnecessary visual or other sensory input.

Reduce extraneous sensory inputs to the level at which the child can tolerate.

Use objects that are familiar to the student, e.g., objects in his/her daily routines, before presenting unfamiliar or novel items.

For those who can tolerate more sensory input such as auditory than visual alone, language can be instrumental in helping the child's use of his/her vision. The use of language may include description words, encouraging words, alerting words, and reinforcing words.

Repetition is essential in integrating new knowledge/skills and putting it/them to use.

Be aware of the child's visual latency and allow for extra response time before giving the child more information or changing the activity.

As is true with all students with physical and/or multiple disabilities, proper positioning is critical in developing and enhancing the child's visual functioning and learning.

Appropriate lighting is important. Some students are sensitive to light, others need more light.

Any change to the background or environment may result in the child's inconsistent performance. For example, a child, who is generally able to detect certain obstacles in a setting, is unable to do the same when the decorations of the setting or sensory input changed.

Children with CVI are indeed a tremendous challenge given their complex characteristics, but the chances

are good that they will make a significant progress if appropriate assessment and intervention is provided. A consistent intervention across settings (home, school, and community) is definitely critical in developing and enhancing the child's visual functioning and learning across all areas.

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## 2009 MAER Conference Summary



### Diabetes: A Personal and Hands-On Experience

Roberta McCall and Leela Kausch

This presentation was designed to introduce basic hands-on materials related to insulin pumps, basic diabetes, and diabetic issues in rehabilitation. There were approximately 30 people who attended the session. Several pumps, examples of different infusion sets (the part of the system that gets changed every 2-4 days), and insulin-measuring templates were available to check out during the session. All audience members were given a “insulin pump” to tape onto their bellies to give them a sense of the 24-7 feeling all pumpers must accept as part of this therapy.

We explained the basics of pump therapy which requires that the pumper “think like a pancreas” because the pump infuses a small amount of insulin every hour. This insulin is called the basal insulin and the amount infused each hour is called a basal rate. The purpose of using a pump is to allow the body to have the amount of insulin it needs to function when food is not eaten. This means that the pumper has more freedom and flexibility because s/he is not tied to the peaks of insulin action that happen with conventional shot therapy.

When a pumper eats a meal or snack, s/he must program a “bolus” or amount of insulin to cover the carbohydrates eaten. The amount of insulin units taken relate to the number of grams of carbs and vary from individual to indi-

vidual. Exercise may also be used to compensate for carbohydrates eaten. This is the beauty of pumping; if you miss a meal, you don’t have problems with hypoglycemia (low blood sugar) because the only insulin is the basal which covers only the body’s “resting” insulin requirements.

The only kind of insulin used in an insulin pump is short-acting insulin (regular or an analog insulin). This ends any concern of getting two kinds of insulin confused and taking the wrong kind of insulin. Therefore, no adaptive or non-visual labeling of insulin bottles is necessary.

Pumpers who are blind or have low vision will need to be taught adaptive techniques for measuring insulin into a reservoir (a large syringe) which can include one of several different types of templates. Other adaptive requirements are devising a system for telling when the pump has been primed, a way of telling how much insulin has been programmed for the bolus, and knowing how much insulin is “on board” two hours after the meal bolus.

The session ran short of time as many do at the fantastic conference sponsored by MAER every year. If you have ideas for conference sessions, speaker suggestions, or just want to talk pumps, feel free to contact me at [mccallr@michigan.gov](mailto:mccallr@michigan.gov) or 517-335-7231.

## MAER is a Breeze!

Sarah Johnson, Erica Ihrke, and Meredith Newhouse



GPS has been changing the way that a person who is blind or visually impaired travels. To this point accessible GPS has been for a “power user”. The introduction of Trekker Breeze GPS has introduced game changing thinking and allowed a greater audience of people with sight disabilities to take advantage of useful information that GPS provides. Leader Dogs for the Blind has been training consumers and professionals in the use of accessible GPS systems for nearly four years and has now introduced GPS use in combination with dog guide training.

Orientation and Mobility Instructors from all of the state participated in this one day presentation which included a general lecture about the basics of GPS, a comparison of devices, and how to select the right device for your client. It also included introductory lessons on how to use the Breeze as well as an outdoor practical application in a residential and college campus environment close to the hotel. Participants reported they enjoyed and appreciated the presentation and found it to be a very valuable experience.

## Vision Services Severity Rating Scale

The Vision Services Severity Rating Scale, created in 1996-97, is currently undergoing revision.



Sponsored by MDE-LIO, the project committee of Susan Langendonk, chairman; Marcia Pavkovich, Crystal Yacheik, Kathy Christensen and Cheryl Nametz will undertake the up-

date. The process was begun in July 2009 and the estimated completion date is 2010 for the MAER Annual Conference.

Langendonk stated, “The Vision Severity Rating Scale is in the process of being updated as a project sponsored by MDE-LIO. It is anticipated that this will be at least a year long process. Individuals interested in having input or attending a committee work session can contact Susan Langendonk at [susanlangendonk@gmail.com](mailto:susanlangendonk@gmail.com).”



## Parents Corner

Gwen Botting, President of MPVI

Alicia Li has graciously extended an invitation to me to write an article from a parent's perspective. As President of Michigan Parents of Children with Visual Impairments, and Chair of the Quality Education Team for Students who are Blind or Visually Impaired, and a parent of a 15-year-old student who is blind, I talk with many parents who are overwhelmed, in doubt, wondering who is on their side, and if their child has any future at all. At our recent first annual "Braille-a-Thon" at the Capitol in Lansing, one family discovered that even though their young child is blind, he could eventually attend college, hold a job, and raise a family. One person in my church asked me how I could teach gardening to blind children – how can you garden if you can't see? I responded that all it takes is a little creativity and a few boards, and gardening is a great activity for a person with a visual impairment. Our community at large is full of people who cannot imagine losing their vision, and who are terrified of it. Parents with blind children have no reason to disbelieve these pervasive myths, except that they know they want more for their child than a room in a foster care facility and an SSI check.

YOU who our children's teachers, and those adults who have become successful and contributing citizens regardless of their inability to see, represent the most precious thing on earth to us – HOPE. Hope that our children will grow and learn and hold jobs and raise families. Hope that our children will become as independent as they

possibly can be. But you will not be able to give us that sense of hope unless you BELIEVE in our children's abilities yourselves.

I hear from parents whose child's teachers seem to believe that because a child can see enough to read some large print they don't need Braille, or if they try to read Braille with their eyes, or are resistant to learning Braille, that they won't be able to learn it. I also hear from parents whose child's teachers believe that the child is "too disabled" to learn Braille. Or that a stove is too dangerous for a blind child to learn to use, or canoes are too tippy for blind children, or that a child has to be able to speak before they can learn to listen to echoes off walls and doorways.

I understand that Braille takes a lot of instructional time to learn, but learning to read print also takes a long time and a lot of instruction. Kids who are resistant to learning to read print are not excused from doing so. Blind children, unless they have a lot of other issues, can learn read, to cook, use knives safely, make bread from scratch, and canoe, too.

On the other hand, I hear from many teachers that parents often don't attend their child's IEP. I wonder about this, and the only answer I can up with is that they don't have any HOPE. Some parents may still feel the shame which was so prevalent in past centuries of having a disabled child. They feel they have no power, no ability to affect

their child's future, and that translates into hopelessness. They don't BELIEVE in their child's abilities, or in the school's ability to help. If they also feel that their opinions on who their child is are not RESPECTed by the "professionals", and that they are not a part of the team, then I think I can understand why they don't show up, especially if you hold the IEP when they are at work.

Some of our children come with heartbreaking histories – of premature birth and multiple surgeries, of abuse at the hands of a babysitter, of brain bleeds, cancers, chromosomal deletions, accidents or inherited diseases. But in some families, the blind child may be the least of their worries. Perhaps they are unemployed, or have other children with more severe difficulties than the blind child. Perhaps they are in bankruptcy. Perhaps they care for aged parents as well as raise a child with a disability. Perhaps my washing machine broke, my dog got into a tangle with a skunk and my son came home from school with head lice, all in the same day.

Perhaps the daily challenges of raising my child are too much for my abilities. Perhaps out of love, or so I thought, I did everything for my blind child because no one ever told me that what I was doing was bad for him. Or because I work two jobs to keep my family afloat, I just don't have time to teach my blind child all the things she can't learn

about because she can't see it. Perhaps no one believed that my child was capable of learning with others of his same age, and I bought into it only to realize later that we were all wrong.

Or perhaps I am a parent driven to be sure that my child succeeds. I force him to learn to tie his shoes at the same age his brothers did. I insist that he learn to play baseball and ride a bike. I sit beside him for four or five hours every night of the week doing homework. Our family has very little social life. Everything is tied up in making our blind child successful. Our other children are ignored, and our marriage falls apart.

Every family has a life-story.

As parents, we need you to understand those life-stories. We need you to be positive and proactive and to have as much LOVE for our children as we do ourselves.

But what does LOVE mean? In this case it means giving them the tools they need to succeed, not coddling them. It means explaining over and over again that a child who cannot see must repeat the same skill 20 times or a thousand times more than her sighted sibling. It means expecting only the highest level of achievement from my child, and the highest level of teaching from you and all my child's teachers. It means putting yourself into my child's mind

and world in order to understand how she thinks and learns. It means being TOUGH, and it means being there for them when they need it. It means interpreting the world around my child in ways they can understand, and helping them problem solve through the tough parts of life, and helping me understand my child's world, too.

As parents, we need teachers who give us HOPE, BELIEVE in the abilities of our children, who RESPECT our knowledge of our own children, who can be TOUGH with our kids when they need it, and LOVE them enough to give them the tools they need to be successful. We need teachers who have a positive outlook on the abilities of blind people, and who STAND IN THE GAP – who find the areas that need attention in a student's knowledge base and fill them.

So, HOPE, BELIEVE, RESPECT, be TOUGH, LOVE and STAND IN THE GAP – throw Braille and a white cane into the mix and you'll have it covered!

Gwen Botting

President, Michigan Parents of Children with Visual Impairments  
Chair, Quality Education Team for Students who are Blind or Visually Impaired

Greg's Mom!



## Bulletin Board

### BrailleNote mPower Workshop

Set aside Tuesday, Oct. 6 and 13 for training on BrailleNote mPower led by Mark Carson from Humanware. The workshop will be held from 1 – 5 p.m. in the Porter Building on the campus of Eastern Michigan University.

Register before Oct. 1 by contacting Dr. Alicia Li at [tli@emich.edu](mailto:tli@emich.edu) or 734-487-3300

### Braille Books

Established in 1962, the Temple Beth El Braille Bindery Volunteer is a non-profit organization that provides children's books to schools, libraries, and individuals on a "paper-exchange" basis, without further costs (paper exchange of braille paper—19 hole continuous feed). Donations are always appreciated.

More than 900 books have been embossed and bound by the Temple Beth El Braille Bindery Volunteer. The list of the books is available at [www.TBEonline.org](http://www.TBEonline.org) and will be available at the MAER conference). When you visit the website, scroll down on the right side to find the Temple Beth Braille Bindery link. The books are divided into four categories: 1. Grade One braille books; 2. Grade One braille concept books; 3. Grade 2 braille books; and 4. Grade 2 braille motivational books. The organization charges a reasonable fee for the concept books.

If given advance notice, the organization will consider transcribing braille literary books for school-age students. For information and questions, call Ilene Sawyer, LSW, LPC at 248-788-0358 or email Barbara Mandelbaum at: [asmandell@sbcglobal.net](mailto:asmandell@sbcglobal.net).