

EyeCode 2® - Integrated Iris Analysis Finding The Real Cause of Nearsightedness

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Introduction

What is viewed in the nearsighted eye has a deeper meaning. Behind the physical eye is the conditioned world of the patient's mind. One could consider the conditioning and non-conditioning to be like a code, the EyeCode®¹. The patient has a reason for their myopic behavior. From the conventional medical way of looking at nearsightedness the warps in the physical eye are usually increased axial length, and steeper corneas. Clinically, one can rationalize that this is the only etiology for the patient's myopia.

On the other hand, the nearsightedness begins in the patient's mind as a survival mechanism^{1,2} "protecting them from fearful states of seeing." It is possible that this fear of seeing is inherited through the genetics and conditioned by life experiences with family members, schooling and culture.

The aim of this paper is to present an introduction to an effective diagnostic and therapeutic way of treating myopic behavior by seeing more deeply into the iris of the eye. This will help clinicians to start understanding the not-so-obvious background of the cause of myopic behavior. In this way treatments will effectively dismantle the patient's myopic behavior in addition to treating the nearsighted eye.

History of Iris Interpretation

Primary care practitioners of vision look at the iris in order to rule out pathological conditions. On the other hand, the iris is one of the most extraordinary and colorful structures of the physical eye. It is surprising why the iris of the eye has not attracted more positive attention from Optometrists and

¹EyeCode is a registered trademark.

Ophthalmologists. Philosophically the eye has been called the "window to the soul." The iris may hold part of the mystery to the evolution of myopic development.

Iridology⁴ has a colorful history of practitioners who, observing the variation of coloration and structure in the iris, are able to make predictions about the well-being or sickness of the patient. This system has resisted professional acceptance within behavioral and developmental Optometry and certainly conventional medicine. Recent reports^{5,6} suggest otherwise. Perhaps Iridology has a place alongside standard physical and medical systems of diagnosis.

Denny Ray Johnson, in his book, *What The Eye Reveals*⁷, presented a psycho/behavioral approach to iris interpretation. He correlated the structures in the eye to the material world of nature. For example, even, smooth structures he called *stream*. Deeper crypts, he named *flower*. Raised structures in white or deeper colors of yellow, orange or brown were called *jewels*.

In the late 80's clinicians from a variety of health disciplines began to use this classification of the iris investigating the efficacy of Johnson's system. A standard photographic method was developed in order to accurately record the iris in the most prevailing way as possible. In addition to using the same camera system, the aperture, shutter speed, ASA film speed, and flash settings were standardized.

I correlated my impressions of the iris of my myopic/astigmatic patients with their lens prescriptions. The results of this clinical trial were presented as part of a forum of papers in a conference in 1993 in Utah.⁸ I reported that while designing a spherical and astigmatic prescription for the myopic patient, it is useful to look at the iris and examine what structures are present. The spherical and cylindrical lens prescription can be more freely modified when there is

stream structure. In this way the myopic patient can more easily enter into the feeling nature and have greater flexibility when they look through less minus diopters. With the *jewel* structure, a more conservative lessening of sphere and cylinder is dictated. The *jewel* structure means the patient has adopted more thinking as a way to stay in control. They are mentally less likely to tolerate small changes in lens prescription. In the *flower* iris, the patient is informed that the lessening of the lens prescription can result in deeper feelings coming to the surface.

The Development of the Iris Structure

From 1992 to the present time, I clinically photographed over 5000 nearsighted eyes. The iris images were classified into Johnson's three types. In addition, the iris structure was compared to three personality types of myopic patients, the *logical thinker*, *fitness thinker* and *transformer*.

The *logical thinker* is a nearsighted person who talks a lot, asks questions and gives the impression of being rigid in their ideas and willingness to step out of their inflexible belief system.

The *fitness thinker*, although being nearsighted, has made some steps in not leading their life from their thinking position. These patients show an interest in sports and are willing to begin some self-experience approaches to health and fitness.

The *transformer thinker* on the other hand has recognized that their myopic behavior and nearsightedness is a limitation under their control. These patients freely participate in self-growth processes and are flexible to embrace new healing modalities.

The study included infants of myopic patients who were photographed two to three times during the first seven years of their life and in some cases until age 14. Changes in the visual findings of acuity, diopters and binocular vision were correlated to the coloration changes that occurred in the iris.

The photographs of the iris were examined under great magnification. Myopic patients were chosen because of

my interest in more deeply explaining the not-so-obvious etiology of nearsightedness. A surprising outcome of this investigation was that coloration changes of the iris paralleled the development of vision during the first seven years of the patient's life.

At birth, the color of the iris tends to be uniform and even. Within the first seven years, the coloration goes through changes associated with the patient's life experience.

According to the principles of The Human Design System,⁹ we as a culture are conditioned away from our true nature in a variety of ways. In this context, my studies suggest that the iris is a map of the true nature of the patient as well as a map of how they could or do deviate from their real nature. From the moment we are born, because of modern life styles, we can be steered towards something we are not. This can take the form of beliefs, rules and control mechanisms of others around us. In addition, our minds are constantly being bombarded with fear-based information skillfully planted by the over zealous news media.¹⁰

When there is a *flower* iris structure it is possible to describe somebody as being open to feeling deep emotion. The person sees and feels emotion of what is around them, but they have to discern which emotion is their own and what belongs to another. In some cases the person's human design states that they will experience mostly the emotional wave of others. When these patients act out emotion it is outside of their true self. They can unconsciously be conditioned to believe they are emotional. The patient can believe that this is their true self. This reactive survival state is referred to as the *not self*. They have to learn to suppress this emotional part of themselves. They can learn to use rational thinking as a way to keep the suppression of emotion alive. Soon the person learns to live the *not self*. The *not self* directs the person's seeing. Is it possible that what is measured in the nearsighted eye is a reflection of the way the patient has practised seeing from the *not self*?

Conditioning and Myopic Behavior

Myopic behavior is related to intellectual pursuit and the cultivation of the thought process. The resultant tendency is

for the myopic person to think more than feel. Over-active thinking, at the expense of feeling, is another form of survival conditioning. The patient practises living the thinking *not self*. They view life from a withdrawn feeling and myopic perspective. In vision science terms, the patient loses the retinal/spatial sensitivity. Their vision is central and 75 percent of the time they are lacking optimum foveal binocular integration.³ Their ability to feel and see more deeply into life lacks depth. This is like having a one-sided point-of-view of life. These myopic behaviours are also measured in the form of suppressions of binocular vision.

In the case of a genetic predisposition towards myopia, the parents pass on their conditioning to their children. The genes set the stage for the conditioned development of nearsightedness in the child. When the parents later model their myopic conditioning, the child very soon learns to see through the eye of their *not self*.

The conditioned myopic behavior is the preparatory step that leads the patient to developing a nearsighted eye. With the first presence of nearsightedness in the eye one can predict that the patient is seeing from that part of the mind which is the *not self*. By examining the iris we can learn more about the form of conditioning the myopic patient uses to see.

The Iris and Conditioning

The markings and patterns in the iris can be read like a map of the genetic and life process of the myopic patient. There is a definite design and explainable map within the iris. Like the personality and vision development that occurs within the first seven years of life, the color changes of the iris during this time correlate to specific events and conditioning for the patient.

For the development of a myopic person's individuality to occur, they have to master certain developmental stages in the mind. The personality develops by learning how to integrate thinking with feeling and going to the depth of emotion. This is how we become more conscious of our deepest real self or what is sometimes referred to as the *real me*. The key in integrated vision therapy¹¹ is to assist the patient to identify the *not self*, which is where they see

and behave from the *not me*. They can then recognise their real self. To correctly see the inner and outer world requires an integration of thinking, feeling and emotion. When we become fixated on thinking the survival perceptions are recorded into the matrix of the mind. This sets up myopic patterning¹².

Myopia and A New Classification of the Iris

I found it necessary to expand on Johnson's⁷ classification of the iris types. As I gained a deeper understanding of the workings of the mind, it became useful to use descriptors that more adequately reflected what was happening in the various levels of the myopic patient's mind. Full integration and evolution in the mind requires the patient to effortlessly weave between thinking, feeling and responding to emotion.

TABLE 1.

IRIS STRUCTURES - NEARSIGHTED PATIENTS	

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In addition, the patient has to master linking perceptions generated through the right and left eyes.

Combining Johnson’s classification of the iris with my long-term study revealed four variations of iris patterns. The results are summarized in Table 1.

Feeler (Patient A)

This is the foundational structure of all iris patterns present at birth. The smooth and even markings reveal a profound feeling nature of the patient. The feeling structure can be seen in blue as well as in the darker iris. The myopic patient who is predominantly a feeler tends to be extra sensitive to their surroundings. They are empathic and kinesthetically sense very deeply what is happening in the world around them.

Feeler/Thinker (Patient B)

The white cloud-like structure appears to cover the underlying feeling structure. This form of camouflage acts like a protection for the feeling part of the person. Feeling can still be the dominant feature, hence the feeling/thinker classification. Thinking protects feeling. This thinking structure cover appears to gradually increase during the first seven years. This corresponds to the acquisition of life conditioning as well as the development of vision and personality.

Thinker/Feeler (Patient C)

In the thinker/feeler there is an obvious intensifying of the coloration from the cloudy white of Patient B to the darker brown/orange in Patient C. The colorful thinking pattern almost obliterates the underlying feeling structure. Hence, this classification is called Thinker/Feeler. This happens for a good reason. The highest priority of the human “thinking” mind is survival. When the patient’s family history carries survival perceptions, there is a strong presence for the genetic conditioning of thinking. The genes program a way to think and look in a myopic way.

Emotional/Feeler/Thinker (Patient D)

The presence of the flower/crypt structure means that the patient is prone to emotion. The openings are a stretching and expanding of the normal present feeling structure. The

second and third feeler/thinker part of the description means that those structures are secondary to emotion. From a physical point of view, it appears as if the person needs to have the experience of going more deeply into their feelings. This is exactly the remedy for treating many myopic patients. It is helpful for them to enter into their deeper feelings. An emotional iris structure means that when the patient makes the shift from a *logical thinker* to a *transformer* they will have deep emotional life experiences. In the book, *The Power Behind Your Eyes*¹¹, I have documented integrated vision therapy that is the means to guide suitable patients into this deeper way of seeing themselves and life more clearly.

The Iris, Thinking and The Mind

The more the person develops and believes they are a ‘thinker’ the more they condition this way of being in their mind. When thinking is used as a survival mechanism, the iris reveals this mental conditioning and takes on variations of darker colouration. In addition, increases in the eye’s nearsightedness can parallel the color changes in the iris in the first seven years. For example, in Table 1, Patient A, the overall coloration of the iris is blue. Arrow 1, points to a raised whitish area that over time becomes denser.

Coloration changes in the first seven years coincide with vision, physical and intellectual development. Arrow 1 points to a specific location on the iris where there is a heavier presence of white. This physical presence suggests that a thinking strategy was developed in a particular part of the mind. The interpretation of the iris can also be broken down into quadrants (See Patient A with the four quadrants, A, B, C and D) and even axes, very much like the astigmatic axis. (See red line equivalent to the 150th meridian in Patient A). When a myopic patient has astigmatism, the underlying structure of the iris, corresponding to the axis, can be examined to determine how much conditioning or emotional sensitivity exists. Patient A in Quadrant B just above the axis has an emotional pattern. According to Johnson’s Iris map, and my clinical research, this emotional pattern may be able to explain the astigmatic seeing along the 150th meridian. In Quadrant B of the left eye this region is associated with receiving love and feeling nurtured. Is it possible that during the patient’s development of their astigmatic way of seeing

in their mind they believed or felt a lack of love and nurturing from a female, like their mother, grandmother or aunt?

In Patient B, notice how much more of the iris has the whitish cloud-like covering. In Patient A, there is much less 'thinking' pattern compared to Patient B. As might be expected, the Patient A is only -0.75 in both eyes compared to Patient B, who has -3.50 diopters in both eyes. In addition, patient A was a *fitness thinker* while patient B was a *logical thinker*. During a course of integrated vision therapy Patient A was able to reduce the wearing of his glasses to about 10 percent, which was mostly for night driving. For Patient A, the integrated iris interpretation prognosis for nearsightedness reduction was better, because of the lower 'thinking' conditioning.

For patient B, the process was slower. I first engaged the patient in intellectual conversations about integrated vision therapy. Once the patients became curious I guided her into the actual process of demonstrating new ways of seeing and using integrated vision therapy practices. The iris information gave me additional clues on how to manage this patients future vision care program. I needed to go much slower and educate the patient about future options, like lessening the diopters of their myopic prescription. During integrated vision therapy I constantly reminded the patient to go into their body sensations as I changed visual input. It became less important for the patient to report the changes on the outside. Inner feelings were cultivated.

In Patient C, the presence of brown colouration dominates what is a basically blue iris. At birth, this iris would be blue with similar whitish cloud like tendencies of Patient B. Later the brown coloration intensified. For Patient C, one can conclude that mental conditioning is much more intense than Patients A and B. In addition, the patient might find it very difficult to talk about their feelings. Unless the patient is a *transformer*, a more conservative approach to lens modification and eye patching therapies would be recommended.

Patient D has an iris with many crypts flower-like formations. This crater-like structure is an example of another form of conditioning other than the thinking. This is a variation of

the smoother more closely woven structure of Patient A, and indicates the patient's need to explore depth. For the *flower* iris pattern it is useful to more thoroughly examine the binocular vision system. Very often a binocular disintegration is a way of avoiding looking at deeper feelings.

Clinical Investigation

A pilot study¹ was conducted on 10 nearsighted patients to determine if there was a relationship between the lens power in the diopters, the nearsighted and iris structure classification. It was hypothesized that the higher the nearsighted diopters the more likely the patient would have a thinking iris structure and be a logical thinker in their behavior and personality.

The spherical and cylindrical diopters were averaged and rank ordered. Half the subjects who were more than 5.00 diopters nearsighted were all classified as thinker/feelers by the iris classification. In addition 4 of these 5 were classified as logical thinkers. It appears that the higher the



nearsightedness, the more likely logical thinking dominates and this may be predisposed by genetic conditioning of thinking iris structure in the family tree and triggered by the lifestyle conditioning. This hypothesis should be further investigated with a larger sample.

¹ Study performed by Roberto Kaplan and statistical analysis by Peter Hauschild of LifeCode® Company, www.lifecode.cc

Summary

Nearsightedness is the most common refractive eye condition in our world today. Nearly half of the people in Western countries are nearsighted. What vision clinicians measure as loss of visual acuity, and need for minus diopters, has far deeper implications than the usual minus lens compensating model so prevalent in conventional medicine. The nearsighted eye is a reflection of a myopic way of the patient behaving unskillfully from their mind. Myopia is a deep form of 'non-seeing' that is an epidemic blindness for the millions of people all over the world not seeing and being their 'real self'.

Interpreting the iris of the myopic patient gives the practitioner a deeper look into the causes of myopic behavior. In this way the deeper problems of the patient from a 'whole-person' point of view can be addressed.

Our precarious world situation with the constant fear of terrorism, bombings, and disruption of family lives are strong reasons for us to adopt more myopic conditioning. How long can we pretend to be happy living our lives from our 'not self'? We are able to help patients overcome the denial of the real self. Surely the answer is to use integrative vision therapies that foster clear, comfortable and safe seeing. What are we waiting for?

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