**Multisensory training improves the development of spatial cognition after sight restoration from congenital cataracts**

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**Summary**

Spatial cognition and mobility are typically impaired in congenitally blind individuals, as vision usually calibrates space perception by providing the most accurate distal spatial cues. We have previously shown that sight restoration from congenital bilateral cataracts guides the development of more accurate space perception, even when cataract removal occurs years after birth. However, late cataract-treated individuals do not usually reach the performance levels of the typically-sighted population. Here we developed a brief multisensory training that associated audio-visual feedback with body movements. Late cataract-treated participants quickly improved their space representation and mobility, performing as well as typically-sighted controls in most tasks. Their improvement was comparable to that of a group of blind participants, who underwent training coupling their movements with auditory feedback alone. These findings suggest that spatial cognition can be enhanced by a training program which strengthens the association between bodily movements and their sensory feedback (either auditory or audio-visual).

**Introduction**

Visual experience provides a crucial contribution to the development of spatial perception and cognition. Evidence of this contribution comes from the case of blindness: visual deprivation early in life usually leads to deficits and delays in the development of spatial and motor abilities. For instance, early blind individuals show impairments in auditory, tactile, and proprioceptive spatial localization in the peripersonal and extrapersonal space1-8. Tasks requiring the ability to build and update complex auditory or haptic representations of space or use spatial maps for navigation seem particularly challenging9-17. For instance, in the auditory modality, early blind children and adults fail to understand spatial relationships among different sounds in the environment: this deficit is evident in the auditory spatial bisection task, which requires judging the relative position of a sound within a sequence of consecutive and spatially separated sound sources18-21. Visually impaired individuals also show poor performance when they are asked to localize single sound sources along the vertical mid-sagittal plane, especially for lower elevations4,7,8,22, or to judge their distance in the far space23,24. Furthermore, they present delays in the development of motor skills, such as crawling, standing, balancing, reaching and grasping objects, and navigating25-27, and present balance issues and slower walking speed as compared to sighted controls28.

It has been hypothesized that the critical role of vision in the development of spatial abilities is related to cross-sensory calibration processes: as vision typically conveys the most accurate spatial information about the distal environment29, it is a main source used for calibrating the other sensory modalities in processing spatial features11,18,30-32. Consequently, in the case of early-onset visual deprivation, visual calibration of space cannot take place, contributing to deficits in spatial perception and cognition in all sensory modalities. Moreover, as vision often guides target-directed actions and locomotion, the development of motor abilities is also impaired. Support for this cross-calibration hypothesis also comes from animal studies, which report altered auditory spatial maps following absent or distorted visual input33,34.

We have recently provided further support to the cross-calibration hypothesis, by showing that the visual calibration of the auditory space can occur in participants suffering from congenital bilateral cataracts once vision is surgically restored22. The calibration led by the acquired patterned vision occurs even when participants are treated several years after birth, showing that a considerable level of plasticity is maintained even after prolonged early-onset visual impairment22. In particular, the performance of cataract-treated participants in localization and bisection tasks is more accurate and precise than the performance of untreated cataract participants22. This improvement is related to the quality of post-surgical vision, with participants who gained higher visual acuity performing better in the auditory spatial tasks. However, despite such an improvement in auditory space perception, cataract-treated individuals usually do not reach the performance level of the typically sighted controls in the investigated timeframe (on average, around 1 year after surgery)22. Thus, although some calibration of the auditory space from vision occurs after sight restoration, late cataract-treated participants still present significant impairments in spatial tasks several months or years after cataract-removal surgery. We also observed that the mobility of our cataract-treated participants is limited even years after surgery: they navigate in the environment cautiously (cf.35), and their actions seem less adept than those of sighted controls. In particular, their grasping and reaching behavior is poor right after surgery: cataract-treated children show more sensorimotor noise than sighted controls, and their ability to recalibrate their sensorimotor system takes years to develop after surgery36. Moreover, cataract-treated participants do not rely on visually-predicted object features (such as the estimated weight and size of the to-be-grasped object) for feedforward control of grasping37.

In the present study, we investigated whether some brief training can facilitate the development of spatial perceptual and sensorimotor abilities after surgery in late cataract-treated children and adolescents. Previous evidence has reported an advantage of training based on multisensory input over training that relies on one sensory modality alone for perceptual and motor learning38-44 and for recovery following stroke45-48 or sensory impairment and deprivation49-53. For instance, Gori and colleagues have shown that training procedures relying on the association between auditory, proprioceptive and motor signals are successful in improving space perception and mobility in both blind and sighted children and adults2,41,54-58. The training procedure proposed by Gori and colleagues relies on a set of motor exercises executed while wearing a device named *Audio Bracelet for Blind Interaction* (short: *ABBI*), which, once positioned on the participant’s wrist, provides auditory feedback to the participant’s own arm movements59. While typically sighted individuals mainly acquire spatial competencies via visual-motor associations (i.e., observing the visual consequences of their actions39,60), blind children can use the augmented auditory signal associated with their movements to build a sense of space49. Given that such training strengthens the natural coupling between motor outputs and their sensory feedback, it does not require much attention and cognitive load, resulting in a very intuitive task and thus suitable also for children49,51.

A previous study showed that three months of intensive training with ABBI, reinforcing audio-proprioceptive-motor associations of self-generated movements, induced long-lasting ameliorations of space perception and mobility in a group of blind children49. Given that previous evidence has shown the benefit of including multiple modalities in perceptual and sensorimotor training45,49 and we found that cataract-treated individuals learn to combine vision with other sensory modalities quickly after surgery61, we modified the previous training to also include vision. In other words, instead of using only auditory feedback to participants’ body movements, we also added visual feedback, to provide temporally correlated audio-visual stimulation.

The study aimed to assess whether such training could significantly boost the natural development of spatial, sensory, and sensorimotor abilities that was already taking place–to a certain extent–as a consequence of cataract-removal surgery22,36,61,62. To this end, we included in the training a group of Ethiopian children and adolescents who were surgically treated months to years before the beginning of the training. We tested the effect of the audio-visual-motor training on spatial representation and mobility. As in previous studies, we tested participants’ ability to localize sound sources in the peripersonal and extrapersonal space, to judge their relative position in space, and to reach for them in the environment by walking toward them4,49. In addition to those tasks, we also explored whether the training could ameliorate the representation of participants’ personal space, given that an appropriate representation of the body’s orientation is essential to navigate the environment and to localize external objects with respect to the body63. Finally, as we observed that cataract-treated participants fail to use visual information to scale grip force for grasping37, we investigated whether audio-visual-motor training could support the development of this ability. This was specifically done by including–in the training–activities requiring reaching and manipulating objects.

Importantly, while previous studies in visually-impaired individuals have shown that multisensory training can facilitate the development of accurate space perception in non-visual modalities, here we aimed to assess whether such training can lead to improvements also in the visual domain. In a previous study, we showed that visual acuity and the ability to use vision in spatial tasks (i.e., localization of visual stimuli) quickly improve after cataract removal. However, the performance of cataract-treated individuals is still much poorer than that of sighted controls even more than 1 year after surgery22. We here investigated whether the present multisensory training could enhance the ability to localize visual stimuli after surgery. As previous evidence has shown that cataract-treated individuals can use both visual22 and auditory information64 to recalibrate visual localization, we expect that their visual localization abilities would benefit from training combining audio-visual information.

The training lasted 5 days for most participants and an additional 5 days for a subset of participants who had the chance to continue the training for a second session and to be tested in a follow-up 50 days after the end of the training. To assess the effectiveness of the training, we tested the performance of cataract-treated participants before and after the training. Moreover, we compared the performance of cataract-treated participants to that of three other groups in the same age range. First, we included a control group of blind and low-vision participants who did not participate in the training and took part in standard psychomotor activities provided by their school. Second, to evaluate the specific contribution of adding vision to the audio-motor training originally developed by Gori and colleagues49,56, we compared the effectiveness of the audio-visual-motor training in cataract-treated participants to a purely audio-motor training in a second small group of congenitally blind participants. Third, to assess whether, as a result of the training, participants’ performance could approach or even reach that of the typically-sighted population, we compared their post-training outcomes to the performance of a third group of typically-sighted participants.

**Results**

A total of 18 children and adolescents, surgically treated for congenital bilateral cataracts and tested months or years after surgery (Post-op) and 4 congenitally blind individuals (Blind) took part in a 5-days multisensory training (see STAR Methods, Table S1, and Table S2 for details). A subset of participants (6 Post-op and all Blind) took part in a further 5 days of training and were assessed in a follow-up 50 days after the end of the training. A control group for the training included 9 blind or low-vision control participants (B&LV) who took part in standard psychomotor activities provided by their school. Finally, we tested around 30 typically developing sighed individuals in each task to assess the performance levels in the typical sighted population, as a reference (Sighted, see STAR Methods for details and Figure S1 for a graphical description of the groups and the training).

The training associated augmented sensory feedback (audio-visual for the Post-op and auditory for the Blind) with participants’ bodily movements. To this end, we used different devices to provide sensory feedback (STAR Methods). For instance, we used a modified version of the ABBI (Audio Bracelet for Blind Interaction), which was originally developed to provide auditory feedback to participants’ arm movements49,59. By adding a bright red LED to the device, the ABBI provided temporally congruent auditory and visual feedback to participants’ movements. We also relied on other simple devices (e.g., loudspeakers or balls with embedded rattles) that could be used together with visual feedback. All these devices were used with the intent to provide multisensory feedback to participants’ own movements. Participants mainly took part in entertaining group games aimed at improving their spatial representations and their interaction with the environment. The 5-day training involved 2 sessions per day (one in the morning and one in the afternoon) for each participant, for a total of less than 1.5 hours per day (see STAR Methods).

Participants took turns in wearing or holding the device: one participant had a device (e.g., wore the ABBI), while the others interacted with the auditory and audio-visual feedback. In this way, the participant with the device could improve their spatial representations through the direct associations between their body movements and the provided feedback. At the same time, the other participants could improve their spatial perception by training their ability to localize and reach auditory or audio-visual targets while interacting with other individuals in the environment.

To assess the effectiveness of the multisensory training, we used a battery of tests, administered twice: right before and right after the training. Most of the tests were previously validated as effective measures of spatial and motor skills in visually impaired individuals and presented a high test-retest reliability49,65. The tests assess participants’ ability to localize single sound sources (*Auditory localization*), compare the relative positions of a sequence of sounds in space (*Auditory space bisection*), build a spatial representation of the surrounding environment, and navigate in it (*Mobility*). We added new tests to this battery in order to assess participants’ ability to make use of their newly acquired vision to localize visual stimuli (*Visual localization*) and reach and grasp objects (*Grasping*). Finally, we also added a test measuring participants’ personal space perception (*Body midline*).

**Participants taking part in the multisensory training (audio-visual-motor or audio-motor) improved in spatial and mobility tasks**

*Auditory and visual localization*. This task assessed participants’ ability to localize single sound sources4,22,49 and light sources22 presented on a large circular setup in their frontal plane (Figure 1A, STAR Methods, and cf.22). All participants took part in a block in which they were presented with auditory stimuli. The Post-op and Sighted groups also took part in a block in which they were presented with visual targets. After each stimulus presentation, participants were required to point and reach for the location where they believed the stimulus was displayed on the setup (see STAR Methods). For each trial, we calculated the absolute localization error as the absolute linear distance between the position of the target and that of the participant’s response4,22.

To analyze the effectiveness of the training in the visual block, we fitted the absolute localization error of the Post-op group with a linear mixed effect model (LMM) with the session (pre-training, post-training) as a fixed effect predictor. The model showed that Post-op reduced their visual error between the pre- and post-training session (mean ± standard error, 1.56 ± 0.4 cm vs 0.96 ± 0.25 cm, respectively, t = 3.69, p = 0.0002, Figure 1A, left). Although Post-op participants improved in localizing visual stimuli, they were still less accurate than Sighted controls, who performed the task perfectly without making any error (0 ± 0, Figure 1A, left).

To analyze participants’ ability to localize sounds before and after the training, for each group (i.e., Post-op, Blind separately), we fitted the absolute localization error in the auditory block with an LMM with the session (pre-training, post-training) as a fixed effect predictor. In the Post-op group, the error was significantly larger in the pre- than in the post-training session (11.86 ± 1.14 cm vs 9.48 ± 0.96 cm, respectively, t = 3.78, p = 0.0002). In the Blind group, such a reduction of the error between the pre- and the post-training session was only a trend (9.60 ± 2.39 cm vs 8.06 ± 2.68 cm, t = 1.68, p = 0.09, Figure 1A, middle). However, it is important to consider the low number of participants in the Blind group when interpreting this result, as such a low number affects statistical power (see also the “Limitations of the study” section below). In a second step, we aggregated the data of all participants taking part in the training (i.e., Post-op and Blind together), and compared different LMMs, either including only the session or including also the group (Post-op vs Blind), alone or in interaction with the session, as fixed effect predictors. The winning model, according to the Akaike information criterion (AIC, STAR Methods), was an LMM including only the session as a fixed effect (i.e., not including the group, alone or in interaction). Although the low number of participants in the Blind group suggests caution when interpreting this result, this finding seems to indicate that both groups participating in the training (Post-op and Blind) reduced their error after the training (t = 4.11, p < 0.0001).

When comparing the performance in the post-training session (Post-op and Blind together) to the performance of the Sighted group via an LMM including group (post-training, Sighted) as a fixed effect, we found that the error shown by participants after the training was significantly lower than that presented by the sighted participants (Sighted: 12.16 ± 0.27 cm, t = 3.21, p = 0.001, Figure 1A, right)[[1]](#footnote-1). This indicated that after the training, participants outperformed the typically sighted participants in sound localization. Before the training, participants’ absolute localization error was comparable to that of the typically sighted, as shown by an LMM on the error with the group (Post-op and Blind pre-training vs Sighted) as a fixed effect (group: t = 0.91, p = 0.36). In a previous study, we showed that, while after surgery cataract-treated participants reduce their absolute linear error to reach that of the sighted controls, they still present a localization bias along the vertical axis (i.e., a systematic pointing error toward the center of the set-up), especially for lower heights22. Here we found that, after the training, such bias in the auditory modality tended to decrease (see Figure S2, Supplemental Information). Thus, after the training, cataract-treated participants outperformed sighted controls in localizing sounds in the frontal plane, when considering the absolute error. When looking at their directional error, cataract-treated participants reduced their bias along the vertical axis and no longer significantly differed from sighted controls along the elevation (Figure S2).

*B. Auditory space bisection*. This task tested participants’ understanding of spatial relationships among spatially separated sound sources18. Participants were presented with three consecutive spatially distributed sounds and had to verbally report whether the second sound was spatially closer to the first or the third one18. The position of the first and third sounds was varied on a trial basis (see STAR Methods), while the distance between them was kept constant (covering 40° of visual angle). The second sound (i.e., the probe) was delivered at one of 8 possible positions between the other two sounds, varying across trials (see STAR Methods).

For each group participating in the training (i.e., Post-op, Blind, separately), we fitted the probability of responding “closer to the right sound” with a generalized linear mixed model (GLMM) with the position of second sound (i.e., probe’s relative position to the other two sounds), the session (pre-training, post-training), and their interaction as fixed effect predictors. As a measure of the precision in the performance, the GLMM estimated the just noticeable difference (JND) at the 84th percentile (i.e., corresponding to the value of the probe’s location at which the probability of a “closer to the right sound” response is equal to 84%, see66 for a description of the approach). The results of the GLMM in the Post-op group showed that participants performed better in the task after the training as compared to before. Indeed, the JND was significantly greater, and thus performance was less precise, in the pre- than in the post-training session (estimated JND ± standard error, 11.41 ± 1.24° vs 4.59 ± 0.43°, respectively, t = 6.42, p < 0.0001). Similarly, the Blind group reduced their JND after the training (4.04 ± 0.81°), as compared to before (19.45 ± 7.3°, t = 4.1, p < 0.0001, Figure 1B, middle and right panels). Note that, although both groups showed a significant analogous improvement after the training, they tended to differ before the training (t=1.90, p=0.058). As reported in our previous study22, cataract-treated participants typically show a better performance in the bisection task than untreated cataract participants and blind individuals. When aggregating the data of all participants taking part in the training (i.e., Post-op and Blind together), the winning model, according to the AIC, was a GLMM including only the position of the second sound, the session, and their interaction as fixed effects (i.e., not also including the group). In other words, both groups significantly performed the task more precisely in the post-training session, as compared to the pre-training session (t = 7.61, p < 0.0001).

When comparing the performance in the post-training session of all participants who took part in the training (Post-op and Blind) to the performance of the sighted controls via a GLMM, including the position of the second sound, the group (post-training, Sighted), and their interaction as fixed effects, we found that the performance of Post-op and Blind participants after the training was comparable to that of the Sighted controls (JND Sighted: 4.19 ± 0.27°, t = 1.32, p = 0.19, Figure 1B, right). This indicates that, although before the training participants did not perform as precisely as sighted controls, after the training they improved to reach the levels of their typically sighted peers (Figure 1B).

*C. Mobility*. In two tasks, we tested participants’ ability to navigate in the environment. In the “Reaching for sounds” task, we tested participants’ ability to localize sounds in the environment and reach for them. In each trial, the experimenter placed a small speaker on the ground, at a desired position, and played a sound (Figure 1C and STAR Methods, cf.49,56). Once the sound was off, the participants (blindfolded if not blind) had to reach the position from where they believed the sound originated by walking toward it. For each trial, we calculated the error as the absolute linear distance between the position of the target and the location reached by the participant49,56.

We fitted the participants’ absolute errors with an LMM with the session (pre-training, post-training) as a fixed effect predictor. In Post-op the error was significantly larger in the pre- than in the post-training session (40.37 ± 4.06 cm vs 25.79 ± 3.46 cm, respectively, t = 5.00, p < 0.0001), indicating that cataract-treated participants improved after the training. Although the Blind group tended, on average, to slightly reduce the error (Figure 1C, middle), such a reduction was far from being significant (47.23 ± 5.62 cm vs 41.78 ± 3.66 cm, t = 0.79, p = 0.43). However, when aggregating the data of Post-op and Blind, the winning model, according to the AIC, was an LMM including only session as a fixed effect (i.e., not including also group, alone or in interaction; session: t = 4.77, p < 0.0001).

When comparing the performance in the post-training session of all the participants (Post-op and Blind) to the performance of the Sighted group via an LMM including group (post-training, Sighted) as a fixed effect, we found that the error shown by participants after the training was significantly smaller than that shown by the Sighted (33.38 ± 2.97 cm, t = 2.67, p = 0.008).

In the “Timed up and go test” task, we assessed participants’ general mobility by testing their ability to orient themselves in the environment and measuring the speed needed to solve a brief navigation task49,56. At the beginning of each trial, the participants stood blindfolded (if not blind) at a starting position. Upon a go-signal, they started walking until the experimenter touched their shoulder. At that point, they had to walk back to the starting position as fast as possible. All Sighted and a sub-group of Post-op participants (see STAR Methods) performed the test once with closed eyes and once with open eyes. The time needed to perform each trial (from the go-signal to the moment in which the participant reached the starting position) was recorded. We fitted the time (in seconds, log-transformed) needed by participants to conclude the task in each trial with an LMM with the session (pre-training, post-training) as a fixed effect predictor, for each group and task condition (open eyes, closed eyes). In the closed-eyes condition, Post-op became faster in the post- than in the pre-training session (2.02 ± 0.15 s vs 3.34 ± 0.48 s, respectively, t = 4.95, p < 0.0001). Similarly, the Blind group performed the task faster in the post- than in the pre-training session (2.65 ± 0.35 s vs 3.95 ± 0.50 s, t = 3.15, p = 0.005, Figure 1C, right). When aggregating the Post-op and Blind data, the winning model was an LMM with only the session as a fixed effect (t = 5.73, p < 0.0001), meaning that both groups showed a similar reduction of the time needed to solve the task. When comparing the post-training performance with that of the Sighted group via an LMM with the group (post-training, Sighted) as a fixed effect, we found that Post-op and Blind after training were faster than Sighted who performed the task with closed eyes (4.99 ± 0.52 s, t = 3.48, p = 0.0006, Figure 1C, right). This outcome results from the fact that sighted participants, unaccustomed to walking without vision, considerably reduced their pace when blindfolded compared to when walking with their eyes open (Figure 1C, right panel). It is worth noting that the performance of the groups in the closed eyes condition differed already before the training: an LMM on the pre-training performance with the group (Post-op, Blind, Sighted) as a fixed effect predictor showed that Post-op and Blind were both faster than Sighted (t = 5.33, p < 0.0001 and t = 4.57, p < 0.0001, respectively). Moreover, before the training, Post-op were also faster than Blind (t = 2.64, p = 0.009).

In the open eyes condition, Post-op performed the task faster after the training than before (1.63 ± 0.11 s vs 2.39 ± 0.20 s, respectively, t = 7.56, p < 0.0001). However, despite significantly reducing the time needed to solve the task, Post-op were still slightly slower than Sighted performing the task with open eyes (1.40 ± 0.05 s, post-training session in Post-op vs Sighted, t = 2.19, p = 0.03, Figure 1C, right).

*D. Body midline*. This task evaluated the representation of the perceived egocentric midline, which is essential for body orientation and for localizing external objects relative to the body. We measured the representation of the subjective midline with a straight-ahead pointing task. Blindfolded participants (if not blind) were instructed to perform a series of straight-ahead pointing movements, in front of their perceived body midline at the height of the shoulder (STAR Methods). The experimenter took note of each endpoint pointing position along both the horizontal and vertical axes. In each participant and for each axis (horizontal, vertical) we calculated the variance of the errors, namely the linear distances from the target location (i.e., aligned with the participant’s midsagittal axis and at the height of the shoulder), as a measure of precision. In each group participating in the training, we compared the pre- and post-training variance via Wilcoxon signed-rank tests separately for the horizontal and the vertical axis. After the training, Post-op performed the task significantly more precisely than before. Indeed, they reduced the variance of the error in the post- as compared to the pre-training session along both the horizontal axis (7.03 ± 1.01 cm2 vs 25.88 ± 11.48 cm2, respectively, z = 2.11, p = 0.03) and the vertical axis (9.56 ± 3.29 cm2 vs 20.06 ± 6.26 cm2, respectively, z = 2.68, p = 0.007, Figure 1D). The Blind group showed an analogous reduction of the variance of the error along the vertical axis in the post- as compared to the pre-training session (5.62 ± 1.01 cm2 vs 23.09 ± 12.97 cm2, respectively). However, such a reduction was not significant (p=0.25), due to the very low statistical power associated with the fact that each subject contributed to the analysis with only one data point, and thus only 4 values per session entered the analysis for the Blind group. Instead, along the horizontal axis participants’ performance in the pre-training session was as precise as that in the post-training session (9.25 ± 1.09 cm2 vs 8.53 ± 5.80 cm2, respectively).

We aggregated the data of the post-training session of the two groups (Post-op and Blind), given that their performance did not differ (Wilcoxon rank sum test, horizontal: z = 0.64, p = 0.52; vertical: z = 0.043, p = 0.96). The post-training variance of the error of their post-training session did not differ from that of the Sighted group along the horizontal axis (8.13 ± 1.62 cm2, Wilcoxon rank sum test, z = 0.46, p = 0.66) and the vertical axis (4.06 ± 1.0 cm2, z =1.77, p = 0.08, Figure 1D). This indicates that with the training they improved to reach the levels of the sighted participants.

*E. Grasping*. This task assessed participants’ feed-forward control of grasping, by testing whether they are able to use visual estimations of the to-be-grasped object’s weight in order to scale grip force35,63,64. Participants repeatedly grasped and lifted three equally-weighted wooden objects differing in size as naturally as possible using a pincer grip. We recorded their applied force to each object via a force-torque sensor inserted at each object’s center (STAR Methods, cf.37). Only Post-op and Sighted took part in this task.

We fitted the log-transformed grip force rate in each trial with an LMM with the session (pre-training, post-training), the object width, and their interaction as fixed effect predictors. In Post-op, both the session and the session by width interaction were not significant (t = 0.14, p = 0.89 and t = 0.97, p = 0.33, respectively), meaning that participants did not improve their performance after the training (Figure 1E). The object width was significant (t = 2.57, p = 0.01), which indicated that, at least to some degree, participants were scaling their applied force to the object size. However, they did not do that to the same extent as sighted participants: when comparing the performance of the Post-op group (pre- and post-training aggregated, given that they did not differ) to that of the Sighted group via an LMM with the group (Post-op, Sighted), the object width, and their interaction as fixed effects, the object width differed between the two groups (object width by group, t = 3.40, p = 0.0007). This indicated that Sighted scaled their applied force rate to the object size significantly more than Post-op (Figure 1E), as we have previously shown37.

Taken together, the present findings demonstrated that a few days of training providing multisensory experience (either audio-visual-motor or audio-motor) were sufficient to lead to beneficial effects on spatial performance in both the Post-op and Blind groups. The two groups showed similar error reduction in most tasks (Figure 1). In cataract-treated participants, most pre-training abilities were not affected by the amount of visual experience gained in the months to years after surgery (as shown by the lack of significant correlations between pre-training performance in each task and time since surgery in most tasks, Figure S3). In other words, in cataract-treated participants, less than 1 week of training led to improvements that participants had not shown in the months to years after cataract removal.

**Most improvements were maintained in the follow-up**

Details on the second 5-day training session and on the follow-up occurring 50 days after the end of the training are provided in Figure S4 in the Supplemental Information. Overall, the improvements were maintained for most tasks, with the exception of the *Reaching for sounds* task, where performance in the follow-up went back to pre-training levels in both the Post-op and Blind groups (see Supplemental Information).

**Blind and low-vision controls who took part in standard psychomotor activities did not show any improvement**

Blind and low-vision controls (B&LV group) did not show any difference between the performance in the first and second tests (Figure 2). In detail for each task, the test 1 vs test 2 results are as follows. *Auditory localization*, error: 11.98 ± 1.97 cm vs 10.89 ± 1.27 cm, t = 1.29, p = 0.20; *Visual localization* (n=2 low-vision controls), error: 1.95 ± 1.95 cm vs 3.50 ± 2.56 cm; *Auditory space Bisection*, JND: 15.15 ± 2.82° vs 14.31 ± 3.59°, t = 0.23 p = 0.81; *Mobility: Reaching for sounds*, error: 51.48 ± 5.47 cm vs 45.67 ± 4.69 cm, t = 1.12, p = 0.26; *Timed up and go*, time: 3.54 ± 0.71 s vs 3.17 ± 0.49 s, t = 0.94, p = 0.35; *Body midline*, variance, horizontal axis: 21.91 ± 6.15 cm2 vs 31.12 ± 9.57 cm2, Wilcoxon W = 10, p = 0.16, vertical axis: 19.49 ± 4.86 cm2 vs 19.49 ± 3.11 cm2, W = 11, p = 0.20 (Figure 2). These findings ruled out the possibility that the improvement observed in the groups undergoing multisensory training is either non-specific to the training type (i.e., linked to the participation in any activities) or merely related to the familiarity with the evaluation tests, which were repeated in close temporal proximity.

**Discussion**

In the present study, we investigated whether a brief audio-visual-motor training can enhance spatial abilities and mobility in individuals who were surgically treated for congenital cataracts several years after birth. We found improvement in most tasks after just 5 days of training, while no changes occurred in the control group. Such improvement was maintained in most tasks in a subset of participants that had the opportunity to participate in a second 5-day training session and to be tested in a follow-up 50 days after the end of the training. These results confirm and extend previous findings that reported enhanced spatial cognition and mobility in visually impaired children following 12 weeks of multisensory training49. Here we found that even much shorter training can lead to persistent improvements. Importantly, we found that participants’ performance after less than one week of training often approached or even reached the performance of the typically sighted controls.

In a previous study, we demonstrated that the structured vision gained after late cataract removal surgery leads to the development of some recalibration of the perceived space22. In particular, we showed that cataract-treated participants are better than participants with untreated cataracts and blind participants at localizing single stimuli and at bisecting a sequence of sounds22. The current study further validates and expands these findings, revealing that before training, cataract-treated individuals outperformed blind participants not only in the bisection task but also in spatially reaching for sound in their environment. This reaffirms the substantial role of vision in calibrating spatial representation, which persists even after prolonged visual impairment. However, despite such an improvement, our earlier study highlighted that the performance of cataract-treated participants in visual and auditory localization tasks, as well as in an auditory spatial bisection task, did not, on average, reach the level demonstrated by the sighted controls even one year after surgery or more 22. In particular, the ability of cataract-treated children to localize single flashes of light was rather poor compared to typically sighted controls. This finding aligns with the fact that, although visual acuity recovers quickly and remains generally stable after surgery, it is nonetheless inferior to normative levels67-69. Here we showed that less than one week of training was sufficient for participants to significantly improve their ability to localize visual stimuli. Impressively, in the auditory localization and bisection tasks, cataract-treated participants reduced their error to reach the performance shown by sighted controls, and this enhancement was maintained over time.

Participants showed better performance also in mobility tasks, becoming more accurate and precise in reaching for auditory sources in the environment and faster in executing a short navigation task. However, only the benefit of the increased speed (which approached the speed shown by sighted controls) was maintained in the subset of participants tested in the follow-up. Beneficial effects of the training were also observed in the representation of the personal space: cataract-treated participants performed a straight-ahead pointing task more precisely after the training, as compared to before the training. The only task in which we did not see any benefit from the training was the grasping task: before the training, participants did not scale their grip force to the visually estimated size and weight of the object to be grasped as much as the controls did. In a previous study37, we showed that cataract-treated participants did not scale grip force and hand aperture to the object’s estimated size and weight even several months after surgery (on average, 9 months after surgery). Here we found that with more time (and thus experience) from surgery, cataract-treated participants showed some very small signs of force scaling to the object’s size and expected weight. However, their performance was still very far from that shown by sighted controls (cf.37). Although we included an activity involving reaching and manipulating objects in the training, participants’ poor performance was unchanged after the training. This finding confirms our previous evidence that prolonged early-onset visual impairment harms the development of the ability to use visually-predicted properties of objects for feedforward control of grasping. However, it is important to note that, during the training, participants managed to achieve the action goal in each trial (i.e., reaching and manipulating the target), although they did not do it efficiently (i.e., by scaling grip force to object’s size, as sighted do). Future studies should explore whether training strategies providing error feedback whenever the grasp is not performed efficiently could improve these fine aspects of feedforward control of grasping.

We found significant improvement in most tasks also in the group of blind individuals participating in the training. An obvious difference between the cataract-treated group and the blind group is the absence of vision in the multisensory training of the latter. Although the lack of vision results in less information for perceptual learning for the blind participants, the two groups showed analogous benefits from the training in most tasks. This is the case also for the auditory space bisection task: despite the cataract-treated participants showed a trend for some improvement in this task over time after surgery even before the training (cf.22 and Figure S3), the cataract-treated and blind groups exhibited comparable improvement following the training, reaching the performance levels of typically sighted participants. Although the small sample size of blind participants warrants caution in interpreting the data, this result suggests that the success of the multisensory training is not dependent on prior visual experience: similar benefits can be obtained also in the case of visual deprivation. The only exception to the comparable outcome in the two groups is the reaching for sounds task, where the cataract-treated group showed greater improvement. While this finding aligns with evidence showing that vision plays a key role in navigating the environment70, the small number of participants in the blind group does not allow us to draw strong conclusions about this possible difference. Thus, although the results in the blind are only preliminary, overall, the fact that the two groups show similar benefits in most tasks suggests that the integration of auditory, proprioceptive, and motor signals may be enough to enhance the representation of space. In other words, coupling self-generated body movements with auditory feedback is sufficient to efficiently guide the development of spatial abilities, even without the additional contribution of visual feedback. This is in line with previous studies demonstrating that brief audio-motor training impacts auditory localization in the blind (e.g.57). This type of multisensory training offers a clear advantage over most training procedures relying on substitution devices, i.e., devices that convert the absent sensory input into signals accessible to another sensory modality51. Indeed, many sensory substitution devices often require the user to participate in several hours of training to learn to interpret the converted signals (e.g.,71-76). Although recent sensory substitution devices and approaches offer rapid benefits50,52, a few training sessions are still often needed and such procedures are typically developed for adult participants, rather than children. An advantage of the multisensory training used in the present study is that it strengthens the natural association between own intentional movements and their sensory outcome (in the form of augmented feedback). This makes it an intuitive and user-friendly task, suitable even for children, which does not require extensive familiarization sessions49,56,57.

It is surprising to see that only 5 days of training is enough for our participants to improve so dramatically. Although cataract-treated participants are exposed to multisensory events in the environment, in previous studies we found that they need time for developing some ability to use vision in concert with multisensory information and for producing fine motor control. Such development is often slow, with cataract-treated participants still lagging behind their typically sighted peers months to years after surgery22,36,37,61,62. The fact that their everyday multisensory experience is not sufficient to fully develop multisensory integration, space representation, and mobility is in line with previous studies in dark- or noise-reared cats, showing that simple exposure to a natural environment after months of sensory deprivation is not enough for these cats to develop enhanced responses to multisensory stimuli at the neural level77. Instead, sensory training consisting just of repeated exposure to spatiotemporally congruent audio-visual stimuli leads to the development of multisensory enhanced capabilities in these cats in just a few weeks78. These findings show that the multisensory experience needs to be congruent, consistent, and repeated in order to be effective. In addition to this aspect, in our training, such multisensory information (involving auditory, visual, and proprioceptive inputs) is systematically correlated with the participant’s voluntary bodily movements. We can speculate that the participants can also benefit from the use of the efferent copy generated by their voluntary movements, and from the sense of agency derived from this process. The efferent copy provides the input to a forward internal model, used to generate the predicted multisensory feedback, resulting from the motor command.

In summary, we found that less than one week of training was sufficient to develop spatial and motor abilities analogous to those shown by typically sighted controls. Importantly, the children themselves, their caregivers, and the teachers in the schools for the blind reported an improvement in the children’s quality of life, everyday activities, and social interactions. As the training consisted mainly of group activities in the form of games, thus presenting an important social component, it was beneficial also to participants’ social skills. The fact that social interactions benefitted from the training is particularly important, as visually impaired individuals often have limited interactions with others51. Finally, as we did not want this successful training to be just a unique event, we instructed the teachers in the two schools for the blind in Ethiopia where we conducted the training. Although we did not leave the multisensory ABBI there (as it was still a prototype), we donated all the other multisensory devices that we used in the training, so that the teachers could go on with the training also in our absence. In this way, these multisensory exercises became part of the weekly activities systematically provided by their schools to all their visually impaired pupils. This allows us to reach a much larger community than the one originally included in our study. Moreover, as these activities are in the form of entertaining group games, children spontaneously engage in them during their recreational time, hence increasing their learning opportunities.

**Limitations of the study**

The present study had a limited number of participants. Participants who got treated for congenital bilateral cataracts several years after birth are extremely rare, thus the sample size in our study was determined by the availability of participants suffering from this rare condition. We included in the training all the available participants we could find over the years of the runtime of the project (N=18). Ideally, a better control group for the multisensory training should have included a group of cataract-treated participants not taking part in our training (i.e., participating in the control activities). However, we decided to include all the cataract-treated participants in the experimental group (audio-visual-motor training), rather than splitting them into two groups (experimental training vs control activities) for two reasons. The first one is that the total number of cataract-treated participants was small and the group was heterogeneous in terms of age at test, age at surgery, visual acuity, and time from surgery. Therefore, we preferred not to split the sample into two rather small groups. The second and more important reason is that we wanted to offer the opportunity to all our cataract-treated participants to participate in the training, rather than exclude some of them from the only occasion they got–so far–to receive a targeted training procedure to improve their condition. For this reason, we included all cataract-treated participants in the training group and we included a control group of blind and low-vision participants who were already involved in standard psychomotor activities provided by their school. Future studies would benefit from considering a control group involving low-vision participants whose characteristics closely resemble those of our cataract-treated group. For instance, a same-size group of low-vision participants individually matched for age and visual acuity to our cataract-treated cohort could serve as a more suitable control.

To isolate the contribution of vision during the multisensory training, we involved also a small group of blind individuals. It is important to consider the low number of participants in this group when interpreting the results, as such a low number affects statistical power. Future studies involving more participants are needed to be able to draw definitive conclusions about the effectiveness of the training in blind individuals. However, the fact that our blind participants showed the same improvement profile as the cataract-treated participants is promising. In particular, this finding hints at the fact that much shorter multisensory training than that described in49 may be already effective and future studies should be designed to explicitly test this point.

Another limit of the study was that, due to the worsening of the political situation in Ethiopia and the Covid-19 pandemic, we did not have the chance to organize a second trip to Ethiopia in 2020/21 to conduct a second 5-day training session with some of the participants and to retest all of them in the follow-up. For the same reason, we could not extend the audio-motor training to a larger group of blind participants, as initially planned.

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**Author contributions**

Conceptualization, I.S., M.G., M.O.E.; methodology, I.S., S.P., M.G., M.O.E.; setups and devices, I.S., S.P., C.M.; software, I.S., S.P.; investigation, I.S., S.P., C.M.; formal analyses, I.S.; resources, M.O.E., E.C.; data curation, I.S.; writing – original draft, I.S.; writing – review & editing, I.S., S.P., C.M., M.O.E., M.G.; funding acquisition, M.O.E.

**Declaration of interests**

The authors declare no competing interests.

**Inclusion and diversity**

We support inclusive, diverse, and equitable conduct of research.

**FIGURE LEGENDS**

**Figure 1. Results of the audio-visual motor training in Post-op and of the audio-motor training in Blind participants**. A. Localization of visual and auditory stimuli. Left: setup. All participants localized single sounds, while Post-op and Sighted localized also flashes of light in a large setup placed in front of them. Middle and Right: localization error (as the absolute distance between target and participant’s response) in the visual and auditory tasks, averaged across participants in each group and in each session, i.e., before (blue) and after (orange) 5 days of training (Post-op, N=18; Blind, N=4, Sighted, N=29). B. Auditory space bisection. Left: setup. Participants were presented with a sequence of three consecutive sounds and reported whether the second sound (i.e., the probe) was spatially closer to the first (left) or third (right) sound. Middle: Psychometric functions. Proportions of “closer to the right” responses are plotted as a function of the position of the probe, with negative and positive values indicating probe stimulus closer to the left and the right sound, respectively. Aggregated data, obtained by pulling together the data from all participants, are shown for each group and session. Right: Just Noticeable Differences (JNDs) are shown for each group and session (Post-op, N=15; Blind, N=4, Sighted, N=30). C. Mobility. Left: setup. In the “Reaching for sounds” task participants had to localize sounds in the environment and walk towards them. In the “Timed up and go task” they had to perform a brief navigation task as fast as possible. Middle: localization error (as the absolute distance between the position of the target and the location reached by the participant) in the Reaching for sounds task, averaged across participants for each group and session. Right: time needed to perform the Timed-up-and-go task, with closed eyes and open eyes, averaged across participants for each group and session (Post-op, closed eyes, N=18, open eyes, N=12, Blind=4, Sighted, N=34). D. Body midline representation. Left: procedure. Participants performed a straight-ahead pointing task. Middle and Right: variance of errors (as deviation from the midsagittal plane at the height of the shoulder) along the horizontal and vertical axes, averaged across participants in each group and session (Post-op, N=18; Blind, N=4, Sighted, N=29). E. Grasping. Left: procedure. Participants grasped equally weighted objects differing in width. Middle: applied forces (measured via a removable six-axis force-torque sensor embedded in the to-be-gasped objects) used to lift each object, averaged across participants in each session and group (Post-op, N=18, Sighted, N=22).

For each task, bars represent the group average and error bars represent SEMS. The purple dashed lines and bars indicate the mean performance and SEM of the Sighted participants, respectively, shown for reference. Asterisks indicate significant differences (p < 0.05).

**Figure 2**. **Performance of Blind and low-vision (B&LV) control participants**. Blind (N=7) and low-vision (N=2) control participants took part in each task twice, 5-6 days apart without taking part in the multisensory training (they took part in the standard psychomotor activities provided by their schools). Performance, averaged across participants in each testing session, is shown for each task. All 9 control participants took part in each task, except for the visual localization task that was feasible only for the 2 low-vision individuals. Bars represent group averages for each session (test 1, test 2). Error bars represent SEM.

**STAR METHODS**

**RESOURCE AVAILABILITY**

**Lead contact**

Further information and requests for resources should be directed and will be fulfilled by the Lead Contact, Irene Senna (sennai@hope.ac.uk).

**Materials availability**

This study did not generate new unique reagents.

**Data and code availability**

• Full datasets including all the experimental results of each test have been deposited on Mendeley at http://dx.doi.org/10.17632/mf48nrdf55.1 and are publicly available as of the date of publication.

• This study did not generate unique codes.

• Any additional information required to reanalyze the data reported in this paper is available from the Lead Contact upon request.

**Key resources table**

|  |  |  |
| --- | --- | --- |
| REAGENT or RESOURCE | SOURCE | IDENTIFIER |
| Deposited data |
| Dataset with all experimental results | Mendeley Data | <http://dx.doi.org/10.17632/mf48nrdf55.1> |
| Software and algorithms |
| MATLAB R2021a | MathWorks | https://www.mathworks.com/ |

**EXPERIMENTAL MODEL AND STUDY PARTICIPANT DETAILS**

*Participants*

Eighteen Ethiopian children and adolescent surgically treated for congenital dense bilateral cataracts (Post-op, sex: 10/8 females/males, 1 left-handed, mean age: 12.21 y, age range: 9-16 y, visual acuity tested right before the training: 4.94 cycles per degree, cpd, range: 0.83-11.56 cpd, time since surgery: 1.48 y, range: 5.16 months–4.13 years) and 4 Ethiopian congenitally blind individuals (Blind, 2/2 f/m, all right-handed, mean age: 12 y, range: 11-13 y) took part in a 5-days multisensory training (see Procedure). Post-op participants presented light perception before surgery (see Table S1 and Table S2 for details on the individual participants).

We included a control group of 9 blind and low-vision control participants who took part in control activities (see Procedure) and were tested twice, with a 5-6 days interval, without taking part in the multisensory training (B&LV, 6/3 f/m, all right-handed, mean age: 11.02 y, range: 7-16 y). Seven participants in this control group were congenitally blind, 1 had severe low vision, and 1 was partially blind and had spared light perception (Table S1). Five of them were Ethiopian (all blind) and 4 were Italian (2 blind, 2 low-vision). We aggregated the data of the Ethiopian and Italian controls due to overlapping 95% confidence intervals among them in all tested measures.

Finally, we included a group of 89 sighted participants in a similar age range (Sighted). This was done to assess whether, after the training, the participant’s performance reached the performance levels exhibited by the typically developing sighted population. The participants in this group were either German or Ethiopian: since their performance did not differ, the data of the two samples was aggregated. Out of the total number of 89 sighted participants, 29 Sighted (all German, 23/6 f/m, 2 left-handed, mean age: 13.1 y, range: 9-16 y) took part in the *Auditory and visual localization* task (see next paragraph), 30 Sighted (21 German, 9 Ethiopian, 12/18 f/m, 2 left-handed, mean age: 12.38 y, range: 8-17 y) in the *Auditory space bisection* task, 28 Sighted (21 German, 7 Ethiopian, 20/8 f/m, 1 left-handed, mean age: 13.76 y, range: 9-16 y) in the *Body midline* task, 34 Sighted (all German, 30/4 f/m, 4 left-handed, mean age: 14.57 y, range: 13-16 y) in the *Mobility* tasks and 22 Sighted (all German, 9/13 f/m, all right-handed, mean age: 12.78 y, range: 7-21 y) in the *Grasping* task. Around half of the Sighted participants participated in at least two of the abovementioned tasks (see Figure S1 for a graphical description of the study and a summary of the composition of the groups). Participants with cataracts received an ophthalmological examination and underwent cataract removal surgery at the Hawassa Referral Hospital, Ethiopia. Ethiopian participants performed the tasks at the Shashamane Catholic School for the blind or at the Sebeta Blind School. We tested German participants in several schools in the southwest of Germany. We tested blind and low-vision Italian controls at the Istituto David Chiossone for blind and low-vision people, Genova, Italy. The study was approved by the ethics committee of the University of Bielefeld, Germany (EUB 2015-139), Hawassa University, Ethiopia, the Italian Institute of Technology (IIT) and ASL3, Genova, Italy. Participants, or their parents or legal guardians in the case of minors, gave their written consent to participate in the study. A subset of the data relative to the pre-training session of the Post-op and Blind participants and to the performance of the Sighted controls in the *Auditory and visual localization* and *Auditory space bisection* tasks was previously published in22.

**METHOD DETAILS**

*Procedure*

For the Post-op and Blind participants taking part in the multisensory training, the procedure consisted of three phases: pre-evaluation assessment, multisensory training (audio-visual-motor for the Post-op group and audio-motor for the Blind), and post-evaluation assessment. The training lasted 5 days. To assess the effectiveness of the training, we tested several spatial abilities of the participants right before and right after the training via a battery of tests. The tests were administered on the first day of the training, right before the training started, and then repeated right after the training. Thus, all participants took part in the evaluation tests twice, at 5-6 days distance. Similarly, the B&LV control participants took part in the same assessment twice, 5-6 days apart. The control participants took part in the standard psychomotor lessons provided by the schools for the blind in which they and Post-op participants lived or by the institute caring for them (cf.49).

A subset of participants (6 Post-op, and all Blind) took part in a further 5-days of training, and was tested again at the end of this second session and in a follow-up taking place 50 days after the end of the training to check for the stability of any possible improvements. Due to the worsening of the political situation in Ethiopia and the Covid-19 pandemic, we did not have the opportunity to include all participants in the second session of training and in the follow-up.

*Multisensory training*

The training relied on the use of sensory feedback (auditory for the Blind group, and audio-visual for the Post-op group) to provide spatial information about self-motion (cf.4,49,56). To this end, we used different devices. First, we used a modified version of the ABBI (Audio Bracelet for Blind Interaction), which was originally developed to produce auditory feedback to arm movements49,56,57,59. Being equipped with motion sensors and an audio system, the bracelet starts making sounds as soon as the participant who is wearing the device moves. In the present study, we added a red LED to the bracelet, in addition to a sound (a pure tone of 500 Hz and 180 bpm). The light and the sound were temporally correlated and delivered with the same frequency. We provided this type of stimulation as previous evidence found that concurrent audio-visual feedback (with the same spatiotemporal characteristics) can improve localization, probably via mechanisms of multisensory enhancement involving the superior colliculus (e.g.45). In the training, we also used other simple devices providing auditory feedback, such as a loudspeaker and a ball with rattles inside.

The training lasted less than 1.5 hours/day per participant and mainly involved group activities. Each participant took part in two training sessions per day, involving mainly group activities: the first session took place in the morning and lasted 45 minutes, with each group including around 6-7 participants. The second one, in the afternoon, lasted 30 minutes and involved smaller groups of 2-3 participants. In addition to group activities, each person participated in an individual session lasting around 5-10 minutes per day. We chose to form groups with different numbers of participants and to include also individual activities in order to make sure that each participant would actively participate in all the activities. Participants were sorted into groups based on their “level of activity”, with individuals who tended to be more participative and active being included in the same groups, and participants who appeared to be less active in other groups. Creating larger groups allowed to have more entertaining, active, and socially interactive activities, while having smaller groups allowed the opportunity to grant a higher level of participation to each participant.All these strategies were adopted to guarantee that all participants would have around the same amount of experience and exposure to the multisensory stimulation.

In each of the group activities described below, participants took turns wearing or holding the device while interacting with each other. The following activities, mainly in the form of entertaining group games, were either adapted from previous studies49 (“*Spatial localization in the environment*”, “*Localization and interactions with trajectories in motion*”) or introduced in the present study (“*Reaching and manipulation of objects*”). To ensure that Post-op participants attended to both the auditory and visual modalities, we sometimes blindfolded them while participating in the activities, to force them to rely on audition. All participants were blindfolded a few times during each session, for a few minutes at a time (i.e., so that, when taking part in one specific activity, among those described below, they would do so with open eyes in some trials, and closed eyes in other trials). The different activities aimed to improve spatial representations and promote locomotion in the environment through interactions with other participants and with objects. The activities described below involved interacting with and reaching for targets in both the peripersonal and the extrapersonal space (i.e., out of reaching), where the localization of sound sources is particularly poor in visually-impaired participants23,24. Each training session includes all the following activities:

*- Spatial localization in the environment*. In different tasks, participants were required to localize a stimulus either in their extra-personal or peri-personal space. For instance, in one task, a group of 2-3 participants sat at the table with one participant wearing the ABBI and sitting on one side of the table and the other two sitting on the opposite side. The participant wearing the ABBI moved the arm freely for a few seconds. As soon as the participant stopped moving (and thus the audio-visual feedback provided by the ABBI stopped), the other participant(s) had to reach for the ABBI (by grabbing it) as soon as possible. This task allowed us to train localization abilities in the peripersonal space, especially in the frontal plane and along elevation. In another task, one participant held the ball with the rattles or the speaker (providing a metronome sound) and walked freely in the environment. As soon as the participants stopped and the auditory stimulus stopped, the other participants had to run and reach for the ball/speaker as soon as possible. The first who arrived took the ball/speaker and it was their turn to move with the device. In other tasks, they had to reach for a static sound source as fast as possible. The experimenter made sure that each participant would wear/hold the device at least once for each activity.

*- Localization and interactions with trajectories in motion*. In a series of tasks, participants were required to localize and interact with moving audio-visual stimuli rather than localize static stimuli or estimate the ending point of their trajectory once they stopped,as in the examples above. For instance, in one task one participant held a device and ran around with it. The others had to run after him/her and intercept the device online as soon as possible by grabbing it. Participants took turns carrying the device. Post-op participants carrying the device were allowed to open their eyes, while the others, who had to intercept it, were blindfolded. In another task, participants were asked to stay in a circle and pass the rattling ball to each other either by kicking it with their foot or throwing it with their hands.

- *Reaching and manipulation of objects*. This individual activity involved the manipulation and the interaction with objects, rather than with the other participants. This activity was included because in a previous study we found that the ability to program grasping in a feedforward manner based on visual cues (i.e., by scaling grip force and hand aperture to the object’s visual size and visually estimated weight) is impaired after cataract removal surgery37. Given the nature and the aim of this activity, only Post-op participants (i.e., not Blind) took part in it. During this activity, the participant was sitting at the table and was presented with different objects and had to reach for them and move them to new locations. One Post-op participant at the time wore the ABBI and sat in front of a setup consisting of a board (45 by 30 cm) with five embedded circular plates (7.5 cm diameter) that could light up by means of LEDs placed below them. Four objects (differing in shape, size and weight) were placed on top of the circular plates, one on top of each plate, while one plate was left free. At the beginning of each trial, one of the plates below the objects lightened up and the participant had to grasp the object on top of it and move it to the plate that was left free, as fast as possible.

*Control training*

The B&LV control participants took part in the standard psychomotor activities provided by their schools (cf.49). These programs aim at the development of fine and gross motor skills, by integrating locomotion activities and motor exercises designed to enhance balance, orientation, coordination, and social interaction, using the unimpaired senses. Furthermore, sports are adapted to accommodate the visually impaired; for instance, interactive games involve children running while holding onto a rope held by others, promoting inclusive participation. Children participate also in musicotherapy and dance sessions.

*Pre- and post-training evaluation assessment*

We used a battery of tests to assess the effectiveness of the multisensory training. Most of the tests were previously validated as effective measures of spatial and motor skills in visually impaired individuals and present a high test-retest reliability49,65. The tests assess participants’ ability to localize single sounds, compare the relative positions of a sequence of sounds in space, build a spatial representation of the surrounding environment, and navigate in it. We added new tests to this battery to assess participants’ ability to make use of their newly acquired vision to localize or reach and grasp visual stimuli. Finally, we also added a test measuring their personal space perception. The tests were the following:

*A. Auditory and visual localization*. This task assessed participants’ ability to localize single sound sources4,22,49 and light sources22. Participants were blindfolded (if not blind) and sat in front of the setup, which consisted of a circular bull’s eye printed on fabric (1 m diameter) hanging from the ceiling, with its center halfway between participants’ eye and ear level (Figure 1A, cf. 22). All participants took part in a block in which they had to localize auditory stimuli. The Post-op and Sighted groups were presented also with another block in which they were asked to localize visual stimuli. The order of the auditory and visual blocks was counterbalanced across participants. In each trial, the experimenter presented each stimulus by hand directly on the circular setup. In the auditory block, at the beginning of each trial, the experimenter placed a speaker (5 cm per side) on the circular setup at the desired position and played the sound of a metronome (single pulse at 500 Hz, intermittent sound at 180 bpm) for around 3 s (cf.4,22). Then, the speaker was removed. In the visual block, the blindfold was removed, and participants had to keep their eyes closed. At the beginning of each trial, the experimenter positioned a small torch behind the circular setup. When the torch was in the desired position, the experimenter switched it on and asked participants to open their eyes. The light (in the form of a 2 cm diameter disk) was turned off after around 1 s and participants were asked to close their eyes again (cf.22). After each stimulus presentation, participants were required to reach for the location where they believed the stimulus was displayed, by directly touching the setup with the index finger of their dominant hand. To make the stimuli easily reachable by each participant, the diameter of the circle in which the stimuli could be presented was 60 cm for the shorter (typically younger) participants, and 90 cm for the taller (typically older) participants, leading to an average diameter of 75 cm (see22 for more details).

 To help the experimenter cover the whole task space, eight different lines were marked inside the circle, splitting the circle into 8 equally sized sectors (see Figure 1 A, cf.4,22). In each block (auditory and visual condition), the stimuli were delivered in two random positions for each of the 8 sectors, resulting in a total of 16 trials for each block. A numbered grid was printed on the setup, so that the experimenter could note down the number (or combination of numbers) corresponding to the location of the target stimulus and of the participant’s response (endpoint pointing location) for each trial. Such numbers were then converted offline via a table of conversion. For each trial, we calculated the absolute localization error as the absolute linear distance between the position of the target and that of the participant’s response, cf.4,22).

*B. Auditory space bisection*. By judging their relative position, this task tested participants’ understanding of complex spatial relationships among spatially separated sound sources18. We used the same procedure and stimuli that we used in a previous study involving sighted, cataract-treated, and blind participants22. Participants were blindfolded (if not blind) and sat at a table with their heads comfortably resting on a chin-rest in front of the setup. The setup consisted of a semicircle printed on fabric, where the experimenter manually placed three speakers (5 cm per side, Figure 1B, left panel, cf.22). Participants were presented with three consecutive spatially distributed sounds and had to verbally report whether the second sound was spatially closer to the first or the third sound18. The first sound was presented to the participant’s left, the third sound to the participant’s right, while the second sound (i.e., the probe) was delivered at one of 8 possible positions between the two, varying across trials. In each trial, the first and third speakers could be presented in one of four possible combinations, while the distance between them was kept constant (covering 40° of visual angle): -30° and +10°, -10° and +30°, -22° and +18°, -18° and +22°, where negative and positive values indicate locations to the left or right of the participant, respectively (cf.22). We varied the position of the first and third sounds to prevent participants from simply reporting whether the probe was either on the left or right side to their midline (i.e., solving the task by relying on egocentric coordinates), as it would happen if the first and third sounds were kept fixed in the same spatial location across trials, at the far left and right of the participant (cf20). The three sounds were three animal sounds, displayed one after the other at 500ms intervals: a chicken, a horse and a dog. Each auditory stimulus lasted 2 seconds, in which each animal sound was repeated 3 times. We chose animal sounds (as in22), rather than noise bursts or pure tones (as in18-21), to make the task more engaging and easier to understand, especially given that we depended on interpreters for delivering the instructions to participants. After a few practice trials, to familiarize participants with the instructions and the task, participants took part in 2 blocks of 16 trials each. In each block, the probe sound was always the same animal sound (e.g., chicken). In the following block, the probe sound was changed to another one (e.g., dog). We randomized the animal sounds chosen as probes in each block across participants. In each block, the probe was displayed twice for each of the 8 locations, for a total of 32 trials. We have previously verified that results were not affected by the type of animal used as a probe in each specific block (see22 for more details). We did not collect the data of three participants of the Post-op group since they failed to understand the task.

*C. Mobility*. We used two tasks to assess participants’ navigation and mobility. In the “Reaching for sounds” task, we tested participants’ ability to localize sound sources in the environment and reach for them. At the beginning of each trial, participants stood blindfolded (if not blind) in front of the setup, consisting of a 2 x 2 m grid printed on fabric and fixed to the floor (see Figure 1C, cf.49,56 for details). The experimenter placed a small speaker (5 cm per side) on the ground, onto the setup at a desired position, and played the sound (the same used for the Auditory localization task described above) for 5 s. Once the sound was off, the participants had to walk towards the position from where they believed the sound originated and stop where they believed they had reached it. For each participant, the experimenter randomly selected 3 different positions, and each was presented 3 times, for a total of 9 trials. The grid divided the space into 64 squares (0.25 x 0.25 m each, cf.56). Each square was numbered so that the experimenter could note down the number (or combination of numbers) corresponding to the position reached by the participant for each trial. Such numbers were then converted offline via a table of conversion. For each trial, we calculated the error as the absolute linear distance between the position of the target and the location reached by the participant (cf.49,56). In the “Timed up and go test” task, we assessed participants’ general mobility by testing their ability to orient themselves in the environment and measuring the speed needed to solve a brief navigation task (cf.49,56). At the beginning of each trial, the participants stood blindfolded (if not blind) in front of the same setup described above. Upon a go-signal (“ready, 3, 2, 1, go”), they started walking on the grid, until the experimenter touched their shoulder. At that point, they had to walk back to the starting position as fast as possible. For each participant, the test was repeated 3 times. In a sub-group of 12 participants, the test was performed once with closed eyes and once with open eyes. Given that we decided to introduce this further condition (i.e., “open eyes”) once the study was already ongoing, we did not have the chance to test all participants in this condition. The Sighted group performed two blocks: one with open eyes and one with closed eyes. The order of the blocks (open eyes, closed eyes) was counterbalanced across participants. The time needed to perform each trial (from the go-signal to the moment in which the participant reached the starting position) was recorded.

*D. Body midline*. This test assessed the representation of the perceived egocentric midline with a straight-ahead pointing task. Participants stood blindfolded (if sighted) in front of the graduated setup used for the *Auditory and visual localization* task. The centre of the circular setup was aligned with the participant’s midsagittal plane, at the height of the shoulder and arm distance. To have a more precise measurement, we added a measuring tape along the horizontal axis and fixed it onto the setup, with zero at the centre of the setup. Participants were instructed to keep their dominant hand on their chest, at the level of the sternum (starting position) and to point straight ahead, in front of their perceived body midline at the height of the shoulder. After each pointing movement, they returned to the starting position. They performed 10 straight-ahead pointing trials. The experimenter took note of each endpoint pointing position along both the horizontal and vertical axes.

*E. Grasping*. This task evaluated participants’ ability to use visual cues to estimate the to-be-grasped object’s weight to scale grip force for feedforward grasping control37,79,80. At the beginning of each trial, participants sit at the table in front of the setup, with the thumb and index finger of their dominant hand resting in a closed pinch-grip posture on one small screw (starting position) and with the elbow flexed by about 90° (cf.37). They were presented with one object at the time, at a comfortable reaching distance (45% of the distance between the acromion and the metacarpophalangeal joint of the middle finger). They were asked to repeatedly grasp and lift one of three equally-weighted wooden objects differing in size (width: 25, 40, and 55 mm, weight: 112 g) as naturally as possible using a pincer grip. They had to lift each object a few centimeters above the table, and go back to the starting position afterwards. We recorded their applied force to lift each object via a removable six-axis force-torque sensor (ATI Mini40) inserted at each object’s center (cf.37). Participants took part in 4 blocks of 3 trials each, yielding a total of 12 trials. In each block, the three objects were presented once, in random order. Only Post-op and Sighted took part in this task.

**QUANTIFICATION AND STATISTICAL ANALYSIS**

*Audio-visual-motor and audio-motor training*

To analyze participants’ performance in each task, we proceeded as follows. In the first step, we assessed the effectiveness of the 5 days of training, by comparing the performance of the participants in each group (i.e., Post-op and Blind separately) before the training to their performance at the end of the 5 days of training in each task (i.e., pre- vs post-training session).

In a second step, we compared the two groups taking part in the training (i.e., Post-op vs Blind), to investigate whether they were similarly affected by the training or whether the visual component added to the training would lead to further benefits for the Post-op group. For most tasks (see Results section), this was done by aggregating the results of both groups and comparing models of increasing complexity, either including only the session or including also the group (Post-op vs Blind), alone or in interaction with the session, as fixed effect predictors. The aim was to check whether the results were better explained by aggregating the data of the two groups or by treating them as separate groups.

In a third step, we assessed whether participants’ performance following the training reached the level of the typical sighed population. This was done by comparing the performance in the post-training session in each task (Post-op and Blind aggregated if allowed by the previous analysis) to that of the Sighted group.

Depending on the dependent variable in each task and its distribution (see Results section for details for each task), we either used linear mixed effect models (LMM), generalized linear mixed models (GLMM), or non-parametric statistics to analyze the data. When linear mixed effect models (LMM) were employed, maximum likelihood estimation was used to estimate the parameters. A Probit link function was applied in the case of generalized linear mixed models (GLMM). To account for the heterogeneity among different participants, we included the random intercept as a random effect predictor in each model. When we compared competing models of different complexity, the selection of the best statistical model was based on the Akaike information criterion (AIC66,81), with the best model being the one with the smallest AIC.

The assumptions for the linear models were generally met by our dataset in most cases.

*Training: additional 5 days + follow-up*

To assess whether a further 5 days of training would result in further improvements and whether the effects of the training were maintained over time, we compared the performance of the subset of participants who were tested over time across the four sessions (pre-training, post-first 5 days session, post-second 5 days session, follow-up) for each task. To this end, for most tasks (see Results section for details), we combined the data from both groups (n= 6 Post-op and 4 Blind) and compared models of increasing complexity. These models either included only the session or included also the group (Post-op vs Blind), either alone or in interaction, as fixed effect predictors. This was done to check whether participants’ performance was better explained either by treating Post-op and Blind as two separate groups or by aggregating their data. Results are reported in Figure S4 in the Supplemental Information.

*Blind and low-vision Controls*

To make sure that any possible improvement seen in the training was specifically driven by the training and not by the mere fact that participants were involved in some psychomotor activities, we compared the performance of the B&LV control group in the first and in the second test, 5-6 days apart (test 1 vs test2) in each task. To this end, for each task, we used the same analyses used to compare the pre- vs post-training session performance of the Post-op and Blind groups.

**References**

1. Cappagli G., Gori M. (2016). Auditory spatial localization: Developmental delay in children with visual impairments. *Res Dev Disabil* **53**, 391–398. doi: 10.1016/j.ridd.2016.02.019
2. Cappagli G., Cocchi E., Gori M. (2017). Auditory and proprioceptive spatial impairments in blind children and adults. *Dev Sci* **20**, e12374. doi: 10.1111/desc.12374
3. Collignon O., Charbonneau G., Lassonde M., Lepore F. (2009). Early visual deprivation alters multisensory processing in peripersonal space. *Neuropsychologia*, **47**, 3236–3243. doi: 10.1016/j.neuropsychologia.2009.07.025
4. Finocchietti F., Cappagli G., Gori M. (2015a). Encoding audio motion: spatial impairment in early blind individuals. *Front Psychol*, **7**;6:1357. doi: 10.3389/fpsyg.2015.01357
5. Gori M., Amadeo M.B., Campus C. (2020). Spatial metric in blindness: behavioural and cortical processing. *Neurosci Biobehav Rev*, **109**, 54–62. doi: 10.1016/j.neubiorev.2019.12.031
6. Gori M., Campus C., Signorini S., Rivara E., Bremner A.J. (2021). Multisensory spatial perception in visually impaired infants. *Curr Biol*, **31 (22)**, 5093-5101.e5. doi: 10.1016/j.cub.2021.09.011
7. Lewald J. (2002). Vertical sound localization in blind humans. *Neuropsychologia*, **40**, 1868–1872. doi: 10.1016/s0028-3932(02)00071-4
8. Zwiers M.P., Van Opstal A.J., Cruysberg J.R. (2001). A spatial hearing deficit in early-blind humans. *J Neurosci*, **21**: RC142: 1–5. doi: 10.1523/JNEUROSCI.21-09-j0002.2001
9. Bigelow A.E. (1996). Blind and sighted children’s spatial knowledge of their home environments. *Int J Behav Dev*, **19**, 797–816. doi: 10.1080/016502596385587
10. Pasqualotto A., Newell F.N. (2007). The role of visual experience on the representation and updating of novel haptic scenes. *Brain Cogn*, **65**, 184–194. doi: 10.1016/j.bandc.2007.07.009
11. Gori M., Sandini G., Martinoli C., Burr D. (2010). Poor haptic orientation discrimination in nonsighted children may reflect disruption of cross sensory calibration. *Curr Biol*, **20**, 223–225. doi: 10.1016/j.cub.2009.11.069
12. Postma A., Zuidhoek S., Noordzij M.L., Kappers A.M.L. (2008). Keep an eye on your hands: on the role of visual mechanisms in processing of haptic space. *Cogn Process*, **9**, 63–68. doi: 10.1007/s10339-007-0201-z
13. Afonso A., Blum A., Katz B.F.G., Tarroux P., Borst G., Denis M. (2010). Structural properties of spatial representations in blind people: Scanning images constructed from haptic exploration or from locomotion in a 3-D audio virtual environment. *Mem Cogn* **38**, 591–604. doi: 10.3758/MC.38.5.591
14. Cattaneo Z., Vecchi T., Cornoldi C., Mammarella I., Bonino D., Ricciardi E., Pietrini P. (2008). Imagery and spatial processes in blindness and visual impairment. *Neurosci Biobehav Rev*, **8**, 1346–1360. doi: 10.1016/j.neubiorev.2008.05.002
15. Cattaneo Z., Vecchi T., Monegato M., Pece A., Cornoldi C. (2007). Effects of late visual impairment on mental representations activated by visual and tactile stimuli. *Brain Res*, **1148**, 170–176. doi: 10.1016/j.brainres.2007.02.033
16. Noordzij M.L., Zuidhoek S., Postma A. (2007). The influence of visual experience on visual and spatial imagery. *Perception*, **36**, 101–112. doi: 10.1068/p5390
17. Ungar S., Blades M., Spencer C. (1995). Mental rotation of a tactile layout by young visually impaired children. *Perception*, **24**, 891–900. doi: 10.1068/p240891
18. Gori M., Sandini G., Martinoli C., Burr D. C. (2014). Impairment of auditory spatial localization in congenitally blind human subjects. *Brain*, **137**, 288–293. doi: 10.1093/brain/awt311
19. Vercillo T., Burr D., Gori M. (2016). Early visual deprivation severely compromises the auditory sense of space in congenitally blind children. *Dev Psychol*, **52(6)**, 847–853. doi: 10.1037/dev0000103
20. Vercillo T., Gori M. (2016). Blind individuals represent the auditory space in an egocentric rather than allocentric reference frame. *Imaging Sci J,* **28**, 1–5. doi: 10.2352/ISSN.2470-1173.2016.16.HVEI-096
21. Vercillo T., Tonelli A., Gori M. (2017). Early visual deprivation prompts the use of body-centered frames of reference for auditory localization. *Cogn*, **170**, 263-269. doi: 10.1016/j.cognition.2017.10.013
22. Senna I., Piller S., Gori M., Ernst M.O. (2022). The power of vision: calibration of auditory space after sight restoration from congenital cataracts. *Proc R Soc B: Biol Sci*, **289(1984)**:20220768. doi: 10.1098/rspb.2022.0768
23. Kolarik A.J, Pardhan S., Cirstea S., Moore B.C.J. (2017). Auditory spatial representations of the world are compressed in blind humans. *Exp Brain Res*, **235(2)**, 597–606. doi: doi: 10.1007/s00221-016-4823-1
24. Auditory distance perception by blind and sighted participants for both within- and beyond-reach sources. *J Exp Psychol Hum Percept Perform*, **48(5)**, 467–480. doi: 10.1037/xhp0001003
25. Elisa, F. Josée L., Ferrari-Ginevra O., Claudia A., Luparia A., Signorini S., Lanzi G. (2002). Gross motor development and reach on sound as critical tools for the development of the blind child. *Brain Dev*, **24**, 269–275. doi: 10.1016/s0387-7604(02)00021-9
26. Houwen S., Hartman E., Visscher C. (2009). Physical activity and motor skills in children with and without visual impairments. *Med Sci Sports Exerc*, **41(1)**:103–109. doi: 10.1249/MSS.0b013e318183389d
27. Levtzion‐Korach O., Tennenbaum A., Schnitzer R., Ornoy A. (2000). Early motor development of blind children. *J Paediatr Child Health*, **36**, 226–229. doi: 10.1046/j.1440-1754.2000.00501.x
28. Hallemans A., Ortibus E., Truijen S., Meire F. (2011). Development of independent locomotion in children with a severe visual impairment. *Res Dev Disabil*, **32**, 2069–2074. doi: 10.1016/j.ridd.2011.08.017
29. Alais D., Burr, D. (2004). The ventriloquist effect results from near-optimal bimodal integration, *Curr Biol*, **14**, 257–262. doi: 10.1016/j.cub.2004.01.029
30. Burr D., Gori M. (2012). Multisensory integration develops late in humans. In M.M. Murray & M.T. Wallace (Eds.), *Frontiers in the neural bases of multisensory processes* (pp. 345–362). London: Taylor & Francis. doi: 10.1201/9781439812174-23
31. Gori M., Del Viva M., Sandini G., Burr D.C. (2008). Young children do not integrate visual and haptic form information. *Curr Biol*, **18**, 694–698. doi: 10.1016/j.cub.2008.04.036
32. Gori, M., Sandini, G., Burr, D. (2012). Development of visuo-auditory integration in space and time. *Front Integr Neurosci*, 6:77. doi: 10.3389/fnint.2012.00077
33. King A.J., Carlile S. (1993). Changes induced in the representation of auditory space in the superior colliculus by rearing ferrets with binocular eyelid suture. *Exp Brain Res*, **94**, 444–455. doi: 10.1007/BF00230202
34. Knudsen E.I., Knudsen P.F. (1989). Visuomotor adaptation to displacing prisms by adult and baby barn owls. *J Neurosci*, **9**, 3297–3305. doi: 10.1523/JNEUROSCI.09-09-03297.1989
35. McKyton A., Ben-Zion I., Doron R., Zohary E. (2015). The limits of shape recognition following late emergence from blindness. *Curr Biol*, **25**, 2373–2378. doi: 10.1016/j.cub.2015.06.040
36. Senna I., Piller S., Ben-Zion I., Ernst, M.O. (2022). Recalibrating vision-for-action requires years after sight restoration from congenital cataracts, *eLife*, 11:e78734. doi: 10.7554/eLife.78734
37. Piller S., Senna I., Wiebusch D., Ben-Zion I., Ernst M.O. (2023). Grasping behavior does not recover after sight restoration from congenital blindness. *Curr Biol*, **33**, 2104-2110.e4. doi: 10.1016/j.cub.2023.04.017
38. Bernstein L.E., Auer E.T. jr, Eberhardt S.P., Jiang J. (2013). Auditory perceptual learning for speech perception can be enhanced by audiovisual training*. Front Neurosci,* **7**:34. doi: 10.3389/fnins.2013.00034
39. Bremner A.J., Holmes N.P., Spence C. (2008). Infants lost in (peripersonal) space? *Trends Cogn Sci*, **12**, 298–305. doi: 10.1016/j.tics.2008.05.003
40. Bremner A.J., Spence C. (2008). Unimodal experience constraints while multisensory experiences enrich cognitive construction. *Behav Brain Sci*, **31**, 335–336. doi: 10.1017/S0140525X0800410X
41. Cuppone A.V., Cappagli G., Gori M. (2018). Audio feedback associated with body movement enhances audio and somatosensory spatial representation. *Sci Rep*, **9**, 3303. doi: 10.3389/fnint.2018.00037
42. Murray M.M., Wallace M.T. (2012). The Neural Bases of Multisensory Processes. CRC Press, Boca Raton, FL (USA). Bookshelf ID: NBK92848
43. Shams L., Seitz A.R. (2008). Benefits of multisensory learning. *Trends Cogn Sci*, **12(11)**, 411–417. doi: 10.1016/j.tics.2008.07.006
44. Sigrist R., Rauter G., Riener R., Wolf P. (2013). Augmented visual, auditory, haptic, and multimodal feedback in motor learning: a review. *Psychon Bull Rev*, **20**, 21–53. doi: 10.3758/s13423-012-0333-8
45. Bolognini N., Vallar G. (2020). Hemianopia, spatial neglect, and their multisensory rehabilitation. In K. Sathian & V. S. Ramachandran (Eds.), *Multisensory Perception* (423–447). Academic Press/Elsevier. doi: 10.1016/B978-0-12-812492-5.00019-X
46. Frassinetti F., Bolognini N., Bottari D., Bonora A., Làdavas E. (2005). Audiovisual integration in patients with visual deficit. *J Cogn Neurosci,* **17**, 1442–1452. doi: 10.1162/0898929054985446
47. Keller I., Lefin-Rank G. (2010). Improvement of visual search after audiovisual exploration training in hemianopic patients. *Neurorehabil Neural Repair*, **24**, 666–673. doi: 10.1177/1545968310372774
48. Tinga A. M., Visser-Meily J.M.A., van der Smagt M.J., Van der Stigchel S., van Ee R., Nijboer T.C.W. (2016). Multisensory stimulation to improve low-and higher-level sensory deficits after stroke: A systematic review. *Neuropsychol Rev*, **26**, 73–91. doi: 10.1007/s11065-015-9301-1
49. Cappagli, G., Finocchietti, S., Cocchi E., Giammari G., Zumiani R., Cuppone A.V., Baud-Bovy G.,Gori M. (2019). Audio motor training improves mobility and spatial cognition in visually impaired children. *Sci Rep*, **9**, 3303. doi: 10.1038/s41598-019-39981-x
50. Cieśla K., Wolak T., Lorens A., Mentzel M., Skarżyński H., Amedi A. (2019). Effects of training and using an audio‑tactile sensory substitution device on speech‑in‑noise understanding. *Sci Rep*, **12**, 3206. doi: 10.1038/s41598-022-06855-8
51. Gori M., Cappagli G., Tonelli A., Baud-Bovy G., Finocchietti S. (2016), Devices for visually impaired people: high technological devices with low user acceptance and no adaptability for children. *Neurosci Biobehav Rev*, **69**, 79–88. doi: 10.1016/j.neubiorev.2016.06.043
52. Heimler B., Amedi A. (2020). Task-selectivity in the sensory deprived brain and sensory substitution approaches for clinical practice. In *Multisensory Perception*, eds Sathian, K. & Ramachandran, V. S., 321–342, Springer. doi: 10.1016/B978-0-12-812492-5.00015-2
53. Huang J., Sheffield B., Lin P., Zeng F. (2017). Electro-tactile stimulation enhances cochlear implant speech recognition in noise. *Sci Rep*, **7**, 2196. doi: 10.1038/s41598-017-02429-1
54. Aggius-Vella E., Campus C., Finocchietti S, Gori M. (2017). Audio spatial representation around the body. *Front Psychol*, **8**:1932. doi: 10.3389/fpsyg.2017.01932. eCollection 2017
55. Cuppone A.V., Cappagli G., Gori M. (2019). Audio-motor training enhances auditory and proprioceptive functions in the blind adult. *Front Neurosci*, **13**: 1272. doi: 10.3389/fnins.2019.01272. eCollection 2019
56. Finocchietti F., Cappagli G., Porquis L.B., Baud-Bovy G., Cocchi E., Gori M. (2015). Evaluation of the Audio Bracelet for Blind Interaction for improving mobility and spatial cognition in early blind children – A pilot study. *Annu Int Conf IEEE Eng Med Biol Soc*, 7998–8001. doi: 10.1109/EMBC.2015.732024
57. Finocchietti S., Cappagli G., Gori M. (2017). Auditory spatial recalibration in congenital blind individuals. *Front Neurosci*, **11**: 76. doi: 10.3389/fnins.2017.00076
58. Martolini C., Cappagli G., Luparia A., Signorini S., Gori M. (2020). The impact of vision loss on allocentric spatial coding. *Front Neurosci,* **14**:565. doi: 10.3389/fnins.2020.00565
59. Porquis L.B., Finocchietti S., Zini G., Cappagli G., Gori M., Baud-Bovy G. (2017). ABBI: A wearable device for improving spatial cognition in visually-impaired children. *IEEE Trans Biomed Circuits Syst*, Turin, 1–4. doi: 10.1109/BIOCAS.2017.8325128
60. Brambring M. (2006). Divergent development of gross motor skills in children who are blind or sighted. *J Vis Impair Blind*, **100(10)**, 620–634. doi: 10.1177/0145482X0610001014
61. Senna I., Andres E., McKyton A., Ben-Zion I., Zohary E., Ernst M.O. (2021). Development of multisensory integration following prolonged early-onset visual deprivation. *Curr Biol*, **31(21)**:4879-4885.e6. doi: 10.1016/j.cub.2021.08.060
62. Piller S., Senna I, Ernst M.O. (2023). Visual experience shapes the Bouba-Kiki effect and the size-weight illusion upon sight restoration from congenital blindness. *Sci Rep*, **13(1)**:11435. doi: 10.1038/s41598-023-38486-y
63. Karnath H.O. (1994). Subjective body orientation in neglect and the interactive contribution of neck muscle proprioception and vestibular stimulation. *Brain*, **117**, 1001–1012. doi: 10.1093/brain/117.5.1001
64. Bruns P., Li L., Guerreiro M.J.S., Shareef I., Rajendran S.S., Pitchaimuthu K., Kekunnaya R., Röder B. (2022). Audiovisual spatial recalibration but not integration is shaped by early sensory experience. *iScience*, **25(6)**:104439. doi: 10.1016/j.isci.2022.104439
65. Aprile G., Cappagli G., Morelli F., Gor M., Signorini S. (2020). Standardized and experimental tools to assess spatial cognition in visually impaired children: a mini-review. *Front Neurosci*, **14**, 562589. doi: 10.3389/fnins.2020.562589
66. Moscatelli A, Mezzetti M, Lacquaniti F. (2012) Modelling psychophysical data at the population level: the generalized linear mixed model. *J Vis*, **12**, 1–17. doi: 10.1167/12.11.26
67. Ganesh, S., Arora, P., Sethi, S., Gandhi, T.K., Kalia, A., Chatterjee, G., Sinha, P. (2014). Results of late surgical intervention in children with early onset bilateral cataracts. *Br J Ophthalmol*, 98, 1424–1428. doi: 10.1136/bjophthalmol-2013-304475
68. Kalia A., Lesmes L.A., Dorr M., Gandhi T., Chatterjee G., Ganesh S., Bex P.J., Sinha P. (2014). Development of pattern vision following early and extended blindness. *Proc Natl Acad Sci U.S.A.*, 111, 2035–2039. doi: 10.1073/pnas.1311041111
69. Lewis T.L., Maurer D. (2005). Multiple sensitive periods in human visual development: evidence from visually deprived children. *Dev Psychobiol*, **46**, 163–183. doi: 10.1002/dev.20055
70. Schinazi V.R., Thrash T., Chebat D.‐R. (2016). Spatial navigation by congenitally blind individuals. *Wiley Interdiscip Rev Cogn Sci,* **7(1)**, 37–58. doi: 10.1002/wcs.1375
71. Auvray M., Hanneton S., Lenay C., O’Regan K. (2005). There is something out there: distal attribution in sensory substitution, twenty years later. *J Integr Neurosci*, **4**, 505–521. doi: 10.1142/s0219635205001002
72. Auvray M., Hanneton S., O’Regan J.K. (2007). Learning to perceive with a visuo-auditory substitution system: localisation and object recognition with ‘The Voice’. *Perception*, **36**, 416–430. doi: 10.1068/p5631
73. Bach-y-Rita P. (1972). *Brain Mechanisms in Sensory Substitution*. Academic Press New York. ISBN 13: 9780120710409
74. Jones L.A., Lockyer B., Piateski E. (2006). Tactile display and vibrotactile pattern recognition on the torso. *Adv Robot*, **20**, 1359–1374. doi: 10.1163/156855306778960563
75. Matsuda Y., Sakuma I., Jimbo Y., Kobayashi E., Arafune T., Isomura T. (2008). Finger Braille recognition system for people who communicate with deafblind people. *Proc. IEEE Int. Conf. Mechatronics Autom*, 268–273. doi: 10.1109/ICMA.2007.4304074
76. Proulx M.J., Harder A. (2008). Sensory substitution. Visual-to-auditory sensory substitution devices for the blind. *Dutch J Ergon*, **33**, 20–22.
77. Xu J., Yu L., Rowland B.A., Stein B.E. (2017). The normal environment delays the development of multisensory integration. *Sci Rep*, **7(1)**, 4772. doi: 10.1038/s41598-017-05118-1.
78. Yu L., Rowland B.A., Stein B.E. (2010). Initiating the development of multisensory integration by manipulating sensory experience. *J Neurosci*, **30(14)**, 4904–4913. doi: 10.1523/JNEUROSCI.5575-09.2010.
79. Cole K.J. (2008). Lifting a familiar object: Visual size analysis, not memory for object weight, scales lift force. *Exp Brain Res*, **188**, 551–557. Doi: 10.1007/s00221-008-1392-y.
80. Gordon A.M., Forssberg H., Johansson R.S., Westling G. (1991). Visual size cues in the programming of manipulative forces during precision grip. *Exp Brain Res*, **83**, 477–482. doi: 10.1007/BF00229824.
81. Akaike H. (1973). Information theory and an extension of maximum likelihood principle. In B. N. Petrov, & F. F. Csáki, (Eds.), *IEEE Int. Symp. Inf. Theory – Proc*, 267–281, Budapest, Hungary: Akadémiai Kiadó. DOI:10.1007/978-1-4612-0919-5\_38

**Supplemental Information**

|  |
| --- |
| **Post-op participants** |
| **Subject** | **Sex** | **Age (years)** | **Pre-op visual assessment up to:** | **Pre-op CSF cutoff (cpd)** | **Post-op CSF cutoff (cpd)** | **Time since surgery (y,m,d)** |
| p01p02p03p04p05p06p07p08p09p10p11p12p13p14p15p16p17p18 | fffmmfffmfffmmmfmm | 1491114111011917171210171110111215 | HMLPFC 50 cmFC 3m FC 5mHMHMLPLPFC 2mFC 3mFC 1mHMFC 20 cmHMHMHMFC 3m | 0.90Unknown 0.230.384.920.040.040.040.082.912.841.311.500.600.712.031.893.40 | 1.571.561.4511.569.063.7610.610.873.137.564.838.780.831.996.076.031.307.88 | 1,5,244,6,170,5,40,5,40,5,41,1,11,0,291,0,291,5,91,5,101,5,101,5,101,5,101,5,101,5,241,5,241,5,243,4,25 |

**Blind participants**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Subject** | **Sex** | **Age (years)** | **Group (T=training C=control)** | **Pathology description** | **Visual acuity (cpd)** |
| b1b2b3b4bc1bc2bc3bc4bc5bc6bc7bc8bc9 | mmffmmffffffm | 12121311121412119168107 | TTTTCCCCCCCCC | Ocular malformationOcular malformationCongenital blindnessAnophthalmiaMicrophthalmiaCongenital blindnessCongenital blindnessCongenital blindnessCongenital blindnesshypothalamic chiasmatic pilocytic astrocytoma (with nystagmus)Retinopathy of prematurityCongenital bilateral glaucomaRetinopathy of prematurity | NoneNoneNoneNoneNoneNoneNoneNoneNone4.34None0.68None |

**Table S1. Clinical characteristics of the cataract-treated, blind, and low-vision participants, related to STAR Methods: participants**. For the cataract-treated participants, sex assigned at birth, age at test, pre-surgical visual assessment, visual acuity (in cycles per degree, cpd) before and after surgery, and time since surgery at test (in years (y), months (m), days (d)) are reported. Participants’ dense bilateral cataracts were classified as congenital, meaning they were either present at birth or developed within the first weeks or months of life [S1]. The diagnosis was based on the participants’ families reporting that their children had bright white eyes since birth, and was supported by the fact that all participants showed optical nystagmus, which is considered a signature of early-onset visual deprivation [S2]. Most cataract-treated participants had strabismus and almost half of them had a family history of congenital cataracts, suggesting their congenital cataracts were hereditary (autosomal dominant). Participants were included in the study only for isolated congenital bilateral cataracts (i.e., without further ocular or systemic comorbidity). They underwent a complete ophthalmological evaluation, which included a B-scan ultra-sound ensuring the retina was intact. Prior to surgery, all participants had light perception (*LP*), some perceived hand motion (*HM*), and some could even count fingers (*FC*) up to the specified distance: we report the highest measure participants were able to perform. We tested participants’ spatial visual acuity before (when possible) and after surgery by measuring their contrast sensitivity function (CSF) cut-off frequency with the adaptive procedure described in [S3-S5]. According to the pre-surgical test, most participants were classified as suffering from legal blindness or severe low vision. Legal blindness is defined as a visual acuity below 20/400, corresponding to a 1.5 cpd cutoff frequency, according to the taxonomy of the World Health Organization (WHO, ICD, 10th revision), or below 20/200, corresponding to 3 cpd cutoff frequency, according to the guidelines of the National Institute of Health of the United States (NIH). After surgery, participants’ visual acuity significantly improved, and many participants transitioned out from the category of legal blindness (pre- vs post-surgery visual acuity, mean ± standard deviation, 1.42 ± 1.42 cpd vs 4.94 ± 3.60 cpd, Wilcoxon signed-rank test, z = 3.43, p = 0.0006). The post-surgical visual acuity was evaluated the same day on which the pre-training battery of tests was administered. For the congenitally blind and low-vision participants, either involved in the training or in the control group, sex, age at test, description of the pathology, and visual acuity at test (the CSF cutoff frequency in cpd is reported for low-vision participants) are indicated. While some Ethiopian participants were blind due to congenital peripheral damages, we have no medical records regarding the cause of blindness of the remaining participants (for which only ‘congenital blindness’ is reported). However, their parents or legal guardians reported they had been completely blind since birth. The last 4 blind participants were Italian, all the others Ethiopian.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Task** |   |  **Post-op** |  **Blind** | **B&LV controls** |  **Sighted** |
|  |   | **N** | **Age**  | **N** | **Age**  | **N** | **Age**  | **N** | **Age** |
| **Auditory and visual localization** | 5 days training | 18 | 12.2 (2.7) | 4 | 12 (0.7) | 9 (2 visuo, 9 audio) | 11 (0.7) | 29 | 13.1 (2.3) |
|  | 5+5 days&follow-up | 6 | 12.2 (2.4) | 4 | 12 (0.7) |   |   |   |   |
| **Bisection** | 5 days training | 15 | 12.3 (2.8) | 4 | 12 (0.7) | 9 | 11 (0.7) | 30 | 12.4 (2.4) |
|  | 5+5 days&follow-up | 4 | 12.4 (2.2) | 4 | 12 (0.7) |  - |  - |  - | -  |
| **Mobility** | 5 days training | 18 open eyes 12 closed eyes 17 time-up  | 12.2 (2.7) 12.2 (2.9) 12.4 (2.6) | 4 | 12 (0.7) | 9 | 11 (0.7) | 34 | 14.6 (1) |
|  | 5+5 days&follow-up | 5 | 12.8 (2.1) | 4 | 12 (0.7) | -  |  - |  - | -  |
| **Midline** | 5 days training | 18 | 12.2 (2.7) | 4 | 12 (0.7) | 9 | 11 (0.7) | 28 | 13.8 (2.2) |
|  | 5+5 days&follow-up | 6 | 12.2 (2.4) | 4 | 12 (0.7) | -  | -  |  - | -  |
| **Grasping** | 5 days training | 18 | 12.2 (2.7) | - | - | - | - | 22 | 12.8 (3.8) |
|   | 5+5 days&follow-up | 6 | 12.2 (2.4) | - | - | - | - |  - | -  |

**Table S2. Participants’ number and age for each group and task, related to STAR Methods, Participants.** The table shows the number and age (group mean in years (standard deviation)) of the participants in each group, task, and session (i.e., 5-day training for all participants in Post-op and Blind groups and 5 days + additional 5 days + follow-up in a sub-group of participants). Age was comparable across groups in all tasks, except for the Mobility task (Kruskal-Wallis test, Chi-squared = 19.9, p < 0.001), where the Sighted were on average slightly but significantly older than Post-op (Bonferroni-corrected Wilcoxon rank sum test p = 0.02), Blind (p = 0.008), and Blind & Low vision controls (p = 0.006).



**Figure S1. Diagrammatic representation of the timeline of the study and of the compositions of the groups, related to STAR Methods, Participants**. Cataract-treated (Post-op group) and blind participants (Blind group) took part in 5 days of multisensory training (audio-visuo-motor and audio-motor, respectively). Blind and low-vision controls (B&LV group) took part in control activities. Participants were tested before and after the training. Typically developing sighted participants (Sighted group) were tested for reference (i.e., for providing information about the performance levels shown by the healthy sighted population). A subset of the participants continued the training for an additional 5-day session and were re-tested after this additional session and in a follow-up taking place 50 days after the end of the training.

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**Figure S2. Directional error in the auditory localization task before and after the training in Post-op participants, related to Figure 1 A.**Left: pointing performance is summarized in the pre- (T1) and post-training (T2) sessions in the Post-op group by averaging targets’ positions and participants’ endpoint locations along azimuth (x-axis) and elevation (y-axis) in nine different regions of the set-up (defined by the dashed lines, cf. [S5]). The nine regions result from dividing the setup space into nine equally sized regions: the central region was 25 cm wide and high (i.e., 12.5 cm in each direction from the centre). Given that the target sounds were presented in a 75 cm diameter circle on average across participants, each region was 25 cm wide and high. The grey grid connects the averaged actual targets’ locations. The magenta grid connects the averaged position of participants’ responses. The horizontal dashed lines indicate the boundaries of the different heights in the analyses: upper (Up), middle (Mid) and lower (Low). Right: directional localization error for the different heights (Up, Mid, Low) along the horizontal and vertical axes in the Post-op group in the pre- (T1) and post-training (T2) sessions. The purple dashed lines and bars indicate the mean performance and SEM of the Sighted control participants. Error bars represent SEM. For each of the two sessions (T1, T2) and for each trial, we calculated the directional error as the difference between the location of the response and that of the target sound along the horizontal axis and along the vertical axis. We divided the analysis into three heights (Up, Mid, Low, cf. [S5]). As the diameter of the target circle in which the stimuli could be presented was 75 cm on average across participants (see STAR Methods), the Mid height was 25 cm (12.5 below/above the centre line), while the Up and Low heights included all target locations above/below that Mid height. For each participant, axis (horizontal, vertical), and height (Up, Mid, Low) we calculated the mean directional error across trials.

Before the training (T1), Post-op participants presented a localization bias along elevation (i.e., a systematic pointing error toward the centre of the set-up), especially for lower heights. This poor localization performance in the lower part of the frontal space, especially along elevation, is in line with previous evidence in blind individuals [S6-S8]. The phenomenon has been attributed to the fact that the visual calibration of the auditory space may be crucial where the contribution of binaural cues is less efficient, as in the case of the vertical mid-sagittal plane [S9]. After the training (T2), Post-op participants reduced such a bias in sound localization. Although such a reduction of the localisation error between the pre-training (mean ± SEM, 10.44 ± 2.08 cm) and the post-training (6.61 ± 1.88 cm) sessions was not statistically significant (Wilcoxon sign rank test, z = 1.37, p = 0.17), such an error did not differ any longer from that of the Sighted participants (4.14 ± 1.66 cm) after the training (Wilcoxon rank sum test, z = 0.73, p = 0.46), as it did before the training (z=2.11, p=0.035). Despite this improvement for the lower heights, Post-op still differed from Sighted in their localisation error in the Mid height in the post-training session (Post-op: 3.64 ± 1.74 cm, Sighted: -2.44 ± 1.33 cm, z = 2.1, p = 0.037), as they did in the pre-training (3.19 ± 1.91 cm, z = 2.53, p = 0.012). The error in the Up height was comparable among Post-op in the pre- training (-1.24 ± 1.88 cm) and post-training (-1.41 ± 1.55 cm) sessions and the Sighted participants (-3.79 ± 1.41 cm, all p-values > 0.27). The localization error along the x-axis was comparable among the Post-op participants in the pre- and post-training sessions and the Sighed participants for all heights (p-values > 0.17).



**Figure S3. Development of visual acuity and contribution of experience to the development of spatial skills before and after surgery, related to Figure 1.** A. Stability of visual acuity following surgery. Participants’ visual acuity was tested before surgery and multiple times following surgery. While visual acuity significantly improved after surgery as compared to the pre-surgery evaluation, it was stable after surgery, at the group level: participants’ visual acuity tested right before the training (i.e., on average, 1 year and a half after surgery, range: 5.16 months–4.13 years) did not significantly differ from the visual acuity tested on average 3 months after surgery, meaning around 1 year earlier (range: 4 months- 3 years earlier, Wilcoxon signed-rank test, z = 1.24, p = 0.21). Individual performance is shown as grey circles, with lines connecting data from the same participant. Coloured larger circles indicate the group’s average performance before surgery (black), around 3 months after surgery (dark blue), and at the time of the training, around 1 year and a half after surgery (light blue). B. Performance in the visual localization task (cf. Figure 1 A, left) in a group of participants tested before cataract removal (from [S5], average in black), after surgery before the training (average in light blue), and after the audio-visual-motor training (average in orange). C-I. Correlation between the performance tested in each task before the training and time since surgery (log-transformed). We present these correlations as an indicator of the impact of the amount of post-surgery experience on performance. Typically, performance was not significantly correlated with time since surgery. For instance, the ability to localise visual stimuli improved quickly after surgery (cf. [S5]), but it was stable in the months to year after surgery and before the training. The only task in which performance showed a trend to improve naturally over time after surgery was the auditory spatial bisection (cf. [S5]). However, such improvement happened very slowly, as participants’ performance was still far, on average, from the performance level of the sighted controls more than 1 year after surgery (i.e., right before the training). J-P. Correlation between age at surgery and performance in each task. We present these correlations as an indicator of the impact of maturational factors (reflected by age) and of the amount of pre-surgery experience on performance. Age at surgery typically did not correlate with task performance, except for the grasping task, in which older children tended to show greater scaling of the grip force, in accordance with previous studies ([S10]). Correlations considering age at test, rather than age at surgery, lead to analogous results in each task.

In each panel, we report the Pearson correlation coefficient r between time since surgery or age at surgery and performance in that task and the associated p-value. The light-grey shaded area indicates the 95% confidence interval of the regression line.



**Figure S4. Results of an additional 5-day training session and the follow-up in a subset of Post-op participants and in Blind participants, related to Figure 1**. T1: pre-training assessment, T2: tests administered right after the first 5-day training session, T3: evaluation at the end of the second 5-day training session, T4: follow-up 50 days after the end of the second training session. *A. Auditory and visual localization*. We analyzed the error in each trial (linear distance between the target’s location and the participant’s response) separately for the auditory and visual tasks. In the auditory task, the winning model according to AIC was an LMM including only session (T1 (pre), T2, T3, T4) as a fixed effect predictor: irrespective of the group (Post-op or Blind), participants’ error declined in T3, as compared to T2 (9.26 ± 1.29 cm vs 10.68 ± 1.67 cm, respectively, t = 2.05, p = 0.041, Figure S2A). Note that this differed with what we found in the whole sample (see main text): when considering the whole sample of 18 Post-op participants and not only the 6 retested over time, such an error reduction at the group level occurred already at the end of the first 5 days of training (T2), compared to pre-training (T1). Importantly, participants performed more accurately in the follow-up session (T4, error: 7.63 ± 1.19 cm) than in all the other sessions: T1 (10.17 ± 1.55 cm, t = 3.44, p = 0.0006), T2 (t = 4.18, p < 0.0001) and T3 (t = 2.07, p = 0.039). This finding indicates that the error reduction taking place after the second training session continued with time after the end of the training. In the visual task, a LMM on the error of the Post-op with session as a fixed effect predictor indicated that the error was larger in the pre-training session (T1, 1.73 ± 0.66 cm) as compared to any other session (T2: 1.01 ± 0.42 cm, t = 2.65, p = 0.008; T3: 0.76 ± 0.34 cm, t = 3.59, p = 0.0004; T4: 0.69 ± 0.32 cm, t = 3.84, p = 0.0001). This result indicates that the error in the visual task was reduced in the first 5-day training session and was stable in the following tests.

*B. Auditory space bisection*. The winning model was a GLMM on the probability of responding “closer to the right sound” with position of second sound, session, and their interaction as fixed effect predictors (i.e., without group). The just noticeable difference (JND), calculated from the GLMM at the 84th percentile, was significantly greater, and thus performance was less precise, in the pre-training (T1: 8.73 ± 1.21 °) than in any other session (T2: 3.79 ± 0.54 °, t = 4.02, p < 0.0001; T3: 1.99 ± 0.34 °, t = 4.70, p < 0.0001; T4: 3.50 ± 0.50 °, t = 4.24, p < 0.0001). After improving already following the first 5 days of training, performance further improved in T3 compared with T2 (t = 2.72, p = 0.007). In T4, the JND slightly increased compared to T3 (t = 2.44, p = 0.01), to reach levels comparable to the first post-training session, T2 (t = 0.43, p = 0.67). Despite the winning model did not include group, from the figure (Figure S2B), it is evident that the reduction of the JND was driven by the Blind group. This happened because, incidentally, the 6 Post-op participants tested over time were the ones performing better in this task already before the training, within the whole sample of 15 Post-op participants. Indeed, they were already at the performance levels of the Sighted group in the pre-training session.

*C. Mobility*. In the “Reaching for sounds” task, the winning model was an LMM on the absolute error with both session and group (without their interactions) as fixed effect predictors. Irrespective of the session, the error done by the Post-op was overall smaller than the error in the Blind group (t = 6.51, p < 0.0001, Figure S2C, left). However, both groups showed a similar pattern across the different sessions: they tended to reduce the error in T2 (Post-op: 17.43 ± 5.64 cm, Blind: 41.77 ± 3.66 cm) as compared to the pre-training (T1, Post-op: 26 ± 8.13 cm, Blind: 47.23 ± 5.62 cm, t = 1.89, p = 0.059), and they further reduced the error in T3 (Post op: 11.86 ± 2.19 cm, Blind: 26.01 ± 3.13 cm), which significantly differed from T1 (t = 7.4, p <0.0001) and T2 (t = 2.66, p = 0.008). Unfortunately, this improvement was not maintained in the follow-up, where the error increased to reach pre-training levels in both groups (Post-op: 30.98 ± 6.57 cm, Blind: 41.49 ± 3.46 cm, T4 vs T1, t = 0.06, p = 0.96). The error in T4 showed a trend for being higher than that in T2 (t = 1.95, p = 0.052) and was significantly higher than the error in T3 (t = 4.61, p < 0.0001). These results indicate that participants reduced the error in the first 5 days of training and they further reduced it with an additional 5-days session of training, but they did not maintain such an improvement over time following the end of the training.

In the “Timed up and go test” task (closed eyes condition) the winning model was an LMM on the time needed to conclude the task in each trial with session, group (Post-op, Blind) and their interaction as fixed effect predictors. Overall, Post-op were faster than Blind (Group: t = 5.78, p < 0.0001, Figure S2C, right). This happened because, as it happened for the *auditory space bisection* task, the 6 Post-op tested over time were the fastest ones within the whole sample of 17 Post-op already in the pre-training session. Being already so fast in the pre-training session (1.69 ± 0.44 s), they did not further significantly reduce the time needed to perform the task in the following sessions compared to the pre-training T1 (T2: 1.80 ± 0.37 s, t = 0.25, p = 0.80; T3: 1.33 ± 0.32 s, t = 1.25, p = 0.22, T4: 1.44 ± 0.08 s, t = 0.04, p = 0.97, Figure S2C, right). Instead, the Blind group was significantly slower in the pre-training session (T1, 3.95 ± 0.50 s) than in all other sessions (T2: 2.65 ± 0.35 s, t = 3.28, p = 0.002; T3: 2.42 ± 0.23 s, T4: 1.93 ± 0.11s). Participants became faster already after 5 days of training, and they maintained this speed also the next session of training (T2 vs T3: t = 0.76, p = 0.45). In the follow-up (T4), participants further reduced the time needed to perform the task as compared to T2 (t = 2.34, p = 0.024), while their performance did not significantly differ from that in T3 (t = 1.58, p = 0.12). We did not have data on the open eyes condition, because that condition was introduced in a second step and, unfortunately, we did not manage to test any of the participants included in the follow-up in that condition.

*D. Body midline*. For each participant, axis (horizontal, vertical), and session, we calculated the variance of the errors, namely the linear distances from the 0 in the 10 trials for each axis. We compared the variance across the different sessions via Friedman tests, separately for the horizontal and the vertical axis. Given that the patterns of results were similar in the two groups (Post-op, Blind), we aggregated their data (Figure S2D). Outliers above or below 2 SD from the group mean for each axis were excluded from the analyses. This led to the exclusion of 2 participants from the analysis on the vertical axis and 1 from that on the horizontal. Results were not significant for both the vertical (Chi-square = 3.15, p = 0.37) and horizontal axis (Chi-square = 2.47, p = 0.48), and the same happens when treating the two groups separately. However, from their average variances in Figure S2D, it is possible to appreciate that, overall, the variance seemed to be reduced in the first two sessions of training. However, while such a reduction appeared to be maintained in the follow-up for the vertical axis, this was not the case for the horizontal, where the variance raised again at pre-training values.

*E. Grasping*. We fitted the log-transformed grip force rate in each trial with an LMM with the four sessions, object width, and their interactions as fixed effect predictors. Neither session or the session by object width interaction were significant (all p-values > 0.22), indicating that the performance of the Post-op participants was similar in the four sessions (Figure S2E). Moreover, object width was not significant, indicating that participants did not scale their applied force to the object size, as sighted participants typically do. These findings indicate that participant’s performance in this task was not affected by the training.

In summary, the subset of the participants that could take part in a second 5-day training session and be tested in a follow-up improved and maintained the improvement in most tasks, with the exception of the *Reaching for sounds* task, where performance in the follow-up went back to pre-training levels in both the Post-op and Blind groups. Moreover, cataract-treated participants did not show any benefit from the training in the grasping task: they did not show any improvement at the end of the first 5-day training session, and the situation was unchanged after the second 5-day training session and in the follow-up.

**Supplemental references**

S1. Wu X., Long E., Lin H., Liu Y. (2016). Prevalence and epidemiological characteristics of congenital cataract: a systematic review and meta-analysis. *Sci Rep*, **6**, 1–10. doi: 10.1038/srep28564

S2. Papageorgiou E., McLean R.J., Gottlob I. (2014). Nystagmus in childhood. *Pediatr Neonatol*, **55(5)**, 341–351. doi: 10.1016/j.pedneo.2014.02.007

S3. Senna I., Andres E., McKyton A., Ben-Zion I., Zohary E., Ernst M.O. (2021). Development of multisensory integration following prolonged early-onset visual deprivation. *Curr Biol*, **31(21)**:4879-4885.e6. doi: 10.1016/j.cub.2021.08.060

S4. Senna I., Piller S., Ben-Zion I., Ernst, M.O. (2022). Recalibrating vision-for-action requires years after sight restoration from congenital cataracts, *eLife*, 11:e78734. doi: 10.7554/eLife.78734

S5. Senna I., Piller S., Gori M., Ernst M.O. (2022). The Power of Vision: Calibration of auditory space after sight restoration from congenital cataracts. *Proc R Soc B: Biol Sci*, **289(1984)**:20220768. doi: 10.1098/rspb.2022.0768

S6. Finocchietti, S., Cappagli, G., Gori, M. (2015). Encoding audio motion: spatial impairment in early blind individuals. *Front Psychol*, **6**:1357. doi: 10.3389/fpsyg.2015.01357

S7. Lewald J. (2002). Vertical sound localization in blind humans. *Neuropsychologia*, **40**, 1868–1872. doi: 10.1016/s0028-3932(02)00071-4

S8. Zwiers M.P., Van Opstal A.J., Cruysberg J.R. (2001). A spatial hearing deficit in early-blind humans. *J Neurosci*, **21**: RC142: 1–5. doi: 10.1523/JNEUROSCI.21-09-j0002.2001.

S9. Voss P. (2016). Auditory spatial perception without vision. *Front Psychol*, **7**:1960. doi: 10.3389/fpsyg.2016.01960

S10. Gordon A.M., Forssberg H., Johansson R.S., Eliasson A.C., Westling G. (1992). Development of human precision grip - III. Integration of visual size cues during the programming of isometric forces. *Exp Brain Res*, **90 (2)**, 399–403. doi: 10.1007/BF00227254.

1. We typically assessed whether participants’ performance following the training reached the level of the typical sighed population, by comparing the aggregated performance of Post-op and Blind in the post-training session in each task to that of the Sighted group. Note that the analyses yielded consistent results even when comparing the post-training performance of the Post-op participants alone (i.e., without including the Blind group) to that of the Sighted group (better performance in Post-op after training than in Sighted in *Auditory localization*: t = 2.88, p = 0.004, *Reaching for sounds*: t = 3.00, p = 0.003, and *Time-up-and-go* with closed eyes, t = 4.20, p < 0.0001; Same performance in Post-op after training vs Sighted in *Auditory space* *bisection*: t=1.57, p=0.12 and Body midline, along the vertical, z = 1.45, p = 0.15 and the horizontal axis, z = 0.66, p = 0.51). [↑](#footnote-ref-1)