The Psychology of Vision Loss: Understanding Psychosocial Impacts of Visual Impairment/ Blindness and incorporating appropriate patient counseling.

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A. Psychological Co Morbidities of Vision Loss
    a. Depression
        i. Defined
        ii. Impairs self-care, Activities of Daily Living (ADL's)
        iii. Leading cause of Suicide
        iv. Treatment
        v. Effective in 60-80%, <10-25% receive treatment.[i]
        vi. Associated with Heart disease, CVA, Diabetes, Cancer, Parkinson's, Arthritis, Pulmonary, and Vision Loss.[ii],[iii]
    b. Anxiety: symptoms versus disorder
        i. Symptoms are normal reactions to stress
        ii. Disorder is prominent, persistent, disruptive and abnormal
            1. Affects ~ 25% US population (at some point).[iv]
    c. Phobic Anxiety
        i. Focus on a particular object
        ii. Subject awareness of the irrationality of phobia
    d. Somatization (or Briquet Syndrome) [v]
        i. Physical symptoms involving more than one body part
        ii. NO identifiable physical cause.
        iii. Female >> Male
    e. Adjustment Disorder
        i. Emotional/ behavioral reaction to a stressful event
        ii. Stronger/ greater than expected reaction
        iii. Symptoms
            1. Generally acute, resolves within 6 months after stress cessation
            2. Chronic conditions can be associated with attempts at suicide.

B. Psychological Impact of Vision Loss: Other Factors
    a. Impact specific to Age

i. Elderly patients (70-93 years) suffer from the lowest visual acuity, global physical health, and low vision-specific quality of life

b. Impact specified economic strata, gender, faiths and race differences

c. Impact specific to Ocular Disease

i. Age Related Macular Degeneration (ARMD)

1. Preventing Depression in ARMD Trial[vi, vii viii]

2. Unilateral blindness & Emotional distress.[ix]

3. ~33% risk of developing depressive disorders.

ii. Glaucoma

1. Effect on treatment compliance

iii. Diabetic Retinopathy (DR)

1. Compounded by the loss of diabetes self-management skills.

iv. Retinitis Pigmentosa (RP), retinopathies

v. Retinopathy of Prematurity

vi. Congenital & Deaf-Blind

C. Psychosocial Aspects & Quality of Life (QOL)

a. Children & Young Adults

i. Social-emotional development (personality) and growth

ii. Assessment of intellect/ achievement in school

iii. Are there autistic features in congenitally blind children?

iv. Self Esteem and Blindness

b. Adults

i. Sleep problems in visual impairment

ii. Military: Working with Post Traumatic Stress Disorder (PTSD)

c. Elderly

i. Compounded by other age-related loss

ii. Neuropsychological degenerative diseases (in combination with vision loss)

iii. Charles Bonnet Syndrome (CBS).[x]

1. Neuropsychological screening during low vision assessment

2. Treatment options [xi]

3. Differential Diagnosis: psychiatric, neurological disorders such as drug or alcohol abuse (delirium tremens), Alice in Wonderland syndrome (AIWS), psychosis,

schizophrenia, dementia, narcolepsy, epilepsy, Parkinson disease, brain tumors, migraine, long term sleep deprivation.[xii]

D. Acquired Vision Loss: Mourning Process (Thomas Carroll)
    i. Loss of psychological security
    ii. Loss of basic skills
    iii. Loss in communication
    iv. Loss in appreciation
    v. Loss concerning occupation and recreation
    vi. Loss affecting whole personality
  b. Practice/ Acceptance
  c. Adaptation
    i. Rehabilitation of the visually impaired/ Blind: Teaching techniques to complete tasks in novel ways may restore feelings of independence/ control, and patient realization of social event and active participation is vital to overcome depression
  d. (Re)defining Identity for acquired vision loss: death of their sighted self is slow and painful
    i. Self
    ii. Family
    iii. Society

E. Assessment: Tests utilized to measure impact of vision loss
  a. Psychological Assessment Tools
    i. Brief Symptom Index, Perceived Stress Scale, Profile of Mood States survey (65-item self-reported inventory to assess emotional distress)
  b. Visual Assessment Tools
    i. Adaptation to Age-Related Vision Loss (AVL) Scale, NEI-VFQ National Eye Institute Visual Function Questionnaire, VF-14 (14-item visual functioning index), VAQ Visual Activities Questionnaire
  c. Specific Assessment Tools
    i. The Hypoglycemic Fear Survey (DR)
    ii. HRQOL health-related quality of life

F. Treatment
  a. Psychotherapy
  b. Developing effective problem-solving skills

c. Novel methods for completing ADL's.

d. Clinical Theory

i. "Loss theory" vs. Immediate Rehabilitation

e. Family vs. Individual Treatment

G. Other Treatment & Research

a. Pharmacological treatment

b. Alternative therapy: relaxation, meditation, hypnosis

H. Role of the Psychologist, Psychiatrist, Geriatrician, Optometrist

a. Optometric/ Ophthalmology Evaluation

i. Assessment of patient acceptance, psychological profile.

ii. Low-vision evaluation & prescription of optical low vision devices

b. Psychology & Psychiatry

i. Psychotherapy (+/-) Pharmacological treatment

c. Internal Medicine/ Geriatric Physician

i. Health status and other affecting factors

d. Vision rehabilitation professionals: Activities of Daily Living (ADL), Orientation and Mobility (O&M) safe travel, non optical rehabilitation, technology evaluation

I. What can you do?

a. Community resource referral: State Agency for Vision Loss, Aging, Transportation, etc.

b. Recognize psychosocial issues in patients AND families

c. Recognize depression affects care.[xiii]

d. Counsel patients

i. Simple strategies: high contrast and illumination at home, simple devices: sun lenses outdoors and brighter indoor environments

e. Knowledge of the latest research in vision rehabilitation and treatment of ocular conditions

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[i] http://www.who.int/mental_health/management/depression/definition/en/

[ii] Cole Steven A, Christensen John F, Raju Cole Mary, Cohen Henry, Feldman Mitchell D, "Chapter 22. Depression" (Chapter). Feldman MD, Christensen JF: Behavioral Medicine: A Guide for Clinical Practice, 3e: http://www.accessmedicine.com/content.aspx?aID=6441215.

[iii] Robin J. Casten PhD, and Barry W. Rovner, MD. Vision Loss and Depression in the Elderly. Psychiatric Times. Vol. 23 No. 13 November 1, 2006

[iv] Internet

[v] http://www.nlm.nih.gov/medlineplus/ency/article/000955.htm

[vi] Rovner BW, Casten RJ, Tasman WS. Effect of depression on vision function in age-related macular degeneration. Arch Ophthalmol. 2002;120:1041-1044.

[vii] Williams RA, Brody BL, Thomas RG, et al. The psychosocial impact of macular degeneration. Arch Ophthalmol. 1998;116:514-520.

[viii] Robin J. Casten PhD, and Barry W. Rovner, MD. Vision Loss and Depression in the Elderly. Psychiatric Times. Vol. 23 No. 13 November 1, 2006

[ix] Robin J. Casten PhD, and Barry W. Rovner, MD. Vision Loss and Depression in the Elderly. Psychiatric Times. Vol. 23 No. 13 November 1, 2006

[x] Vojniković B, Radeljak S, Dessardo S, Zarković-Palijan T, Bajek G, Linsak Z. What associates Charles Bonnet syndrome with age-related macular degeneration? Coll Antropol. 2010 Apr;34 Suppl 2:45-8.

[xi] Schadlu AP, Schadlu R, Shepherd JB 3rd. Charles Bonnet syndrome: a review. Curr Opin Ophthalmol. 2009 May;20(3):219-22.

[xii] Vojniković B, Radeljak S, Dessardo S, Zarković-Palijan T, Bajek G, Linsak Z. What associates Charles Bonnet syndrome with age-related macular degeneration? Coll Antropol. 2010 Apr;34 Suppl 2:45-8.

[xiii] Robin J. Casten PhD, and Barry W. Rovner, MD. Vision Loss and Depression in the Elderly. Psychiatric Times. Vol. 23 No. 13 November 1, 2006