



FACT SHEET

Vision Loss: The Grief Cycle and Depression

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Patients with emerging visual impairments represent a largely unrecognised group who require not only optical and diagnostic help but also empathy and psychological support.

The perception when visiting a high street optometrist is for sight enhancement via optical correction, rather than primary health care. Since the expectation when vision is reduced is that stronger spectacles will correct the problem, it is an understandable shock to be told this is not the case. The temptation to prescribe new spectacles, unless a significant improvement can be attained, must be avoided as this will simply compound the disappointment when they apparently underperform, leaving the patient in a more vulnerable position. Simply saying the prescription has not changed is equally inappropriate when the patient is fully aware their vision has deteriorated.

The emotional and psychosocial impact of visual disabilities is now recognised to be of paramount importance.

The optometrist should initiate the education process; necessarily time consuming but essential for the patient's understanding, acceptance and rehabilitation.

The Optometrist: Initiator of the Rehabilitation Process

A grief cycle, including denial, anger, bargaining, depression and finally acceptance, is now widely believed to apply to any personal trauma or change.

Blindness is recognised as the most feared disability inducing emotional distress comparable to cancer.

While the grief stages must be considered positive processes in the required life adjustment to any loss, the normal bereavement can evolve into more serious depressive disorders if the depressive mood persists. While it is expected a level of depression will accompany the adaption process, the often irreversible nature of vision loss means the trigger for depression does not dissipate.

People with reduced vision have significantly greater difficulty shopping, managing finances, meal preparation, housework and using telephones. Restricting activities of daily living leads to frustration which impacts on depression rates; in turn magnifying the visual problems.

The resilience and self-sufficiency of each patient is important.

Patients already exhibiting depressed signs at diagnosis are significantly more likely to show a decline in visual function over time. A patient with a history of anxiety and depression is more likely to require emotional and counselling support.

Even when affecting only one eye, vision loss can induce marked levels of depression, regardless of good binocular function. It has been suggested these levels of depression reflect the fear of progression.

Further, sub-threshold depression has been shown to compound the functional disability, beyond that attributable to the vision alone.

Patients minimally depressed at diagnosis are at high risk of developing severe depressive disorders and to suffer reduced visual function regardless of clinically stable vision. Managing depression, even in isolation, will improve functional visual performance.

Problem Solving Strategies – Managing Depression

A significant factor in rehabilitative success is the patient taking personal control of the situation, committing to themselves and dependents and approaching change as challenges rather than threats. These concepts should be incorporated at the earliest stage; when the initiating optometrist first realises the failure of spectacles to fulfil the patient expectations.

The initiating optometrist is an invaluable source of information and basic counselling to help patients adapt to their vision loss. These processes must be handled with empathy and understanding; the attitude of professionals delivering care has been demonstrated to be crucial to the successful adaptation to vision loss. A valid low vision appointment may consist solely of talking.

Even if onward referral for another professional's help is appropriate, optometrists must initiate patient empowerment and introduce a problem solving ethos. 'Problem Solving Treatment' has been demonstrated to reduce the development of depressive states, which in turn improves functional visual outcomes.

Patients must be active participants in the rehabilitative process; this necessitates an understanding of the disease process. Also important is a good support network; the entire

family, including carers, are victims of the vision loss and, with the patient's approval, need to be included in the education and rehabilitative process. Our many FACT SHEETS help educate patients and family members.

For emerging visual impairment, such as cataracts, the introduction of alternative visual strategies is of great help to the patient and family. The advice needs to be introduced in terms of easily surmountable problems. Demonstrating 'Spot Lighting' when reading, for instance has an immediate positive impact. This demonstration initiates discussion on environmental aspects of vision, contrast and lighting for instance, as opposed to a simple optical appliance. Advice and supporting information of 'Big/Bright/Bold', 'reading reserves', 'spot tasking', 'low contrast vision' and types of field restrictions do not improve a person's vision but help them appreciate how to adjust to the challenges. The patient and family are in control.

Caution is needed prescribing low vision devices before the patient has necessarily accepted the problem. However their acceptance is far more likely if introduced as a normal enhancement of vision rather than a low vision device. Anecdotal examples of spot tasks, such as reading coloured packets, are excellent in opening communication about real life difficulties with which many practitioners can also identify.

It is crucial the patient realises they are not alone. A caring and understanding manner may ensure the optometrist is the only professional necessary to fulfil the patient's visual and emotional needs.