

# Blindness, Fear of Sight Loss, and Suicide

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*Numerous studies have examined the emotional impact exerted by sight loss. Research has tended to focus on clinical–diagnostic rather than therapeutic–preventive aspects. Blindness and sight restoration have been reported to induce both temporary and longer term psychopathology, usually followed by psychosocial readjustment. However, in some cases, readjustment may not occur and suicide may result. Together with an extensive review of available literature, the authors present cases taken from their psychological autopsy study database. When compared with a hearing-impaired control group, impaired sight alone can acutely affect otherwise psychologically healthy individuals. Ophthalmologists need to be aware of this problem and to develop closer collaboration with mental health professionals. Serious consideration of this problem and definition of clear guidelines may prevent suicidal behavior. (Psychosomatics 1999; 40:339–344)*

Of the five senses possessed by humans, sight has always been considered the most important. It has long been acknowledged that vision loss may bring about varying degrees of psychic suffering, undoubtedly greater than the distress resulting from other forms of sensorial impairment, at all ages. In a comparative study on two populations of young males with sensory deprivation, for example, Abolfotouh and Telmesani<sup>1</sup> reported depressive symptoms to be more common among the blind than the deaf. From a study by Apollonio et al.,<sup>2</sup> the finding emerged that, in a sample of 1,000 elderly people with severe visual impairment, the most depressed subjects with the least socialization and highest mortality rate were those in whom visual impairment had been neglected or not sufficiently corrected.

Although there is no specific psychopathological reaction to blindness, clear clinical pictures have been reported to emerge, enabling degree of suffering and possible outcomes to be diagnosed and prognoses formulated. One typical patient reaction is depression of varying duration and severity, according to the patient's underlying personal characteristics and socioeconomic status. A radical change in life-style has been indicated in all patients, including loss of employment, self-sufficiency, and self-esteem. Authors

such as Cholden,<sup>3</sup> Blank,<sup>4</sup> and Shulz<sup>5</sup> have linked the response to blindness to a grief reaction, in which patients mourn the loss of the sighted self. In some cases, this reaction is complicated to the point of precipitating suicide.

Only very few studies have to date been oriented toward helping ophthalmologists recognize, assess, and treat psychopathological symptoms concomitant with blindness in this difficult type of patient. Therefore, the aim of this work is to analyze, on the basis of our own data and on the available literature, the relationship between sight loss, especially the fear of losing sight, and individual reactions, with a view to identifying issues that physicians must bear in mind to avoid the onset of a psychopathological syndrome, which may, in turn, lead to suicide.

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### PHYSIOLOGICAL AND PATHOLOGICAL REACTIONS TO SIGHT LOSS

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According to Adams and Pearlman,<sup>6</sup> there are three types of responses to sight loss: acceptance, denial, and depression/anxiety. Acceptance is undoubtedly the best response. Denial, which is an unconscious defense mechanism, may in some cases aid progressive acceptance of the handicap. Following diagnosis, some patients make a pilgrimage to a whole host of ophthalmologists in the hope of finding a cure. Although these trips are generally made in vain, they may reduce anxiety that might otherwise become pervasive. According to Riffenburgh,<sup>7</sup> acceptance of blindness in other patients is achieved through a physiological depressive reaction, which should not be considered negatively, but encouraged, as should the expression of feelings of fear, anger (including anger directed at the doctor), and self-pity. Indeed, the author considers manifestation of these feelings to have a cathartic effect.

A strong discrepancy emerged between the patients with different clinical prognoses, that is, between those blind and those affected by partial sight loss. The psychopathological picture was worse for those with partial sight loss who displayed a more marked presence of depressed mood, anger, and hostility.<sup>8</sup> Correction of gradually deteriorating sight seemed to pose greater problems than adaptation to total, definitive loss.<sup>9,10</sup> Completely blind subjects probably had to cope with an irrefutable handicap, forcing them to accept their new social role and making them more malleable to rehabilitation techniques that, objectively, permitted better social adjustment.<sup>11-13</sup> Persistence of false hopes, on the other hand, tended to be more frequent in those with residual light perception or fluctuations in sight, which was typically the case of patients affected by glaucoma or diabetic retinopathy, for whom eye examinations or palliative treatment with unexpected temporary benefits were common.

Unfortunately, such reactions to sight loss do not always remain within the normal limits but may assume "pathological" characteristics that persist over time. In a sample of patients with acquired blindness, Fitzgerald<sup>14</sup> reported the presence of depressed mood in 90% of the studied cases, accompanied by a series of typically depressive symptoms, such as insomnia, loss of appetite, social withdrawal, loss of self-esteem, crying, and suicidal ideation, the outcome of which is reason for concern. These symptoms were present in over 50% of the interviewed subjects, and signs of anxiety were displayed by over 70% of the sample. Hallucinations, suspiciousness, paranoia, and al-

cohol abuse were present in less than half the cases. Together with sight loss, two-thirds of the sample complained of a deterioration of preexisting somatic symptomatology; in 37% of the cases, symptoms/pathologies were of new onset. These findings imply a strong correlation between sight disorders, psychic distress, and somatic outcome.

The situation worsens if the psychopathological symptomatology becomes chronic. In a 4-year follow-up study on the aforementioned sample, Fitzgerald et al.<sup>15</sup> reported the persistence of a depressive-anxious syndrome in over 50% of the cases, indicating that the initial crisis had not been resolved. Psychotic symptoms, too, persisted, without any improvement after the 4 years, in patients displaying them at the onset of blindness. Decreased overall coping capacity, increased stress, a higher incidence of chronic organic pathologies, and a decline in social status were reported. Wittkomer and Davenport,<sup>16</sup> Rochlin,<sup>17</sup> and Emerson<sup>18</sup> reached the same conclusion on completion of 1- to 4-year follow-up studies. Depressive symptoms, including suicidal ideation, were present in over 50% of the cases.

### RISK FACTORS

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Personal traits appear to be the first discriminating element. Gentle, timid, obedient, conforming subjects, who respect authority, appeared to be most vulnerable.<sup>19</sup> To "die" as a sighted person and be "reborn" as a blind person seems to be facilitated in subjects with an experimental-type personality. Dependent personalities, in contrast, constitute an impediment to the development of an alternative life-style.

Not only personal characteristics, however, are discriminatory. Being young, of good financial status, and in a moderate-to-high sociocultural level<sup>12</sup> have all proved to be protective factors against the onset of psychopathology. Persons with these characteristics maintained good social relations and avoided isolation, which is a risk factor for depression. These same factors applied to good premorbid social integration. In addition, the subjects with a history of chronic organic pathologies appeared to have poorer coping skills with respect to their blindness, which was experienced as an additional aggravating factor and an attack on their person.<sup>12,14</sup>

Contrary to common belief, no differences emerged in the process of accepting blindness between those becoming blind over a period of a few months and those whose sight had deteriorated over several years.<sup>12,14</sup> The fact that the reaction to loss was the same suggests that the approach to the handicap is more important than the time factor.

Bernbaum et al.<sup>13</sup> demonstrated that, in a sample of

patients affected by progressive diabetic retinopathy, only those who had reached total blindness actually displayed a decrease in psychic symptomatology, through learning rehabilitation techniques. More marked distress remained in the subjects with persisting partial sight. Unfulfilled expectations probably increased frustration at daily defeats, coupled with fear of complete loss of residual sight. Acceptance of one's pathology and final outcome is the basis for approaching and acquiring new behavioral patterns and creating good mental, physical, and social equilibrium in those who become blind.<sup>20-22</sup>

Another important point of reference for patients with visual impairment is the family. Shulz<sup>5</sup> describes four reactions that may occur in family members: denial, refusal, acceptance, and overprotection. The latter reaction is the most frequent, but also the most counterproductive, insofar as it reinforces the patient's objective physical and financial dependence on others. The link among dependence, regression, and depression has proved to be strong.<sup>15</sup> Dependence and loss of autonomy have been reported to bring about self-depreciation. A follow-up study by Fitzgerald *et al.*<sup>15</sup> confirmed this hypothesis by demonstrating that the subjects making the most use of rehabilitation instruments, who lived alone, and preserved their own mobility and occupation were the least depressed, with the lowest risk of suicide and the highest level of social integration.

To assume a supportive attitude aimed at promoting the autonomy of a blind relative, families must undergo a maturation process, leading to acceptance of their relative's sight loss and the difficulties this loss entails. Considerable effort is required, and results are not always positive. In the early stages of the disorder/disease, divorce or family problems ascribed to sight impairment have been reported,<sup>23</sup> while family integration and acceptance of the affected person's new role has proved less difficult for patients with a family history of blindness.<sup>15</sup>

#### FEAR OF SIGHT LOSS: PSYCHOLOGICAL AUTOPSY OBSERVATIONS

Although literature exists on blindness and the possible pathological repercussions of its late onset, there is a paucity of information on the pathological reactions to the fear of going blind. To better understand the differences mentioned earlier, as well as investigate a population of suicides involving the fear of blindness, a comparison was made of suicides by those with visual vs. hearing impairment. Our aim was to highlight and analyze the differences between cases of sensory apparatus loss and suicide, trying

to identify important causal factors involved in the precipitation of suicide in these types of cases.

The case studies evaluated in this article were obtained from the coroner's postmortem reports, police reports to the coroner, and the completion, by police, of a structured questionnaire designed by the Australian Institute for Suicide Research and Prevention. The case studies were collected over the period 1990-1997. Twelve cases were identified as being suicides involving those who were visually impaired. Seven cases were identified as involving those who were hearing impaired. One of these cases involved both hearing and sight loss; however, it resulted in being classified as a sight loss case because the deceased had begun to lose his eyesight shortly before committing suicide. Taken together these sensorial impairments represented 0.52% of the total number of suicides recorded in the Queensland Suicide Register during 1990-1997 ( $N = 3,654$ ). The cases were compared according to age, gender, psychiatric history, major recent life changes as a result of impairment, support, and other possible cofactor traumatic events.

#### RESULTS

There were 19 cases of sensory deprivation with a ratio of about 3:2 eyesight-impairment ( $N = 12$ ) to hearing-impairment cases ( $N = 7$ ). The eyesight- and hearing-impaired suicides were not significantly different across age (mean sight: 48.4, range: 20-89; mean hearing: 44.4, range: 19-80, respectively). All hearing-impaired suicides and 75% of the sight-impaired cases were male. This figure contrasts with an overall suicide gender ratio of 4:1. Table 1 summarizes the qualitative differences between the eyesight- and hearing-impairment cases.

The types of suicide cases related to sight and hearing impairment were noticeably different. In all but one of the 12 cases involving sight impairment, substantial anxiety and fear surrounding the progressive sight loss were reported, and this angst was identified as likely to have been a major contributing factor to suicide by those close to the deceased who were interviewed. There were no cases of "blind" persons committing suicide. Similarly, we found no cases of restored eyesight precipitating suicide. Hearing-impaired suicides differed substantially; in only two cases the person's hearing impairments (*i.e.*, tinnitus, Miniere's disease) were reported as being possible contributing factors to the suicides. There were two cases of "deafness," with the rest of the auditory cases involving chronic tinnitus or Miniere's disease. In one case, a person had been

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deaf for an unknown period of time before developing worsening sight deterioration, after which the person soon committed suicide.

Eight percent of sight-impaired suicides and 63% of hearing-impaired suicides had a history of mental illness. Several hearing-impaired cases had Axis I and Axis II comorbidity, such as alcohol abuse and personality disorder. Twenty-five percent of the sight- and 43% of the hearing-impaired cases had other recent traumatic life events occur prior to suicide.

Both groups had similar levels of support, with 75% of the sight-impaired cases and 86% of the hearing-impaired having recognized support systems.

### DISCUSSION

Even if the small sample size does not permit firm conclusions, fundamentally these findings suggest that the foreseeable loss of sight—exclusively—can induce severe psychological distress that can lead to suicide. In one particular case, a patient (age 81) with no known psychopathology or recent traumatic life stressors committed suicide the day she was told that the prognosis of her condition was blindness. Even when compared with other forms of sensory deprivation such as hearing, populations with a prognosis of progressive blindness are at high risk of suicide, seemingly even more so than patients with acquired complete blindness.

A second point of interest arriving from the analysis was that the two sensory-deprived groups were essentially two different suicide populations. Despite both populations being sensorially deprived, potential loss of sight was the main causal factor for suicides involving sight loss, whereas hearing deprivation was coupled with several

other likely causal factors, including psychopathology, symptoms of sensorial problem such as irksome noise, chronic dizziness, recent radical life changes, and bereavement. In spite of these differences, there were almost double the number of sight-impaired suicides.

This finding seems to further emphasize the greater impact of visual problems on the adaptive capabilities of individuals. Unfortunately, given the nature of our data, we could not evaluate the weight of important variables such as objective severity of the impairment, time from first diagnosis, or prognosis (time until the onset of total blindness). Naturally, another important factor to measure would be age, but again, the examined sample did not allow any deeper evaluation because of its small numbers. The same holds true for employment and financial position.

The World Health Organization estimates that there are about 28 million nonsighted persons in the world today and that this number rises to 42 million with the inclusion of subjects with visual acuity of 1/10 or less, which more than justifies interest in this subject. Authors have, to date, tended to consider the question from a clinical–diagnostic point of view, without paying much attention to psychological rehabilitation and preventive aspects. Results now show that in most subjects, blindness tends to cause emotional shock, which provokes strong reactions, typically marked by mood and behavioral swings, but which generally culminate in new social integration.

Quite paradoxically, sight restoration has also been directly associated with the onset of a psychopathological syndrome, even to the point of precipitating suicide. This evidence has been documented over the years by several researchers in various centers.<sup>23–25</sup> Patients can become dejected, depressed, and suicidal. When sight is restored, they must develop an understanding of a new environment,

**TABLE 1. Qualitative summary of sensory impairment cases**

	<b>Eyesight Impairment</b>	<b>Hearing Impairment</b>
Number of cases	12	7
Illness description	All cases were progressive eyesight deterioration.	3 cases of tinnitus, 2 cases Meniere's disease, 2 cases deafness, 1 case "hearing troubles"
Psychological problems	One case had a history of mental health treatment.	Five cases had a history of mental health treatment.
Other traumatic life events	One case involved a long-term relationship break-up, one case suffered a family bereavement, and one case involved a recent retrenchment.	Two cases experienced employment troubles; in another a friend had recently committed suicide.
Support	Nine cases had family or relationship support.	Six cases had either mental health or family support.
Strength of impairment	In 11 cases, eyesight deterioration was identified as a major contributing factor to suicide.	In two cases, hearing-related problems were identified as a major contributing factor to suicide.

*Note:* One case overlaps both sight and hearing loss; however, because eyesight deprivation occurred shortly before the suicide, this case has been grouped as "eyesight impaired."

where things are perceived synchronically vs. sequentially, often inducing shock in patients and the need for intensive rehabilitation programs. In addition, the patient's identity and social role as a blind person, after drawing on various means of support, is lost to imposed autonomy and responsibilities.<sup>23</sup> Lester<sup>26</sup> maintained that the result most frequently observed in these patients was the loss of the illusion that all existential distress depended exclusively on visual impairment. Discovery of the fragility underlying their malaise precipitated intolerable emotions, eventually resolvable by suicide. Technological and surgical progress in sight restoration in the coming years will dictate greater attention to these issues.

These reactions are a mirror image of the same trauma: a change in the individual's life-style. Conversely, the onset in some patients of a more severe psychopathological syndrome often caused suicide to be considered the solution to the distress. Subjects more prone to this outcome appeared to have dependent, introverted personality, with poorer premorbid history of social integration and less family support.

The psychological autopsy findings suggest that those with worsening sight and the prognosis of eventual blindness are at comparatively high risk of suicide and thus may be in need of supportive services. These observations advocate the establishment and extension of therapeutic and preventative programs to include patients with impending and current severe visual impairment who do not qualify for services for the blind. Ophthalmologists should be made aware of these potential consequences and incorporate a place for mental health professionals in their treatment of these types of patients, with a view to preventing the onset of depressive symptomatology, avoiding self-destructive behavior, and improving the quality of life of these patients. Such intervention should occur in the early stages of diagnosis, particularly as many studies have demonstrated how rapid acceptance of the serious visual handicap has led to a better, more productive compliance with rehabilitation programs. Moreover, psychological distress has been reported (and is exemplified by our psychological autopsy study) to be at its highest when sight loss is not complete, but the prognosis is unfavorable.<sup>10</sup> Therefore, early intervention is imperative for enabling successful psychological adjustment.

When an attending doctor objectively believes that there is no hope of recovery, it is better to inform the patient and to base discussion of the prognosis and availability of rehabilitation programs for support and maintenance purposes on the physician's professional experience.<sup>27</sup> Exces-

sive display of compassion or unjustified reassurance have been demonstrated to prolong the patient's distress. Physicians must learn to accept their own defeat and develop alternative, fully comprehensive therapeutic programs that, moreover, have often proved to be effective.<sup>28</sup>

In light of the experiences reported in the literature, management of the subjects reacquiring sight requires detailed preoperative preparation, with particular emphasis on the strong emotion involved with the surgery and its outcome. An intense physical and psychological rehabilitation program should follow, bearing in mind that the longer the patient was blind the greater the effort required will be to recover sight and psychological equilibrium. In both circumstances, patients must be progressively followed to avoid dependence, regression, and isolation and to promote autonomy and good social integration. An important ally in this delicate stage might be found in the patient's family. After being informed of the clinical situation and any secondary complications that may arise, relatives could be trained to offer physical and emotional support, without being overprotective, or worse, pitiful.<sup>29</sup>

The creation of self-help groups for patients, and the inclusion of the more fragile families, should also be a priority. Expressing negative feelings and exchanging them with others, in addition to communicating appropriate coping methods, may constitute a valid form of constructive help.<sup>29</sup>

## CONCLUSION

Seeing the surrounding world is undoubtedly a wonderful experience. Throughout history sight deprivation has been seen as the most severe form of punishment, second only to loss of life. This is demonstrated by the centuries of torture using sensory deprivation—from the use of the red-hot iron stake through the eye during the Crusades, to the enucleation widely practiced in Europe up to the 18th century.<sup>30</sup>

Many patients have become blind or had their sight restored by surgery. The resulting shock is sometimes greater than the shock caused by many organic pathologies, with an unfavorable *quoad valetudinem* prognosis. The findings emerging from studies on the subject clearly stress the need for greater sensitization to the problem, together with the establishment of guidelines for preventing the onset of secondary depression and suicidal behavior. The latter phenomenon, which is rare but not sporadic, is probably the most feared and most traumatic for attendant doctors, since it is a tangible expression of the dramatic

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distress experienced by the patient and may in some cases represent therapeutic defeat. We believe that the close cooperation between ophthalmologists and mental health pro-

fessionals is the key to helping blind patients and those with newly restored sight to appropriately reintegrate into society.

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### References

1. Abolfotouh MA, Telmesani A: A study of some psycho-social characteristics of blind and deaf male students in Abha City, Asir region, Saudi Arabia. *Public Health* 1993;107:261-269
2. Apollonio I, Carabellese C, Frattola L, et al: Effects of sensory aids on the quality of life and mortality of elderly people: A multivariate analysis. *Age Ageing* 1996; 25:89-96
3. Cholden LS: Some psychiatric problems in the rehabilitation of the blind. *Bull Menninger Clinic* 1954;18:107-112
4. Blank HR: Psychoanalysis and blindness. *Psychoanal Q* 1957; 26:1-24
5. Shulz PJ: Reaction to the loss of sight, in *Psychiatric Problems in Ophthalmology*, edited by Pearlman J, Adams G, Sloan S. Springfield, IL, Charles C Thomas, 1977, pp. 60-73
6. Adams L, Pearlman T: Emotional response and management of visually handicapped patients. *Psychol Med* 1970; 1:233-240
7. Riffenburgh RS: The psychology of blindness. *Geriatrics* 1967; 22:127-133
8. Oehler JW, Fitzgerald RG: Group therapy with blind diabetics. *Arch Gen Psychiatry* 1980; 37:463-467
9. Stern NG: Out of sight: Coping with diabetic retinopathy. *Journal of Visual Impairment and Blindness* 1983; 2:304-305
10. Wuslin LR, Jacobson AM, Rand LJ: Psychosocial correlates of mild visual loss. *Psychosom Med* 1991; 53:109-117
11. Carrol TJ: *Blindness: What It Does and How to Live with It*. Boston, MA, Little, Brown, 1961
12. Ash DDG, Keegan DL, Greenough T: Factors in adjustment to blindness. *Can J Ophthalmol* 1978; 13:15-21
13. Bernbaum M, Albert SG, Duckro PN: Psychosocial profiles in patients with visual impairment due to diabetic retinopathy. *Diabetes Care* 1988; 11:551-557
14. Fitzgerald RG: Reactions to blindness: an exploratory study of adults with recent loss of sight. *Arch Gen Psychiatry* 1970; 22:370-379
15. Fitzgerald RG, Ebert JN, Chambers M: Reaction to blindness: a four-year follow-up study. *Percept Mot Skills* 1987; 64:363-378
16. Whittkomer E, Davenport RC: War blinded: their emotional, social and occupational situation. *Psychosom Med* 1946; 8:121-137
17. Rochlin G: *Grief and Discontents: The Forces of Change*. Boston, MA, Little, Brown, 1965
18. Emerson DL: Facing loss of vision: the response of adults to visual impairment. *Journal of Visual Impairment and Blindness* 1981;75:41-45
19. Greenough TJ, Keegan DL, Ash DJ: Psychological adjustment of blind subjects and the 16PF: *J Clin Psychol* 1978; 34:84-87
20. Keegan DL, Ash DDG, Greenough T: Blindness: some psychosocial and social implications. *Can Psychiatr Assoc J* 1976; 21:333-340
21. Thume L, Murphee OD: Acceptance of the white cane and hope for the restoration of sight in blind persons as an indicator of adjustment. *J Clin Psychol* 1961; 17:208-209
22. Diamond BL, Ross A: Emotional adjustment of newly blinded soldiers. *Am J Psychiatry* 1945; 102:367-371
23. Lester D: Suicide after the restoration of sight. *JAMA* 1971; 216:678-679
24. Valvo A: Behavior patterns and visual rehabilitation after early and long-lasting blindness. *Am J Ophthalmol* 1968; 65:19-24
25. Firluk AD: What we fail to see (case report). *JAMA* 1992; 267:1328
26. Lester D: Suicide after restoration of sight (continued) (letter). *JAMA* 1972; 219:757
27. Cholden LS: *Psychiatrist Works With Blindness*. New York, American Foundation for the Blind, 1958, pp. 18-30
28. Caplan LM: Pre-education of the potentially blind as a deterrent to suicide. *Psychosomatics* 1981; 22:165-169
29. Wilson NL: An orientation to vision loss program: meeting the needs of newly visually impaired older adults. *Gerontologist* 1996; 36:534-538
30. McGuffin J: *The Guinea Pigs*. Harmondsworth, UK, Penguin, 1974