Rehabilitation or referral of depressed low vision patients

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Demographic aging will lead to an increased demand for medical care, including low vision rehabilitation. Therefore, in the near future, low vision rehabilitation centers need to make efficient decisions and choose the rehabilitation program that has the greatest likelihood of benefiting each individual. The growing demand for service by our aging population probably means that low vision centers will no longer be able to afford spending too much time on any one patient without being sure the patient is going to benefit from the offered treatment.

We know from a number of studies that even early signs of depression can interfere with rehabilitation outcomes in low vision patients. Reduced scores on vision related quality of life measures for depressed elderly have been reported,[1] which means that the effect of low vision rehabilitation was unsatisfactory for these patients. There may be different ways that depression interferes with low vision rehabilitation outcomes (e.g. reading aids training, mobility training or training in activities of daily life). Depression can affect a person's learning capacity or ability to retain information, and it also could result in a disturbance in thought processes, difficulty in making decisions, or difficulty orienting towards achieving goals.[2] Consequently, some depressed visually impaired persons do not benefit from low vision rehabilitation. Recognizing depression and making referrals to either mental health care or specialized low vision rehabilitation programs is necessary to improve low vision rehabilitation outcomes for those patients. In the Principles & Practice of Low Vision Rehabilitation (PPLVR) course on "Depression and Psychological Adjustment in Low Vision", there are some important suggestions made by Dr. Julia Kleinschmidt and Dr. Barry Rovner, which can be considered guidelines on how to handle individual visually impaired patients who are suffering from depression.

Grief is perfectly normal. Kleinschmidt is very clear about expectations for patients who just lost most or part of their vision or who were recently diagnosed with an irreversible progressive eye disorder. She argues that it is normal for a patient to go through a period of grief — a person who recently lost vision should be grieving. This is important guidance, because as a low vision clinician, a vision rehabilitation worker, a psychologist, a social worker, occupational therapist, or other specialist providing low vision rehabilitation service we might be inclined to jump to conclusions and immediately start giving people advice on how they should react and how they will eventually cope with their problem, that they will find out that life is worth living, even with vision loss. Indeed, we have seen from our "successful" patients that they will progress and that eventually they will be fine once they know better how to handle being visually impaired. Kleinschmidt advises us to first step back and tell our patients that there is nothing wrong with grief. We need to be empathetic and supportive while the patient experiences this initial stage of coping.

But what if a person does not come out of a period of grief? Rovner states that about one third of visually impaired persons keep on being depressed even eight weeks after the diagnosis of an eye disease, or loss of vision. In that case the depression can probably be considered a serious medical condition that is not simply a normal reaction to vision loss. A clinically diagnosed depression can be considered a major threat to quality of life, to the ability to cope with daily life activities and even to life expectancy. In the geriatric literature it is well known that depression often accompanies disabling diseases, that depression aggravates existing disability, and that functioning can improve once it is treated adequately.[3]

Fortunately, not all elderly patients with vision loss suffer from depression. It has been suggested that visually impaired elderly with progressive visual acuity loss, poor health, co-morbidity and less self-efficacy,[4-9] are more prone to develop depressive symptoms than their counterparts. Therefore, the finding of Rovner that it is perfectly normal after diagnosis or vision loss to be depressed, sad or overwhelmed for approximately eight weeks, could be taken as a guideline as well.

Intervention options. Both Kleinschmidt and Rovner suggest to start intervention if it takes too long for a person to come out of the depressive episode. At this point we have to make another decision in our care process for the depressed visually impaired person. Which intervention should we start first? We could start with giving our patients low vision aids, mobility training, occupational therapy, cooking classes, or all regular low vision rehabilitation which one would usually provide to a visually impaired patient. Rovner calls low vision rehabilitation programs a form of psychotherapy, similar to problem solving therapy. There also could be indirect effects of low vision rehabilitation on depression. For example, walking is proven to be an effective therapy for depression in general populations, so once a person is able to go out again because of mobility training, it should at least partly ameliorate the depression. I do think, however, this ‘indirect psychotherapy’ is different from directly addressing the mental problem, which happens in psychotherapy sessions with a psychologist or psychiatrist, which oftentimes includes giving our patients antidepressants.

Which option to choose will probably depend on a more thorough study of our patient. In the past, Leinhaas and Hedstrom (1994) have described a model of low vision services that involved assessment of all patients by social workers for depressive symptoms. Those who met diagnostic criteria were referred to psychiatric consultation and the low vision intervention was delayed pending treatment for depression.[10] To delay all interventions does not seem appropriate, such as prescription of low vision aids or adaptations in the home environment, but a delay could be appropriate for more comprehensive low vision rehabilitation programs that require much effort of the patient, such as orientation and mobility training, activities of daily living training (ADL's), or specific training for the use of various reading aids (e.g. working with a CCTV). In contrast, but similar to what Rovner suggests, Dodds (1991) described a model in which skill training in itself would produce an improvement in the client’s self-perception by letting him see his own competence increasing.[11]

The suggested problem solving therapy (PST) is a very attractive one, because first, with PST it is possible to combine low vision rehabilitation and psychotherapy by teaching patients techniques on how to solve their own problems. Moreover, it will give visually impaired patients more self-esteem once they have actually experienced that it is possible to be independent up to a certain level. Second, PST may be given by social workers or psychologists in a therapy session, but it can be integrated in a rehabilitation worker's every day practice as well.

Taking the severity of depression into account. Despite the best efforts of the rehabilitation specialist, improvement may still depend on the severity of the depression and the factors that underlie the depression. That is why I think it is important to know that different medical decisions should be made when the depression is merely a reaction to vision loss compared to when, for example, the patient has a history of depressive episodes. Moreover, we want to know what the severity is of the current depressive episode in the individual patient.[12,13] Is it a major depression, according to DSM-IV criteria, a minor depression, sub-threshold, dysthymia, seasonal? Recognition of depressive symptoms in older persons can be complicated. Recently, it was found that in my country (the Netherlands) general practitioners failed to diagnose two out of three patients who suffered from depression.[14]

Often the focus of consultation in older persons is directed towards physical complaints and not so much towards psychological symptoms. This is something Rovner mentions as well in the PPLVR-course. It is not the fault of the doctor per se, but also patients more easily address physical problems than mental problems. One can imagine it to be easier for a patient to describe a painful joint than a painful psychological concept. Similarly, low vision rehabilitation centers may fail to detect depression and a patient may fail to mention it because of the focus on vision problems. Consequently, patients are not referred adequately. At the end of Rovner's lecture he gives us two screening instruments "Geriatric Depression Scale" and the "Patient-Health-Questionnaire-9". Although we should be aware that these screeners are not going to answer the question whether the patient is suffering from a major depression according to DSM-IV criteria, they will point us in the direction of a referral inside or outside the low vision rehabilitation center.

We should also be aware that depression in older age may manifest itself differently from that seen in younger people. Another guideline Rovner gives us, is a list of medical and psychosocial variables that are risk factors for depression (e.g. female gender, medical illness, physical disability, economic hardship, etc.). A combination of a screening tool and these easy-to-determine patient characteristics might be essential to filter out persons who will initially not benefit as much from rehabilitation. It may alert us and it will make us see that this individual patient needs to be further evaluated so we can offer adequate treatment.

In conclusion, it may still be difficult to know when to refer depressed visually impaired adults inside or outside the low vision rehabilitation center, especially if the depression is not simply a consequence of the vision loss. Using the information from the PPLVR-course on depression as guidelines could

help us in making these decisions. Then, rehabilitation is expected to be more effective for visually impaired patients suffering from an extra burden, called depression.

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