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Vision Loss and Mental Health: The Hidden Connection

Penn Medicine: Psychiatric medications can lead to vision problems; vision loss can exacerbate psychiatric conditions

NEW YORK – People suffering from vision loss are twice as likely to suffer from depression as the general population.

An educational workshop at the annual meeting of the American Psychiatric Association in New York City this week will shed light on this important, growing topic.

“What we are talking about is not new, but has never been a focus of the psychiatric community,” says Michael Ascher, MD, a clinical associate professor of Psychiatry in Penn’s Perelman School of Medicine, who will co-chair the session. “We want to use our observations to begin the dialogue.”

Visual impairment is not always obvious to the clinician, since only a small percentage of patients with impairments use canes or dogs.

Blindness or vision loss can be a primary or secondary side effect of psychiatric treatment. Typical antipsychotics and selective serotonin reuptake inhibitors (SSRIs) prescribed for patients with depression or anxiety disorders can lead to mydriasis, a dilation of the pupil, which causes the vision to become impaired; tricyclic antidepressants can cause blurred vision; some seizure drugs have been linked to near-sightedness and glaucoma. In addition, certain anti-psychotic medications can increase a patient’s risk for diabetes, which, if not controlled can result in vision loss or blindness. Impairment in color perception can also be affected by anti psychotic medications.

“Depressed patients are less likely to follow-up with medical treatment or make lifestyle modifications to limit visual loss, like quitting smoking or cutting down on drinking, or making an effort to exercise,” says Ascher. “As clinicians, we need to ask the questions to identify these issues before the patient’s health is further compromised and complete vision loss sets in, and the patient’s depression potentially worsens.”

When blindness sets in, clinicians must also treat the additional psychiatric difficulties that come with this diagnosis. “Untreated depression or family support issues can obstruct treatment for more serious illnesses,” says Ascher.

Dr. Ascher and colleagues’ first suggestions are simple: speak to blind and low-vision patients as they approach and leave the office; greet them at the door and escort them by extending an arm and allowing the person to take your elbow; describe the room and monitor the patient’s movements as clues to their comfort level; and talk to the patient, even if they do not look you in the eye.

Low vision or blindness also makes it more difficult for patients to navigate the complex healthcare delivery system. Care coordination with other treating physicians, an ophthalmologist or family physician and the pharmacy is paramount. “In lieu of a family member or outside support, this often falls to the clinician. For example, many low-vision patients rely on their sense of touch to identify their medications. If a generic is substituted by the pharmacy, it could lead to confusion and potentially harmful consequences for the patient,” says Ascher.

Dr. Ascher will be joined by **Sharon Packer, MD**, assistant clinical professor of Psychiatry and Behavioral Sciences and **Melinda Lantz, MD**, associate professor of Clinical Psychiatry and Behavioral Sciences, department of Psychiatry and Behavioral Sciences, both with Albert Einstein College of Medicine, Bronx, NY.

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