

THE EYE AND I: OR PSYCHOLOGICAL ASPECTS OF BLINDNESS

A.H. Reid*

HISTORICAL BACKGROUND

In mythology, and in our collective unconscious, the eye is frequently equated with the 'I' or the self. The ancient Egyptians with their 'Eye of Horus' subscribed to a power that protected against evil and that magically ensured success.¹ Horus came in many forms: the sharp-eyed falcon god (Figure 1) and as a winged deity (Figure 2), for example. In the ritual of *The Book of the Dead*, Wedjat (sacred)-eyes promised reconstitution of the being.² Figure 3 shows Wedjat-eyes from the inner coffin of the commander Sepi.

The counterpart to the protective, wholesome, restorative eye is the concept of the all-watching 'Evil Eye' with its power to bring injury or misfortune to others.



FIGURE 1
Statue of falcon-headed god, Horus. Third Intermediate Period or Late Period. © The British Museum, 1999.



FIGURE 2
Anubis and winged eye of Horus. Nineteenth Dynasty. After 1250 BC. © The British Museum, 1999.

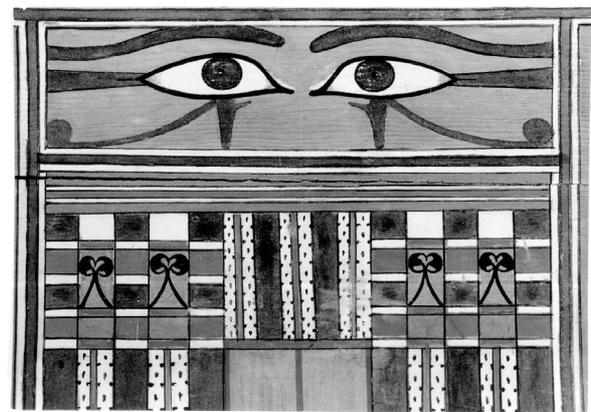


FIGURE 3
Wedjat – eyes above a false door. From head end of the wooden inner coffin of the commander Sepi. From El-Bersha. Middle Kingdom, 2000 BC. © The British Museum, 1999.

*Consultant Psychiatrist, Royal Dundee Liff Hospital, Dundee DD2 5NF

These themes are reflected in the experience of Saul the persecutor who was struck blind as a punishment on the road to Damascus, and was saved and then made whole as Paul by conversion and Ananias, and in the quotation from St Matthew:

The light of the body is the eye: if therefore thine eye be single (sound), thy whole body shall be full of light. But if thine eye be evil, thy whole body shall be full of darkness.
St Matthew 6:22-23

There is also a sexual connotation to the eye: the voyeur who never progressed beyond the stage of looking, and peeping Tom who is struck blind for his look at the naked Lady Godiva. Magritte fused the themes of sexuality, sight and violence in his arresting picture of *The Rape* (Figure 4).

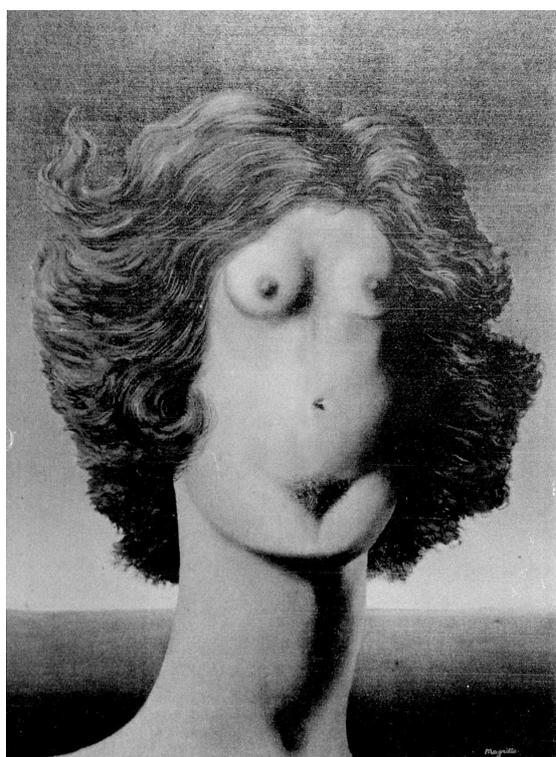


FIGURE 4
René Magritte. *Le viol*. 1934.
© ADAGP, Paris and DACS, London, 1999.

A contemporary drawing of his hallucinatory experiences by a patient with paranoid schizophrenia (Figure 5) shows a decapitated angel, Oroborus, sent by God to punish and torment sinners in Hell: the linkage of eyes and genitalia is apparent. The same patient has painted Isis, mother of Horus and protector of the dead,³ in martial pose and with an all-seeing eye (Figure 6).

One therefore needs to be mindful of the intense psychological significance of the eye and sightedness to our patients, as well as the disruptions to the visual mechanisms on which medical concern usually focuses.⁴ This significance contributes to patients' reactions to blindness, whether it is congenital, of gradual onset and progressive, or the product of an acute process or trauma. This review will focus firstly on general psychological responses to acute adult-onset blindness, and secondly on certain specific psychiatric syndromes.

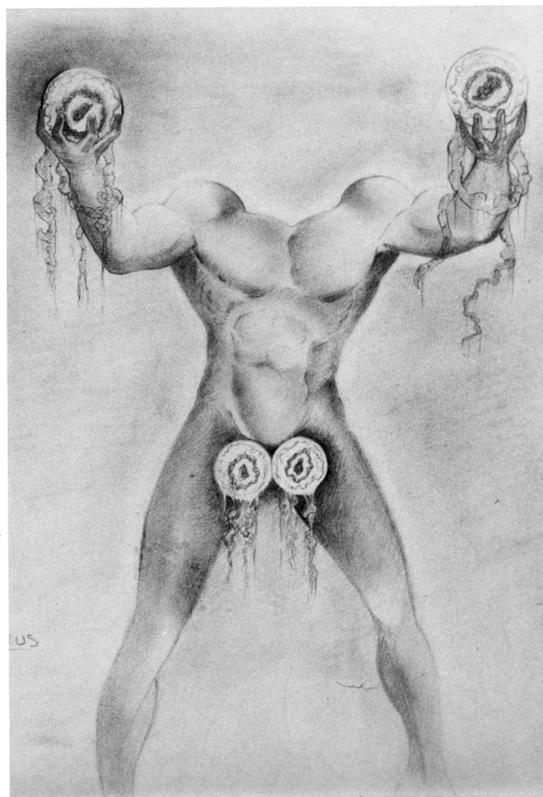


FIGURE 5
Oroborus. Reproduced by kind permission of the artist.

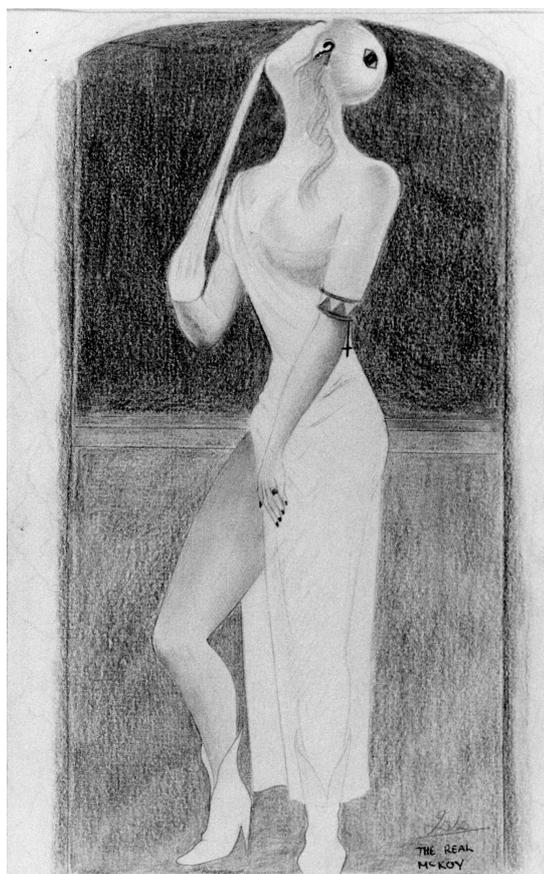


FIGURE 6
Isis. Reproduced by kind permission of the artist.

GENERAL PSYCHOLOGICAL RESPONSES

Bereavement and loss

The initial reaction to sudden blindness may well be one of shock, anger, irritability and grievance: 'Why me?' The patient may blame others and in so doing may well alienate them. There may be clinical features of depression with loss of confidence and self-esteem. Some patients will show their anger and resentment through such escape mechanisms as heavy drinking. Denial can be a major problem. Some patients cannot come to terms with this handicap and insist that they are not so seriously affected, and that they do not need help, counselling or rehabilitation. They may refuse such aids as a white stick, for example, insist on walking down the middle of stairs rather than being guided by touch, and adopt an inappropriate 'I am blind but can do anything' approach. Adjustment may come through time although some counsellors who are blind themselves may have made a particularly successful adjustment to their own disability and think everyone should be able to do the same.⁵

Fitzgerald studied the reactions to blindness of all 66 newly-blinded adults who had been registered blind in London in one year.⁶ Ages ranged from 21 to 65 and onset was mainly over the course of two weeks or thereabouts. Reactions tended to be along the lines of disbelief, denial, distress and depression. Resolution, where it occurred, took place over the course of many months as in the bereavement reaction.

In some patients in Fitzgerald's study, however, the initial mood disturbance gave way to persistent feelings of depression, anxiety, fear, anger and insomnia. A substantial minority showed evidence of ongoing heightened suspicion and paranoid ideation.

Post-traumatic stress disorder

In addition to the process of loss and bereavement the patient may need to adjust to the traumatic event itself, particularly where sudden blindness has been caused by an explosion or car accident, for example. Post-traumatic stress disorder is a well-established sequel to a stressful event of a catastrophic nature and Kolb has delineated the condition in Vietnam war veterans.⁷ He described the characteristic symptomatology of insomnia, intrusive recollection (flashbacks), hypervigilance and enhanced startle reactions, trigger events and avoidance phenomena, anxiety, depression, irritability and outbursts of explosive anger. Sudden, acute onset blindness is a sufficient catastrophe for the development of the syndrome in certain individuals.

Loss of control

With blindness goes loss of control over one's environment and lifestyle, and with it, anxiety, fear and vulnerability.⁸

Simple activities become hazardous and threat exists where none was before. Patients may react with passive helplessness - things happen to you rather than because of what you do. Others may persist in denying the reality of their disability until their illusion of security is shattered by an assault, for example:

Case history. Alison was 20 and congenitally blind. An intelligent and resourceful young woman, she was in the second year of an Honours degree at university and was determined to live an independent life away from home. She was on her own in the flat she shared with two other students when she was raped by an

intruder. Her vulnerability was exposed and her whole world collapsed. She could not identify her assailant, no charges were ever brought, she lost confidence in herself and in her ability to live independently, and she became acutely depressed and suicidal.

Family dynamics and sexual relationships

Blindness impinges on family and sexual relationships. An acutely blind adult usually places a family into shock and turmoil. Roles are reversed and the wage-earner may have to become the dependent, and the home-maker may be disenfranchised of her tasks.

Partners have to learn new lifestyles, relationships are disrupted, a man may feel robbed of his masculinity, and a woman of her attractiveness. Hull has described this process of psychological emasculation vividly.⁹

At a formal dinner, the main course was chicken on the bone. I asked the person next to me to wave to the waitress, to ask the kitchen staff to take the chicken off the bone for me... She said that would be quite unnecessary: she would cut up the chicken... 'I cut up a meal for a handicapped child only the other day'... A disabled adult man loses part of his manhood, part of his adulthood, and part of his humanity.

Attractiveness is greatly valued in our society, and we do not know what substitutes for form and appearance in determining sex appeal in blind people. The sound of the voice certainly becomes a more important signal. Fichten *et al.*¹⁰ note that the reaction of sighted peers is very important in dating behaviour and tends to deter sighted young people from developing relationships with partially-sighted or blind peers.

PSYCHIATRIC SYNDROMES

There is little in the psychiatric literature about blindness, but much of what there is focuses on the following syndromes, although they are probably of less importance than the dynamic and psychopathological features outlined above.

Anorexia nervosa

Anorexia nervosa occurs and has been described in blind people.¹¹ Psychiatrists have been fascinated by its occurrence in blind people because part of the diagnostic criteria is a disturbed body image perception which is held to underlie the drive to lose weight. Anorexics do consistently underestimate their weight and describe a distorted body image perception, and it is intriguing that the syndrome should occur in blind people whose bodily perceptions are presumably so different. In other words 'you do not have actually to see yourself to desire a slimmer physique'.¹²

Sleep and related disorders

Melatonin is the major hormone produced by the pineal gland;¹³ blood levels are higher during darkness and lower during daylight. Melatonin secretion is cued by light and has a role in determining circadian rhythms. The administration of melatonin or bright light treatment is said to have a therapeutic effect in jet lag, shift work, periodic sleep disturbance in blindness, and sleep and behavioural disorders in children with multiple brain damage. Seasonal changes in melatonin secretion in seasonal affective disorder have been demonstrated by Thompson *et al.*¹⁴ but claims

for treatment efficacy have not been substantiated.¹⁵ It raises the possibility that some of the states of chronic depression encountered in some blind people may link in with the syndrome of seasonal affective disorder.

Benign visual hallucinations

Spontaneous visual phenomena, or phantom vision, is quite common in blind people and does not have any psychiatric significance. These phenomena appear suddenly, may be mobile, coloured and complex, and have been described in up to 40% of adventitiously blind clients from the US Veterans Affairs Medical Centres.¹⁶ Needham and Taylor¹⁷ have likened them to other sensory phantoms and have suggested that they may be explicable on the basis of an inherited neural network for the 'body-self', or neuromatrix, that generates sensory phantoms.¹⁸ They do not signify mental illness and are rarely construed as such by those who experience them. Benign visual hallucinations may also occur in blindfold hostage situations.¹⁹

Paranoid and affective syndromes

Cooper and Porter studied visual acuity and ocular pathology in the paranoid and affective psychoses of later life.²⁰ They found bilateral ocular pathology, especially cataract, in paranoid as opposed to affective psychosis in old age. The authors suggest that individuals with a relatively weak genetic predisposition to schizophrenia may resist the onset of illness until subjected to an accumulation of violating circumstances, for example, death, separation, loss of mobility, deafness, blindness.

Charles Bonnet Syndrome

Charles Bonnet was a Genoese naturalist and philosopher; in 1760 he described the case of his grandfather, Charles Lullin. At the age of 78, Lullin was submitted to surgery for cataract. Later, at the age of 89, he started seeing coloured, dynamic and highly organised 'visions'. Bonnet described him as follows:

He still had a remarkably good memory for his age. He read a great deal, retained most of, it and loved entertaining his friends with lectures. He particularly enjoyed history and politics. I was among those who often attended his lectures and I frequently saw him interrupting the description of some historical event to pay attention to a vision that he experienced at that particular moment. 'There it is', he would say to me, 'the tapestry is covered with paintings: the frames are gilded etc.' Immediately after, he would describe in detail another decoration or some other vision; and, after having jested over these fixations of his brain, he would calmly resume his discourse.

Cited by Damas-Mora *et al.*²¹

In essence, therefore, the Charles Bonnet Syndrome consists of the phenomena of vivid, complex visual hallucinations, often highly organised and coloured, sometimes Lilliputian and often continually changing, occurring particularly in the elderly with preserved cognitive function, and often associated with ocular pathology sometimes amounting to total blindness.

The images are usually perceived by the patient with indifference, surprise, curiosity, sometimes delight, and occasionally fear. Insight is retained into the unreality of the visual phenomena despite their compelling nature and detailed character. Jane Hart²² has put together a moving

and detailed account of the phenomena in a personal study based on her mother's hallucinatory experiences in later life when she went blind with glaucoma. It is now considered that some cases of Charles Bonnet Syndrome may be arising on the basis of a Lewy Body dementia.

Teunisse and colleagues in the Netherlands²³ have carried out a definitive epidemiological study of the Charles Bonnet Syndrome. They surveyed 300 consecutive adult patients from the Low Vision Unit and compared them with 200 consecutive patients with preserved visual acuity, all aged over 64, from the Optometry Unit. Two (1%) of the patients from the Optometry Unit had Charles Bonnet Syndrome compared with 33 (11%) of patients from the Low Visual Unit. Charles Bonnet Syndrome had been present for between six months and ten years. There was a positive association with age and with bilateral visual impairment, but no particular association with gender, social isolation or with ophthalmic diagnosis, which was generally age-related macular degeneration and cataract, followed by diabetic retinopathy, glaucoma and corneal disease.

CONCLUSION

It is curious that there has been little research into psychiatric aspects of blindness: most major textbooks of psychiatry do not even index it, in sharp distinction to deafness which has been much more extensively studied. The medical and surgical specialties of ophthalmology focus appropriately on diagnosis and treatment of the primary ophthalmological condition, leaving an opportunity for clinical psychiatry to make an informed contribution on the processes of adjusting to blindness.

The early nineteenth century saw a vogue for eye miniatures which were meant to capture 'the most intimate glances of the window of the soul', but which more often captured a 'repulsively detailed, almost anatomical, account of the mere surface of the eye.'²⁴ By contrast Magritte, as a surrealist painter, would aim to see things differently: he would suggest hidden affinities and new approaches to, and perceptions of, the objects that surround us. His painting of *The False Mirror* (Figure 7) represents an eye in which the active function of looking is replaced by a reflective function, suggesting a wider significance and bringing us back to where we began.

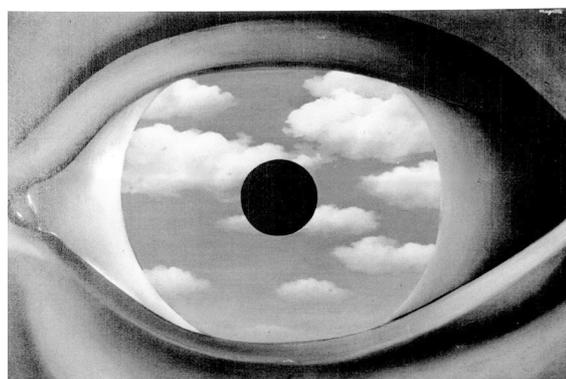


FIGURE 7

René Magritte. *Le faux miroir*. 1928.
© ADAGP, Paris and DACS, London, 1999.

ACKNOWLEDGEMENTS

The title of this article is taken from Chapter 1 in the book by Sloan and Wahl.²⁵

REFERENCES

- ¹ Hart G. *Egyptian myths* London: British Museum Press, 1990.
- ² Desroches-Noblecourt C. Chapter 8 - The dead god is reborn. In: *Tutankhamen: the life and death of a pharaoh* London: Connoisseur and Michael Joseph Ltd, 1963.
- ³ Vassilika E. Egyptian art. Glossary of Egyptian dieties. In: *Fitzwilliam Museum handbook* Cambridge: Cambridge University Press, 1995; 5-9.
- ⁴ Brook A, Elder E, Zalidis S. Psychological aspects of eye disorders. *J R Soc Med* 1998; **91**:270-2.
- ⁵ Fitzgerald RG, Parkes CM. Blindness and loss of other sensory and cognitive functions. *BMJ* 1998; **316**:1160-3.
- ⁶ Fitzgerald RG. Reactions to blindness: an exploratory study in adults with recent loss of sight. *Arch Gen Psychiatry* 1970; **22**:370-9.
- ⁷ Kolb LC. Post-traumatic stress disorder in Vietnam veterans. *N Engl J Med* 1986; **314**:641-2.
- ⁸ Kleinschmidt J, Trunnell E, Reding J *et al*. The role of control in depression, anxiety and life satisfaction among visually impaired older adults. *J Health Education* 1995; 26-36.
- ⁹ Hull JM. Becoming a child. In: *On sight and insight: a journey into the world of blindness* Oxford: One World Publications, 1997; 95-6.
- ¹⁰ Fichten Q, Goodrick G, Amsel R, McKenzie S. Reactions towards dating peers with visual impairments. *Rehabilitation Psychology* 1991; **36**:163-78.
- ¹¹ Yager J, Hatton CA, Ma L. Anorexia nervosa in a woman totally blind since birth. *Br J Psychiatry* 1986; **149**:506-9.
- ¹² Touyz SW, O'Sullivan BT, Gertler R, Beumont PJV. Anorexia nervosa in a woman totally blind since birth. *Br J Psychiatry* 1988; **153**:248-250.
- ¹³ Brown JM. Melatonin in psychiatric and sleep disorders. Therapeutic implications. *CNS drugs* 1995; **3**:209-26.
- ¹⁴ Thompson C, Stinson D, Smith A. Seasonal affective disorder and season dependent abnormalities of melatonin secretion by light. *Lancet* 1990; **336**:703-6.
- ¹⁵ Rodin I, Thompson C. Seasonal affective disorder. *Advances Psychiat Treatment* 1997; **3**:352-9.
- ¹⁶ Lepore FE. Spontaneous visual phenomena with visual loss: 104 patients with lesions of retinal and neural afferent pathways. *Neurology* 1990; **40**:444-7.
- ¹⁷ Needham WE, Taylor RE. Benign visual hallucinations or 'Phantom Vision' in visually impaired, and blind persons. *Journal Visual Impairment Blindness* 1992; **86**:245-8.
- ¹⁸ Melzack R. Phantom limbs and the concept of a neuromatrix. *Trends Neurosci* 1990; **13**:88-92.
- ¹⁹ Fletcher K. The management of released hostages. *Advances Psychiatric Treatment* 1996; **2**:232-40.
- ²⁰ Cooper AF, Porter R. Visual acuity and macular pathology in the paranoid and affective syndromes of later life. *J Psychosom Res* 1976; **20**:107-14.
- ²¹ Damas-Mora J, Skelton-Robinson M, Jenner FA. The Charles Bonnet Syndrome in perspective. *Psychol Med* 1982; **12**:251-61.
- ²² Hart J. Seeing with the mind's eye. Personal Communication.
- ²³ Teunisse RJ, Cruysberg JRM, Verbeek A, Zitinan FG. The Charles Bonnet Syndrome: a large prospective study in the Netherlands. *Br J Psychiatry* 1995; **166**:254-7.
- ²⁴ Coombs K. Chapter 6 - The nineteenth century. In: *The portrait miniature in England* London: V & A Publications, 1998.
- ²⁵ Sloan SH, Wahl CW. Chapter 1 - The Eye and I. In: *Psychiatric problems in ophthalmology* Pearlman JT, Adams GL, Sloan SH (eds). Springfield Illinois USA: Charles C Thomas, 1977.