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THE KASSIM SELAMAT SAGA: UNDERSTANDING THE COMPLEXITY BETWEEN GLAUCOMA, GRIEF AND DEPRESSION

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ABSTRACT

Grief, a universal psychological response, is traditionally associated with bereavement but is often overlooked in the context of life-altering diagnoses such as advanced glaucoma. This type of grief can overlap with depressive disorders, complicating treatment efforts. Managing depression in glaucoma patients presents unique challenges, as commonly prescribed antidepressants like selective serotonin reuptake inhibitors (SSRIs) can increase intraocular pressure and potentially worsen glaucoma. This case report explores the complex relationship between glaucoma, grief, and depression, focusing on diagnostic challenges, treatment options, and management outcomes. A case study of a 60-year-old woman with advanced glaucoma illustrates this complexity. Following her diagnosis, she experienced significant grief, disrupting her participation in a blind rehabilitation program. Subsequent psychiatric evaluation revealed major depressive disorder. Treatment included a novel antidepressant, psychotherapy, and grief counselling. Over six months, antidepressant was tolerated without adverse effects or increased intraocular pressure. Her mood improved significantly, and she resumed the rehabilitation program. This case highlights the importance of assessing depressive symptoms in patients in grief who suffered with chronic condition such as glaucoma. Early psychiatric intervention can enhance the outcome of both mental and physical health. Integrating psychological work into the management of glaucoma is essential for patient care, emphasizing the need for a multidisciplinary holistic approach to address the intertwined physical and emotional challenges of such diagnoses.

1.0 INTRODUCTION

Grief is a universal emotional response to loss, characterized by sadness, longing for the deceased, cognitive disturbances, social isolation, and fluctuating intense emotions. Although traditionally associated with loss such as the death of a loved one, grief can also manifest in response to various other significant losses, such as the permanent loss of one's eyesight [1]. In contrast, depression is a recognized major mental illness, one of psychiatric disorder marked by prolonged and persistent low mood or anhedonia, with associated significant other depressive symptoms including sleep disturbances, reduced concentration and focus, feelings of hopelessness and worthlessness, excessive guilt, and suicidal thoughts. Often, the symptoms of grief such as sadness, irritability and sleep disturbances are overlap with symptoms of depression [2]. Thus, it is imperative to clinically distinguish between these two conditions, as their management approaches differ from one to another. Furthermore, individuals diagnosed with glaucoma are at a higher risk of developing depression, a correlation supported by multiple studies [3-4]. The common pharmacological treatments for depression such as selective serotonin reuptake inhibitors (SSRIs), were reported to be significantly high possible associated with eye disorders such as vision blurred, visual impairment and

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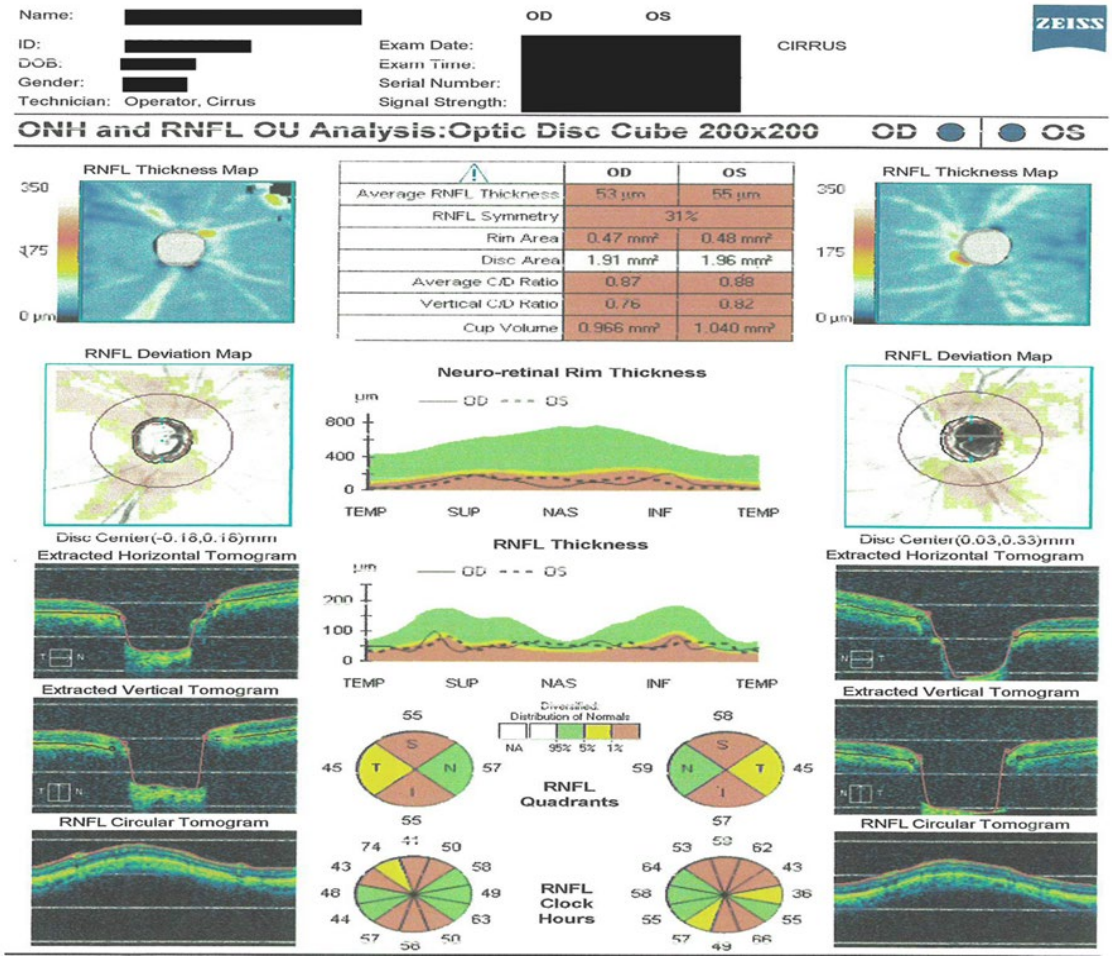
mydriasis [5]. Therefore, careful consideration should be made when choosing the suitable pharmacological treatment for glaucoma patients with comorbidity of depression.

This case illustrated a clinical presentation of a patient who had experienced grief after she was diagnosed with primary open angle glaucoma (POAG) which the loss had happened to her eyesight. It is the most common type of glaucoma and is often referred to as the "silent thief of sight" because it progresses without noticeable symptoms until significant vision loss has occurred. It is one of the leading causes of irreversible blindness for people above 40 years old worldwide [6]. POAG is a progressive optic neuropathy characterized by damage to the optic nerve, often associated with elevated intraocular pressure (IOP). Early signs may include subtle changes in peripheral vision, but as the condition advances, it can lead to tunnel vision and eventual blindness if left untreated. The fundamental goal of treating primary open-angle glaucoma is to lower intraocular pressure to prevent further damage to the optic nerve. Treatment options include medications, laser therapy and surgery [6,7]. This report further discusses the complex interaction between glaucoma, grief, and depressive disorder, along with the challenges in their diagnosis, treatment, and management.

2.0 CASE REPORT

Mrs. A, a 60-year-old woman and an executive at a marketing company with a known case of type 2 diabetes mellitus, presented to the ophthalmology clinic in 2022 due to progressive painless bilateral blurring of vision for one year. At presentation, her visual acuity in the right eye and left eye was 6/24 and 6/12 respectively. Examination revealed increased intraocular pressure (IOP) of 36 bilaterally, with an elevated cup-to-disc ratio (CDR) of 0.9. Optical coherence tomography (OCT) of retinal nerve fibre layer showed thinning of the optic nerve as shown in Figure 1 while the Humphrey visual field test revealed tunnel vision in both eyes as illustrated in Figure 2.



	OD	OS
Average RNFL Thickness	53 µm	55 µm
RNFL Symmetry	31%	
Rim Area	0.47 mm²	0.48 mm²
Disc Area	1.91 mm²	1.96 mm²
Average C/D Ratio	0.87	0.88
Vertical C/D Ratio	0.76	0.82
Cup Volume	0.966 mm³	1.040 mm³

Figure 1. Optical coherence tomography (OCT)

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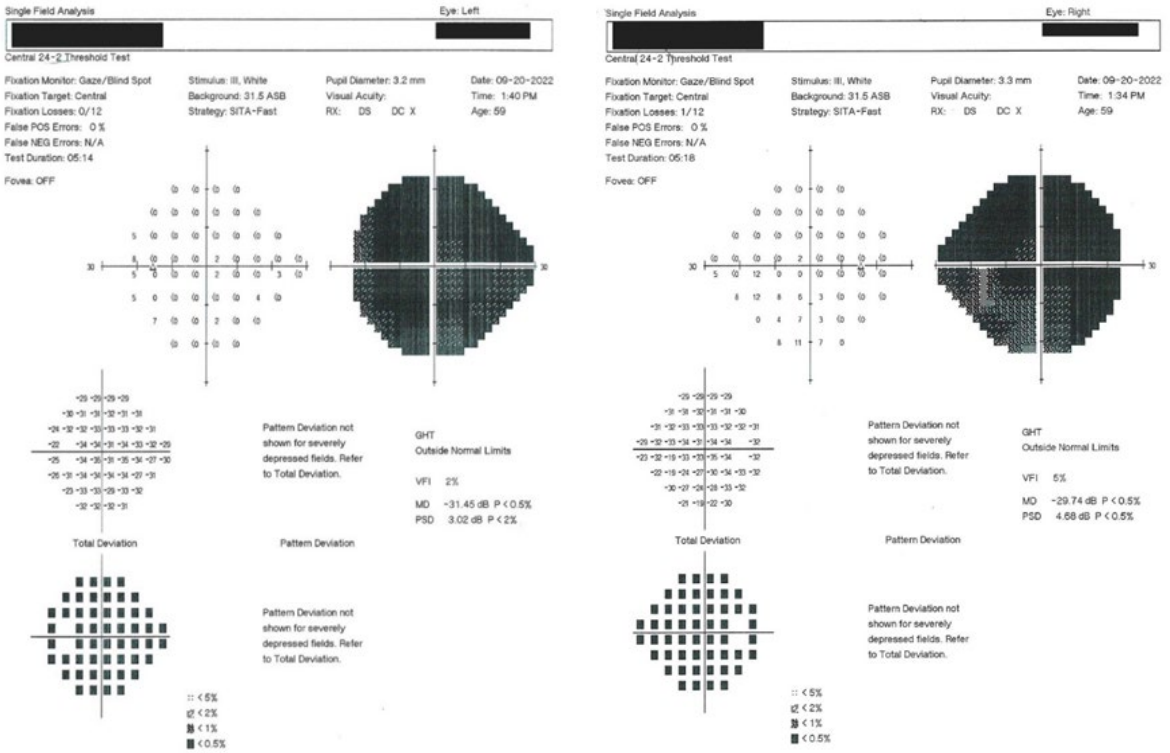

Figure 2. Humphrey visual field test (24-2 protocol)

Figure 1 above shows the OCT of optic nerve head and retinal nerve fibre layer of the patient at her first presentation. Average of cup-disc-ratio right eye and left eye shows 0.87 and 0.88 respectively with thinning of retinal nerve fibre layer seen in both eyes. On top of that, Figure 2 exhibits Humphrey visual field test (24-2 protocol) that showing the presence of severely constricted visual field "tunnel vision" at the patient's first presentation. Mrs. A was diagnosed with advanced primary open-angle glaucoma and was started on two antiglaucoma medications: travoprost and brimonidine. Within two years, two additional medications, timolol and brinzolamide, were prescribed. She also underwent Minimally Invasive Glaucoma Surgery (iStent) procedures to improve her IOP. Despite these interventions, her eyesight progressively worsened which causing significant distress to the patient. The sudden diagnosis and subsequent loss of vision had a profound impact on Mrs. A both professionally and personally. At the height of her career and on the verge of promotion to chief executive officer, she was diagnosed with advanced glaucoma. This forced her to take an extended leave of absence and ultimately resign from her position. Despite the substantial visual impairment, she declined adaptive skills training and refused to use a walking stick. Her mood and motivation were significantly affected. Mrs. A associated the term "blind" with being disabled, which contributed to feelings of stigma and resistance toward accepting her condition. Consequently, she continued to drive herself to clinic appointments, despite being aware of the dangers posed by her substantial visual limitations. During subsequent follow-up visits at the eye clinic, Mrs. A exhibited profound sadness and irritability, prompting her referral to a psychiatrist for further evaluation and support.

During the initial psychiatric consultation, Mrs. A expressed significant anger and frustration toward her treating ophthalmologist, whom she perceived as insensitive to the term "blind" and its implications. For her, blindness signified not only the loss of sight but also the general function loss including her job, her independency, and most importantly her potential career advancement at present and future. She reported been feeling persistent low mood, prolonged sadness, increased in irritability, and feeling not worthy and hopelessness accompanied by difficulty sleeping, following her glaucoma diagnosis since the past three years. Mrs. A had abandoned her hobbies, preferred to be in solitary activities and she withdrew herself from social gatherings, and remained isolated at home. She consistently felt fatigued throughout the day almost every day, subsequently she was hesitant to learn new adaptive visual skills as suggested by her ophthalmologist. She also expressed a constant fear of complete blindness, which triggered some anxiety

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symptoms such as palpitation, tremors and feeling of impending doom. These ongoing grief and bereavement process, had been internaly conflicted to her, thus contributed to more psychological distress. She also refrained from sharing her feelings with anyone as she was concern with fear of being perceived as a weak person. Moreover, she viewed her family members as unsupportive and at times overly critical, often downplaying her struggles with daily activities She experienced a lack of empathy from them, which compounded her emotional distress and sense of being overwhelmed.

At presentation, the mental state examination showed a middle-aged lady, wearing proper attire with a pair of sunglasses. She walked voluntarily, independent and unaided into the interview room but her movement was slow due to her eyesight limitation. She was not forthcoming in the beginning and displayed some irritabilities during the early part of the interview. However, when she began to be more open up, her mood was sad with an appropriate affect. There were worthlessness, pessimistic thoughts, and passive death wishes obtained from her content of thoughts. However, she denied having suicidal thoughts or other psychotic symptoms. Her overall insight and judgment were partial, whereby she was aware that she needed professional help for her psychological problems but still insisted that these issues were not going to be solved as the trigger was permanent. Given the patient's fragile ego strength and reduced psychological resilience at presentation, supportive psychotherapy was initiated to provide emotional support, strengthen ego functions, and facilitate adaptive coping at a pace consistent with her psychological readiness. Her reluctance to accept assistance or engage in adaptive skill training for visual impairment further supported the use of a non-confrontational, empathetic approach to strenghten therapeutic alliance and maintain engagement. Additionally, the patient was taught relaxation techniques to help her manage distressing emotions. A multidisciplinary discussion involving psychiatrists, ophthalmologists, and pharmacists was conducted, and agomelatine was considered as the treatment of choice for this case. Following psychoeducation, Mrs. A made an informed decision to take 25 mg of agomelatine once every night until further review.

At one-month follow-up, she reported better sleep but minimal improvement in other depressive symptoms. The medication was well-tolerated, with no reports of worsening vision or other side effects. Liver function tests and other laboratory investigations were within normal range. Her intraocular pressure was 14 and visual acuity was 6/48 in the right eye, whereas the IOP was 15, and visual acuity was 6/36 in the left eye. Subsequently, the agomelatine dose was optimized to 50 mg nightly. Grief counselling was integrated to address the significant psychological impact of the patient's vision loss, which represents not only a functional impairment but also a profound loss of identity and self-esteem. At the outset, grief counselling aimed to provide a safe space for the patient to express her emotions and feel validated. Additionally, the patient learned that overwhelming emotional responses to major losses are natural and understandable. This therapy helped Mrs. A to navigate and accept these emotions rather than deny or feel ashamed of them. As the therapy progressed, she worked towards finding new meaning in the loss and adapting to the changes accordingly. Throughout the subsequent follow-ups, Mrs. A was able to communicate more openly about her emotions and gradually felt less depressed. She demonstrated increased awareness of her visual impairment and acknowledged the difficulties she was currently experiencing. She agreed to use e-hailing services as a safer mode of transportation for future hospital visits and had resumed low vision rehabilitation training. At six months' follow-up, Mrs. A reported improvement in her mood, energy levels, sleep patterns, and motivation. While she continued to deal with her losses, fortunately her feelings of anger and frustration gradually subsided. Her insight and judgment much improved, and she began to explore her hobbies and became more receptive to support from her close friends. Throughout the treatment period, her IOP remained stable, with no adverse effects on the management of her glaucoma.

3.0 DISCUSSION

Grief is a complex emotional response to loss that encompasses a range of feelings, thoughts, and behaviors. It is a normal psychological process that allows individuals to adapt to their loss and eventually find a way to move forward. The most popular case example of grief in Malaysia is the legendary story in a Malay movie about a young man named Kassim Selamat, a fictional character in the "Ibu Mertuaku" film (1962) [8]. Kassim is a musician who loses his sight due to constant crying and overwhelming grief after being misled about his wife's death. In contrast to Kassim Selamat's storyline where he grieved and cried until he lost his eyesight, this case study reported the grief which was triggered by the sudden and permanent loss of the patient's eyesight that significantly altered her independency and career trajectory. Both stories highlight the profound emotional impact of sudden and significant loss and their journey towards

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acceptance and adaptation. Figure 3. Illustration of the five stages of grief: denial, anger, bargaining, depression, and acceptance. This figure is adapted from the model proposed by Kübler-Ross (1969) and re-illustrated by the author using Canva [9].

Figure 3. Illustration of the five stages of grief

Kübler-Ross [9] described five stages of grief: denial, anger, bargaining, depression, and acceptance, as depicted in Figure 3. Meanwhile, Parkes [10] proposed a four-phase model of grief comprising shock, protest, disorganization, and reorganization. Although differing in terminology, both frameworks offer complementary perspectives on the emotional responses that follow significant loss. In the context of her permanent visual impairment, Mrs. A appeared to experience fluctuating grief reactions that align with the early stages described in both models. Initially, she exhibited signs of denial and anger, as evidenced by her rejection of the diagnosis, reluctance to participate in visual rehabilitation, and irritability toward her treating team. These responses are also consistent with Parkes's shock and protest phases. As she gradually began to confront the irreversible nature of her condition, she seemed to enter a state of disorganization, characterized by despair, frustration, and a diminished sense of identity reflecting the depression stage in Kübler-Ross's model. It is important to recognize that not all individuals experience every stage of grief, nor do these stages necessarily occur in a fixed sequence. Grief is a highly individualized process; thus, understanding these emotional responses is essential in guiding appropriate therapeutic support and interventions. Meanwhile, depression is a recognized clinical condition characterized by persistent low mood and loss of interest that occurred for more than two weeks associated with insomnia, weight loss, lethargy, excessive guilt, worthlessness and suicidal thought or death wishes [11]. Grief is a common triggering factor for depressive disorder whereas depression may overlap or worsen grief symptoms [12]. These complex interactions require careful assessment as depression requires specific clinical interventions. Figure 4 illustrates the common symptoms of grief and depression, along with the overlapping symptoms that exist between these two conditions.

Clinicians may encounter challenges in differentiating between normal grief and depression in patients following a life-altering diagnosis such as advanced glaucoma. Key distinguishing feature is that most individuals experiencing grief feel sadness related to their disability but are still able to experience positive emotions. Their sadness typically diminishes over time as they adapt to their condition, and they remain capable of performing daily routines [14]. In contrast, Mrs. A's case illustrates severe and prolonged depressive symptoms that extend into various aspects of her life, ultimately leading to significant impairment in her psychosocial functioning. Mrs. A was diagnosed with severe major depressive disorder and was indicated for pharmacological treatment. According to the Malaysian Clinical Practice Guidelines (CPG) for the management of major depressive disorder (2019), second-generation antidepressants such as selective serotonin reuptake inhibitors (SSRIs) or serotonin-noradrenaline reuptake inhibitors (SNRIs) are recommended for moderate to severe depression, in conjunction with psychotherapy [15]. However, SSRIs have been associated with an increased risk of raising intraocular pressure (IOP), which may potentially worsen symptoms of glaucoma [5, 16].

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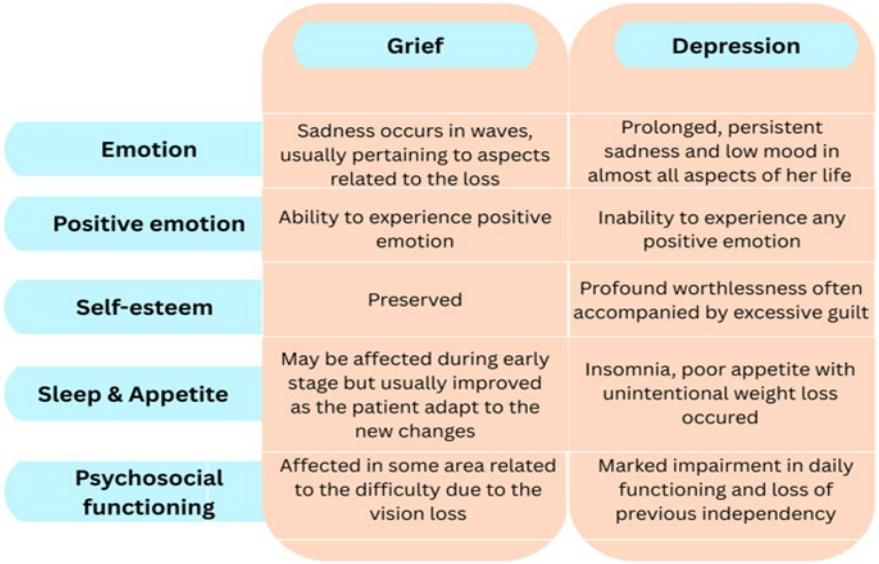

Figure 4. Illustration of the distinguishing symptoms of grief and depression

Figure 4. Illustration of the distinguishing symptoms of grief and depression. This figure is adapted from the work of Kübler-Ross (1969) and the diagnostic criteria for depression from the DSM-5 (American Psychiatric Association, 2013), re-illustrated by the author using Canva. [9, 13]. An important factor influencing the effectiveness of treatment in this case is the ongoing communication among care providers, alongside the active involvement of the patient in the decision-making process. Psychiatrists, ophthalmologists, and other relevant professionals engaged in continuous communication and shared decision-making to ensure that the treatment plan was individualized and clinically appropriate for Mrs. A's condition. Once a suitable treatment option was identified, a discussion was held with the patient to explain the potential benefits and risks, allowing her to make an informed choice and actively participate in her care plan. As a result, Mrs. A was prescribed agomelatine, a novel antidepressant with melatonergic receptor agonist properties [17]. Experimental studies have suggested that agomelatine may exert a hypotensive effect on IOP, making it a potentially advantageous option for patients with coexisting depression and glaucoma [18-19]. Mrs. A tolerated the medication well, with no complaints of worsening vision. She continued her antiglaucoma regimen with close IOP monitoring. Maintaining her IOP within the normal range remains essential in preserving her remaining vision and preventing progression to the stage of no perception of light (NPL).

4.0 CONCLUSIONS

Whilst grief is the expected psychological response when a patient receives a life-altering medical diagnosis, attention should be given to cases where patients display psychological symptoms or become uncooperative towards the treatment plan. The presence of concurrent psychiatric illness may complicate grief; therefore, a thorough psychological assessment and intervention could help improve the overall health outcomes for these patients. Hence, holistic multidisciplinary approaches are pivotal.

5.0 CONFLICT OF INTEREST AND ETHICAL STATEMENT

The authors declare no conflicts of interest.

6.0 AUTHORS CONTRIBUTION

Mahmud, A. A. (Conceptualization; Resources; Clinical data collection; Writing- original draft)
Dasrilsyah, A. M. (Literature review; Methodology; Resources, Writing - review and editing)

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