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REVIEW ARTICLE

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A Critical Point of Focus: Psychological Distress in Retinal Detachment

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ABSTRACT

Retinal detachment, a major cause of acute vision loss, constitutes a serious ophthalmic emergency and necessitates prompt treatment by a vitreoretinal surgeon, particularly in cases where the macula is still attached [1]. Worldwide estimates range from 9,62 per 100,000 population with the highest prevalence of detachment occurring in Europe, followed by Asia and the Americas (ibid). Myopia, a known risk factor for retinal detachment, has been on the rise since the early 2000's and is estimated to continue to increase with aging populations [2]; some studies suggest that incidents of retinal detachment have also increased since the COVID-19 pandemic [1], suggesting a need to develop systemic protocols to address the psychological impact of ophthalmic emergencies on patients. Psychological literature on the subject is sparse, and anecdotal evidence suggests that the perceptual disturbances associated with retinal detachment itself, acuity of the condition, its emergent treatment, and the pre, peri and post-operative recovery, including head positioning, lift restrictions, ongoing limitations related to recovery, potential complications and repeat procedures, generate substantial distress. The authors, all of whom have experienced retinal detachment, have compiled this manuscript as autoethnography to document using our mental health toolkit as trained professionals to address coping with considerable distress associated with this medical condition. The authors propose utilizing strategies to mitigate emotional distress experienced by patients in the pre-, peri and post-operative recovery treatment to reduce anxiety and improve treatment adherence and outcomes. Additional recommendations for retinal surgeons and ophthalmologists include transparent education about surgical procedures and the recovery process, with guidance on how to prepare and manage physically and emotionally post-operatively.

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Introduction

Rhegmatogenous retinal detachment (RRD) constitutes a well-known ophthalmic emergency necessitating prompt surgical repair to prevent blindness [3]. The prevalence of this condition has been on the rise in recent years, with the most recent studies suggesting that the COVID-19 pandemic had worsened incidents of RRD due to patient reluctance to seek surgical care due to fear of COVID infections [4]. During the pandemic, rates of macula-off tears and RRD recurrence had worsened due to hesitation to seek surgical care (ibid). Current estimates suggest an incident of 10-18 per 100,000 population per year in the United States [5]. Risk factors for retinal detachment include aging (it is most prevalent between ages 40 and 70), myopia, family history of myopia and retinal detachment, past eye surgery, including cataract removal, past severe eye injury and other eye diseases, including uveitis, lattice degeneration and retinoschisis [6]. There has even been consideration given to cell phone use at night in the dark and close to the eye, which can lead to increased myopia, a risk factor for RD. A clinical observational study and animal modeling suggests that possibility [7], although their findings merit further research examination. Another correlational study supports the relationship between Smartphone use and increased myopia [8]. For those who are already myopic, and holding the phone close to their face, this consideration may be particularly relevant in elevating their personal risk for retinal detachment later in life.

Most research on psychological distress related to visual difficulties has focused on the blind population, and few studies have examined the emotional distress, anxiety and depression associated with retinal detachment. One study had found associations between visual acuity and HADS scores on anxiety and depression at 3 months after surgery, regardless

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of the type of surgery performed [9] and suggests that the lack of familiarity with the psychological consequences of acute vision loss secondary to retinal detachment prevents more physicians from supplying these patients with additional treatment options and support. Another study found that whilst the incidence of PTSD was low in this population, patients with previous history of PTSD and traumatic events were likelier to meet criteria for PTSD after retinal detachment surgery [10]. Alarmingly, a small study found a high incidence (15%) of visual hallucinations in patients with retinal disease who had bilateral visual impairment, lower visual acuity, decreased functional status and decreased quality of life, and the same patients were less likely to report their somatic experiences to their physicians [11].

Yet another study found elevated psychological distress in patients with symptomatic vitreous floaters [12] and another paper advocates for utilization of meditation and psychotherapy to reduce stress and prevent further vision loss and deterioration [13]. This suggests the importance of guiding physicians "to inculcate positivity and optimism in their patients" and educating patients on the importance of stress reduction (ibid). Interestingly, a recent study examining patient perceptions of surgical recovery from retinal detachment on social media, has found that a prevalence of negative information, negative emotional responses, and misinformation in a leading social media support group. This suggests that positive posts generated less engagement than negative posts and that physicians also should take an active role in reducing the spread of misinformation and coaching patients towards resiliency-building strategies [14]. Another small study found a significant improvement in patient quality of life even soon after surgery [15], suggesting that despite a precipitous emergency, contentment even in post-operative recovery is possible.

Clinical Strategies for treatment of medically-related anxiety

Before moving into the pre-peri and post periods of an RD, it is important to share a selection of literature on anxiety reducing strategies. Mindfulness and acceptance-based strategies and 3rd wave Cognitive Therapy have been repeatedly demonstrated to be effective in reducing anxiety, depression and psychological distress in a plethora of health conditions, including various cancers [16-18], infertility and pregnancy loss [19-21]; perinatal mental health concerns [22]; heart disease [23-25] and pain [26,27] and can be easily applied to the functional loss, anxiety and distress associated with retinal detachment. Cognitive defusion, defined by Steven Hayes as distancing oneself from negative thoughts rather than attempting to change them or get stuck in them [28], can help reduce the intensity and frequency of catastrophic negative thoughts associated with sudden vision loss, the physical and emotional discomfort of post-operative head positioning and the protracted recovery process. Mindfulness meditation can reduce overwhelming emotions, increase present-moment awareness, and reduce rumination. Self-compassion and acceptance can increase positive affect, allowing the patient to celebrate small victories, and tolerate the discomfort of the recovery journey. As mental health professionals, all three of the authors have been highly trained in evidence-based strategies for anxiety reduction. In this paper, we narrate applying our considerable anxiety-fighting toolkit in an ethnographic fashion to this seldom studied problem.

Is it a Retinal Detachment (RD)?

Retinal detachments present in a variety of ways. One of the sure signs is showers of floaters, flashing lights and/or curtaining. There will be no pain. The best way to confirm an RD is to immediately see a retinal specialist for a full examination. For those not aware, curtaining is when one begins to see darkness in certain areas of 360 vision, and the darkness does not go away. Curtaining generally begins in peripheral vision. For one of the authors, all three of those signs began to develop overtime. First, came the emergence of floaters which continued to worsen over time. They appeared as streaks and bubbles moving across the field of vision. They may also present as dots. Then, came a flashing light in the corner of one eye. Initially, it appeared like a flicker, as a sensitive reaction to bright light. However, the flashing continued, becoming particularly bothersome at night, when the environment around was dimmer. Then, came the curtaining. It appeared as a black shadow gradually expanding across a field of vision, starting with the periphery.

Those of us with RD's can be grateful to Allvar Gustrand and Carl Zeiss for inventing the slit lamp in 1911. This is the lamp that all near-sighted people are familiar with, as myopic people have likely undergone regular eye exams since childhood. This lamp is a microscope with a bright light that allows a retinal surgeon to check the health of one's eyes and detect eye disease. Prior to an RD, many may have similar symptoms but not an actual tear or break. This is called a posterior vitreous detachment (PVD) and is quite common as we age, particularly in those with near-sightedness. For those with a PVD, like all the authors on this paper, this was the first notification that something might be amiss. Some studies note that a retinal break may be present in up to 16% of those with PVD [5,29]. However, if there is no retinal break but there is acute, symptomatic PVD, there is a 3% rate of a retinal tear or break in the subsequent weeks [30]. This is the unfortunate category that all three of the authors fell into. All three gradually developed PVD symptoms that progressed to RD with showers of floaters, flashing lights and curtaining, symptoms worsening progressively. The experience felt lonely and frightening, and one of the authors thought about how these visual perceptual disturbances gave her extra empathy towards her patients with psychosis, who also experienced troublesome perceptual disturbances. On the positive side, the outcome was this paper to provide education and guidance on how to manage emotionally and physically pre- and post-surgery. All three of us were also fortunate to be able to lean on our family members and each other for social support, and for those of us who had our RD's later than the other author, we were able to seek validation from one another and answer questions about each other's experiences to alleviate anxiety. The importance of seeing a retinal surgeon for these symptoms right away cannot be underestimated! Even though it felt troublesome to have to rearrange our family lives, work commitments and patient appointments for a lengthy appointment with dilation, repeat visits were necessary to catch the retinal break and preserve vision. All three of us experienced RD without macular involvement, which is why our post-operative outcomes were superior.

Day Before and Day of Surgery

After a lengthy retinal surgeon visit and confirmation of RD, the surgeon will share the type of surgery they plan to complete – scleral buckle, vitrectomy or pneumatic retinopexy. This is valuable information as recovery differs for each procedure. All authors in this paper had a scleral buckle placed, and two also had a vitrectomy. Stricken by anxiety and tearfulness, each of us made our respective ways to the administrative office of the practice where a co-pay was happily offered for an emergent surgery that would save our precarious eyesight. Surgery is likely to be scheduled for the same day or next day. Using the skills of radical acceptance was particularly helpful at this junction in time, as at this point, there was no turning back. Emergency medical leave had to be arranged with work; patient schedules had to be closed and supervisees had to be reassigned. For those of the authors who are more private, disclosing a challenging health condition at work felt very anxiety-provoking. Arranging for childcare and various family responsibilities also felt burdensome. One of the authors reflected that having to take care of these mundane details whilst also sitting with the discomfort of the upcoming procedure, provided her with an illusion of control and made her feel purposeful, steadying her in a moment of overwhelm.

Cardiac clearance is necessary before the surgery, which is standard and expected. At this point, anticipatory anxiety peaks and is also fully normative and very unpleasant. Of note, it is not unreasonable to experience high blood pressure readings due to anxiety during the cardiac clearance, and that is not, typically, a cause for concern. While worrying about what 'might' happen during surgery, we found ourselves worrying about the surgery itself, how surgery would impact any immediate upcoming events, childcare, work schedule and so forth. We found that it was helpful to channel this anticipatory anxiety into action by engaging in preparation for the first post-operative recovery week. The night before surgery, we downloaded podcasts to keep ourselves entertained and mindfulness apps to use to get through the following week. Our favorites are Insight Timer, Calm, Simple Habit, and Covid Coach. We also picked up supplies – saline solution (which some of us already had as long-time contact lens wearers), cotton balls, gauze and medical tape that does not pull at the delicate skin of the face. We also picked up prescription eyedrops that surgeons ordered from the pharmacy, including a steroid eyedrop to fight inflammation (such as Prednisolone) and an antibiotic eyedrop (e.g., Oxofloxacin or Polymyxin) to prevent infection. For those of us who had vitrectomies, in addition to a scleral buckle, we were encouraged to consider purchasing a vitrectomy pillow, or renting a vitrectomy chair. The latter could be quite a costly purchase but is often partially covered by health insurance plan or Flexible Spending Account to make head-down positioning easier. One of us had to be head down for several days after surgery and found a rented vitrectomy chair relieved some back and neck pain and allowed her to participate in her family life during head positioning. Another author, who had to alternate between head down and head to the side positioning, used a vitrectomy pillow, which was relatively inexpensive and readily available to order online. All of us had to refrain from eating or drinking anything after midnight the night before surgery, as is the general rule for all surgical procedures, to prevent aspiration during surgery.

None of us were the first surgical case of the day, and it was several hours before we saw the inside of the operating room. Diaphragmatic breathing exercises were helpful to manage anticipatory anxiety while sitting in the waiting room and laying on the gurney in the perioperative space. Each of us used a typical diaphragmatic breathing exercise that we would engage in with our own patients, as follows:

Sitting or standing, place one hand on your upper chest and the other below your rib cage. This will allow you to feel your diaphragm move as you breathe. Inhale slowly through your nose so that your stomach moves out against your hand. You may find it helpful to engage in box breathing to regulate breath and emotions. Count to 4 as you inhale to regulate your breath. Hold your breath for a count of 4 and exhale slowly to the count of 4 through pursed lips, like you are pushing air through a straw. Tighten your stomach muscles as you breathe, so your chest remains as still as possible.

This type of breathing helped with anticipatory anxiety and panic symptoms while awaiting surgery, and once we were brought back to the perioperative space, we met the anesthesiologist, the surgeon performing the procedure that day, any residents or fellows assisting on the case, and several nurses who helped with pre-operative preparations, including helping with changing into the hospital gown, setting up the IV, and then using marker the face to confirm the correct eye. One of the authors met her surgeon for the first time on the day of the surgery, as he happened to be on call. Of note, this author asked that her glasses be removed once she was already asleep as due to her very high myopia, she noticed that her anxiety was particularly high without her glasses, and she wanted to be aware of what was happening around her until the last possible moment.

Once we were wheeled into the operating room, surrounded by towers of microscopes and carts of surgical equipment, anesthesia thankfully began its vital role. We all fell asleep comfortably and did not remember the rest of the procedure. After the surgery, a trusted family member transported each of us home safely. The surgical eye at that point is bandaged with gauze, a transparent plastic eye protector, and lots of tape. Husbands and other family members were needed for each of the authors, groggy with anesthesia, to hear the post-operative instructions, including positioning rules for the next week or more. One of us was asked to remain face down for every 50 minutes of every hour of the day. Another one was asked to alternate between being face down and keeping her head at a 45-degree angle. This depending on the type of surgery, the location of the retinal tear and the surgeon's decision. The surgeon also asked each of us to walk for brief, 15-minute intervals to prevent blood clots between the times that we had to be required to maintain head positioning. The rest of the day was a blur. Each of us had to rely on the person who got us home safely for post-operative instructions and assistance getting ready for bed, since positioning requires one to lie face down or on a mountain of pillows and maintain a face shield and gauze over the eye to avoid accidentally scratching the eye.

However, each of us was excited to get the bandage off the next day.

Post – Op Day 1

A mix of hope and apprehension flooded each of us on the way to the retinal clinic to be seen by the surgeon covering the clinic that day for the post-operative visit. At that moment, one of us was very eager to have the bandage off and see what is next, but another reported that she never wanted to take the bandage off and was fine with it just staying on her face forever, due to worry about what was happening underneath this bandage. Both responses, each grounded in anxiety, seemed completely normal. Progressive muscle relaxation and diaphragmatic breathing helped pass the time in the waiting room, during the wait that felt like forever. Then, in a small, dimly lit room, a Medical Assistant removes the bandage, pulling tape from a red, splotchy, swollen face and oftentimes, making a comment about how swollen (or not swollen, seemingly) one's face may be and using a great deal of saline to get the surgical eye open. After that, dilating drops are added to the eye, so at this point, seeing anything out of that side of the face becomes impossible. When the assistant held up a few fingers a few feet away from said post-operative face and asked you how many fingers they were holding up, one of us just laughed and said, "You've got to be kidding me". It could have been three or forty-five fingers, and in the hazy post-operative state, with everything dark, blurry and dilated, it would be impossible to tell.

Next, at the optical coherence tomography (OCT) pictures room, more pictures are taken of the eye for the retinal surgeon to review. This sequence – waiting-room, dilation and measurement of intraocular pressure, followed by imaging, would become the sequence of every single appointment moving forward. In our experience, then we were placed in the second waiting room, full of loud phones, people watching videos, speaking to one another, and each of us felt overwhelmed and irritated in that space. One of the authors found it useful to engage in some cognitive restructuring around catastrophic negative thoughts whilst waiting for the surgeon. Once each of us saw the retinal specialist, he casually informed each of us that everything looked good, instructed us to keep positioning for 5-7 days and to be sure to attend to follow-up visits. It is crucial not to miss any post-operative visits, which requires some coordination of functional social support from extended family members, neighbors and friends. The anticipatory anxiety of sitting in various waiting rooms can lead to catastrophic negative thoughts, particularly since vision at this point is so impaired. Diaphragmatic breathing exercises and redirecting negative thoughts, reflecting that we had followed surgeon instructions, and were in the exact right place getting the correct treatment, helped reduce anxiety. Progressive muscle relaxation exercises were useful to redirect nervous energy, as they help focus on other parts of the body.

Post Op Day 2-5 or 7

For those of us who were later in the Retinal Detachment process, it was helpful to have the guidance of one of the authors to prepare ourselves that our vision will be quite impaired for some time. Nothing was clear in the surgical eye, and movement was the first thing that appeared in that impaired field of vision. Due to the visual impairment, spatial awareness was challenging in terms of ambulating up and down the stairs, gauging the distance between pieces of furniture in the room, and that again, required leaning into the considerable anxiety-reducing repertoire at our disposal. Tolerating positioning, sitting with the discomfort of the current situation and trying not to become overwhelmed with anxiety during every single moment of the day became the task of moving through this stage.

With a vitrectomy and scleral buckle, the surgeon had inserted a gas bubble in the eye that worked to reconnect the retina. The positioning keeps the bubble to the back of the eye, which is why the positioning is important for healing. However, the size of the bubble is so large in the eye at that time, that it seemed as though we were seeing floating shapes under water.

As the days began to pass, we began to see color. That was a fun one! Things slowly became clearer, and we continued to wonder 'is this normal' and 'should I be able to see more?' We were at that moment, juggling wearing glasses so as to see out of the non-surgical eye but, since all of us had a preventive laser cryopexy in the non-surgical eye to repair any micro-tears, we experienced some mild vision change as well in the non-surgical eye that took some time to adjust to the laser. Overall, at this point, we were simply sitting with poor and blurry vision for a bit, and some anxiety to boot, and this is exactly where the podcasts and audiobooks came in handy. The authors found that it was easier to listen to things and keep their eyes closed than to try to watch TV. One of the authors found it easier to watch a show on a small telephone screen than the TV screen, as her near vision in the non-surgical eye was better than her distance vision. Guided meditation practices, using the apps we had downloaded, and music helped maintain a positive outlook. One of us has a social coping style, so she enjoyed having close friends and family visit to offer much-needed distraction and support. However, those of us who are more private people preferred avoiding having visitors in this vulnerable state.

All the authors had school-aged children at the time of their surgeries. True to form, adolescents may not even have noticed that their mothers have eyes and continued about their business. They did step up to offer more help with chores around the house, and one of the authors was touched by how gingerly her children helped her walk up and down the steps outside during a brief weekend walk. However, it should be noted that for younger children, a patient may need to explain to them that during the post-operative recovery, he or she may not be able to pick them up due to lift restrictions or to explain to them why their parent has to keep positioning, cannot play or go for walks as usual, or why patient appearance has briefly changed to reduce their anxieties and concerns. Children are remarkably resilient, and they will be much less anxious about with concise, age-appropriate and honest explanations about the problem.

It is imperative to keep the surgical eye dry during post-operative recovery. One of the authors bought nursing sponges and would not take a full shower until cleared by her medical team. Another author proposed showering using a small piece

of gauze at the eye with a plastic patch taped over it and holding a washcloth over the eye to avoid getting it wet in the shower. Notably, hair washing is complicated post-surgery. It may be easier to avoid washing one's hair if one can stand it during the head positioning or immediate post-operative recovery phase. Adaptive strategies for head washing that we had discovered included washing hair over a kitchen sink with the assistance of someone to maximize head positioning and reduce the chances of getting the surgical eye wet. This was another activity that gave us significant perspective on what our medically ill patients go through with daily tasks every single day, and the importance of remaining positive and thinking creatively to adapt. We used makeup wipes to gently wipe our faces and noticed that when we were finally allowed to fully wash our faces, anxiety increased, and we had to slowly ease into this task again. Of note, one author had a significant family event a week after her surgery and nursed her bruised vanity due to not being able to wear eye makeup (eye makeup is not encouraged at this stage of healing to avoid infection). Reframing positively that she would be able to attend and participate in the event and not have to miss it and choosing a particularly bright shade of lipstick to add some extra pep in her step helped her cope with negative thoughts during this stage.

During this time, we continued to use eye drops multiple times per day and noticed increased redness in the surgical eye. Whilst literature notes that this can occur for several weeks after the procedure, in our experience, the redness lingered far longer and for at least one author remained for over a year due to vascular challenges. It was useful to normalize this experience and practice not comparing one's own recovery against published literature to help assuage distress.

Post Op Week 2 - 6

At follow-up appointments and while remaining on medical leave, we were asked to read the eye chart, which felt like a colossal challenge. Some could see the large E and others could not. However, not being able to see the large E is not necessarily an indication of a problem in and of itself. This is why the anxiety related to RD recovery is omnipresent; there is no clear path, and everyone heals differently, which often causes anxiety. Now is the time when worry might spike because of a miniscule floater or of believing that one is seeing flashing. Most likely this is simply the retina, which houses light-sensitive cells, healing. As it heals, the light is perceived differently, particularly when one moves from light to dark or dark to light, notably first thing in the morning, or when one's eyes are particularly tired. One may think that they 'see' pulsating light, and again we presume this is the retina healing as collaborative SLIT lamp information confirms all is well and retina is sealed. Some of us have noticed months out of surgery, eyes becoming more tired and light sensitive towards the end of a long day or after sitting in front of a computer screen for a long time.

At this stage, vision improves very slowly, and the process of lifting restrictions can help boost spirits. At the same time, our collective experience was that hypersensitivity to any visual disturbance, particularly floaters and flashes of light, persisted, and we often found ourselves overwhelmed with catastrophic negative thoughts. Cognitive defusion was found to be an excellent tool for our authors to utilize during the remaining weeks. Mindfulness strategies helped to ground us in the present rather than attempting to worry about or predict the future. The loss of function can be profoundly disorienting, but it is important to remember that it is not permanent, and that every day, the body is doing its job of healing. Additionally, strategies noted to be very helpful during this phase were behavioral activation, such as taking walks outside, with a trusted friend or loved one and keeping one's mind active and busy with positive events and values, with less focus on vision and medical concerns. These practices have shown themselves to be vital to remaining hopeful and optimistic.

All the authors experienced anxious hypervigilance during this time and questioned our eyesight regularly. We fantasized about buying a SLIT lamp or going to the doctor weekly to confirm that we were not having any issues to reduce anxiety. Our retinal teams were very much used to this and seemed to be willing and able to fit us in for emergency visits. Even when we all had great insight that we might simply be experiencing anxiety, it is still better to err on the side of safety and opt for an emergency eye exam to address any burgeoning symptoms. Vision may not return to 20/20 and may be 20/30 in the surgical eye, or even 20/40. This continues to change over time, and it may be close to, or over, a year before vision settles. Patience comes into play here when all one might want to do is head to the optometrist for new glasses, due to the prescription most likely having changed. However, being able to resume much of our former activities helped us return to a sense of normalcy and increase a sense of hope.

We have found that it was vital to consider what value-driven activities give us meaning and purpose, and how they would be impacted by the recovery process. All the authors are active, working mothers, so being able to return to work and resume clinical, academic and administrative activities felt like a giant step towards recovery. Resuming driving, particularly when depth perception was no longer compromised with gradual vision improvement, contributed to an increased sense of hope. All of us agreed that we felt joyful at being able to attend our children's various activities and resume certain household chores that contributed to feeling a sense of normalcy. However, there are some activities that may have to be postponed for some time in the interest of surgical recovery.

This is where we would be remiss not to discuss the gas bubble. To ensure that the retina fully re-attaches, gas is put into the eye during the surgical procedure to help the retina heal. There are specific restrictions on flying during this time, so air travel is prohibited until the gas bubble fully dissolves. The lower pressure in an airplane cabin and quick fluctuations in air pressure during take-off and landing, can cause the gas in the eye to rapidly expand, which can dangerously increase eye pressure. In turn, increased intraocular pressure can damage the retina and cause blindness. Since we have gone through a grueling process including surgery to save vision, it would have been counterintuitive to attempt to fly while the bubble remains present. For the first week or so you, the presence of the gas bubble is not an issue, as overall vision is so poor. However, over time as shapes and then colors begin to come back, the bubble

may become bubble an old friend and a reminder that vision is healing. It also becomes an intimate enemy and a reminder that progress can move at what feels like a glacial pace. The bubble initially appears to take up the entire visual field and as time passes, it gradually becomes smaller and smaller. Before it fully disappears, all authors noted it breaking into numerous smaller bubbles and then disappearing for good. This feels like a freeing point in the process (and quite a mindfulness metaphor), as the flying restriction is lifted, and this is when a medical alert wristband that had to remain wrapped around one's wrist upon discharge from the hospital could finally be removed. Whilst the gas bubble remains in the eye, certain dental procedures are contraindicated due to the use of various gases, and weightlifting, which is a hobby of one of the authors, is also contraindicated. Walking, particularly walking outside, however, serves multiple purposes, not only offering an opportunity for physical exercise but also for continued mindfulness practice.

Of other significance are the body image issues that arise after this surgery. One's face is likely bruised and swollen, and the surgical eye will be red and puffy for a long while. Depending on how well one fared in surgery, there may be issues with ciliary the nerve (i.e. - pupil dilation) or strabismus (i.e. - eye turned to the side). During this healing process all the authors felt they did not look like themselves, which oftentimes led to social isolation or withdrawal. There were anhedonia and lack of desire to engage in once loved activities. Yet for all, a return to work, family gatherings and important milestone events occurred after the RD, since life does not simply stop because of this event. Recognizing that this is part of the healing process and ensuring the presence of social support was important for us all. We benefited from kindly support from those who told us that we looked wonderful as well as trusted others who told us the truth, which is that we certainly looked better than we thought. These image issues popped up periodically throughout the entire first year, and we found that behavioral activation was the best remedy. Setting small achievable goals to rebuild self-esteem as well as reframing negative thoughts from "I look awful" to "I am healing and recovering" as well as engaging in a great deal of self-compassion, helped during these moments.

The authors thought it might be helpful to outline themes noticed throughout the journey correlated with the patient experience and its psychological implications, see Table 1.

Healing is not a straight line

While RD surgical outcomes are often favorable, it is helpful to set expectations that retinal detachment repair sometimes requires more than one surgical intervention. Every one of the authors had some sort of complication or new onset of floaters or flashing after their RD, either in the same eye, or the other eye. Unfortunately, with one RD, the likelihood of another increases but cryopexy, a wonderfully helpful procedure, can be done in the ambulatory office setting. This is a procedure completed with numbing eye drops and lasering of the back of the eye if another PVD appears. For all authors, a new PVD did appear, which does not mean that it will, but in our n of 3, we were at 100%. Only 1 had cryopexy on two different occasions to save the non-surgical eye from another RD. Other complications might include the fact that the surgical eye just does not like the scleral buckle. One of the authors had to have it removed 6 months after the initial placement, which is another risky procedure as it may cause yet another RD. However, there were vascular issues in the eye and ciliary nerve damage which led

Table 1: Psychological themes after RD.

Theme	Patient Experience	Clinical / Psychosocial Implications
Anticipatory anxiety & need for control	Heightened preparation behaviors prior to surgery (e.g., cleaning, organizing) reflecting uncertainty and emotional distress	Preoperative counseling should acknowledge anxiety and normalize attempts to regain control
Postoperative fear & hypervigilance	Fear surrounding bandage removal and early follow-up visits; intense monitoring of recovery	Providers should proactively discuss expected emotional responses during early recovery
Patient–provider perception mismatch	Experiences perceived as catastrophic by patients often viewed as routine by retina teams	Risk of emotional invalidation despite appropriate medical care; need for empathic communication
Positioning demands & physical burden	Strict positioning experienced as essential by patients, regardless of provider reassurance	Physical discomfort may amplify anxiety; clear rationale and validation may reduce distress
Family dynamics & parenting challenges	Adolescents normalize visible impairment; younger children may require explanation and preparation	Family-centered education may support coping for both patients and children
Loss of autonomy & dignity	Difficulty with basic self-care (e.g., delayed bathing, reliance on sponge bathing)	Loss of independence may contribute to vulnerability and distress; anticipatory guidance is beneficial
Body image disturbance & social withdrawal	Visible eye changes (redness, swelling, strabismus, protective eyewear) leading to feeling unattractive, not oneself, and avoidance of social interaction	Body image distress may drive isolation; anticipatory guidance, normalization, and psychosocial screening are warranted
Identity disruption & emotional loss	Grief related to not "feeling like oneself" during prolonged recovery	Psychological support may be needed to address identity loss and adjustment
Evolving emotional response to complications	Initial distress about cataract development later reframed as a hopeful milestone	Emotional responses evolve over time; longitudinal support is important
Need for validation and reassurance-seeking	• Persistent questioning of what is "normal" and preference for frequent follow-up visits • Frequent contact with specialists perceived as necessary for emotional safety	• Reassurance-seeking is adaptive; clear guidance and access reduce anxiety • Normalizing questions and encouraging communication may improve patient experience

to permanent pupil dilation and ultimately, it was the better decision. Thankfully, one of our cornea specialists is adept with pupilloplasty and completed this surgery approximately 6 more months after the buckle was removed. During this procedure, the surgeon also corrected the cataract that had formed from all the Prednisone used to assist the eye in healing.

Unfortunately, preparing oneself for a cataract due to the use of steroids in the surgical eye, is a must and part of post-operative preparation. Having numerous eye surgeries can also cause eyelid damage, so one may find oneself seeing yet another surgeon, a specialist in oculoplastic surgery. This surgeon can fix ptosis, and any new eyelid issues or older ones that have resurfaced. One of the authors had a closed tear duct that needed to be drained and two ended up with a chalazion, and oculoplastics is able to remedy this with an injection, if a course of antibiotics does not work. Our goal in sharing this additional information is simply to normalize that additional steps or changes in the treatment plan can and will occur; fortunately, as patients, we were supported by an exceptional team of ophthalmologists and surgeons, with access to a dedicated eye emergency department if needed. As healthcare professionals, we are often focused on taking care of others and consulting with colleagues across disciplines about the best care for our patients. With a catastrophic ocular emergency, all three of us were forced to practice the very skills we teach our patients for a myriad of other health conditions, to help mitigate the anxiety that came with this health setback. Another unanticipated lesson: extended time in the ophthalmologic emergency department can be part of the experience, and human connection can become an unexpected source of comfort as stories are notably very similar.

All of us had been frequent contact lens wearers prior to our RD's. Contact lenses however, have become rare for all of us after surgery due to rapid post-operative vision changes, cataract development and significant discrepancies between the surgical and the non-surgical eye. After having a cataract repaired, one may only need to wear one contact lens in the non-surgical eye or one in the surgical eye, to equalize the vision and avoid headaches that can be caused by wearing glasses. Different options worked for the authors based on our concerns, stemming from discussions with our cornea surgeons. One author chose to correct the eye and wear another contact, and another wears one contact and then glasses on top only for distance, which allows her to not need reading glasses – a perk from the entire process! Another author's RD is still so recent that she has not yet had her cataract surgery, so she wears glasses pretty much all the time, as she finds them more comfortable.

Looking forward

The authors recognize that this is not a scientific study but a sharing of personal engagement with RD in an autoethnography format. Despite having top-notch care from compassionate physicians, nurses and technicians, our anxiety was notable, particularly with the unknown. However, it was mitigated a great deal by using a variety of coping techniques and a great deal of social support. Moreover, we all found profound meaning in putting this manuscript together to share psycho-education and lessons learned for others' future benefit. We do feel it would be a worthwhile endeavor to complete empirical research on the utilization of mindfulness, cognitive restructuring and behavioral activation on mitigating RD-related anxiety to examine psychological aspects of the process with a more robust population to see if our experiences are consistent with a larger group. Most studies on RD examine the success rate of the procedure – "did the retina re-attach"? However, the sequelae of additional ophthalmic needs, procedures and interventions do foster additional distress and worry for the individual, which is not discussed a great deal in ophthalmology literature and not at all in psychology literature. We also feel that had we been prepared for all the potential 'other' challenges that may arise, there would have been less anxiety. Because the authors' RDs occurred approximately nine months apart, there was, for us, an increasing opportunity for mutual support and education, particularly by the time the third author's RD occurred. Our aim was to share those experiences and lessons here. It is our hope that our conversation can begin the formal development of psychological support for RD's and other ophthalmic emergencies.

Conclusion

Retinal detachment is not only a vision-threatening medical emergency that puts one's vision at risk but potentially, a profoundly anxiety-provoking psychological experience. From the initial diagnosis to surgery, anxiety can be high. However, not many are prepared for the real struggle that occurs after this time with prolonged uncertainty, frequent medical appointments, changing treatment plans, worry about vision and the possibility of additional procedures, as well as potentially mounting medical costs. The authors' collective experience can assure one that anxiety is not confined to the moment of diagnosis and surgery, but it may linger through recovery and through all of the unexpected occurrences along the way. Adaptation and flexibility are a necessity to manage the distress.

We cannot impress enough the importance of distress tolerance skills, staying adaptable, concentrating on the present moment and acceptance of uncertainty as critical in managing the psychological burden associated with retinal detachment. This is especially important when outcomes, timelines and visual recovery remain unclear. These skills support the very normative response to what is initially an acute, and then more chronic, medical stressor.

For our medical colleagues - ophthalmologists and surgical teams – this highlights the importance of anticipatory guidance, clear and compassionate communication and the normalization of emotional distress throughout the course of care. Preparing patients for future potential outcomes will not increase anxiety but normalize it. Setting realistic expectations, the need for potential additional interventions and nonlinear recovery may ultimately reduce distress and foster greater trust. Providing psychologically informed communication has the potential to improve patient experience and adherence, particularly when acknowledgement of anxiety can support patients in feeling less isolated in their experience.

Addressing the psychological dimensions of retinal detachment

is integral to medical care, not secondary to it. Seeking collaborative, interdisciplinary approaches that recognize and validate a patient's anxiety and equipping individuals with practice of coping skills may enhance the psychological health as well as overall improve outcomes in this population.

Disclosure Statement

All three authors of this article underwent emergent surgical procedures to repair rhegmatogenous retinal detachment with vitreoretinal surgeons at Mid-Atlantic Retina and Wills Eye Hospital in Philadelphia, PA. We would like to provide special thanks to Drs. Sprin, Orlin and Fineman. Subsequent care was provided by Ophthalmic Partners and Wills Eye oculoplastic surgeons. We express our deepest gratitude for their exceptional care and support.

References

1. Ge JY, Teo ZL, Chee ML, Tham Y-C, Rim TH, et al. International incidents and temporal trends for rhegmatogenous retinal detachment: A systematic review and meta-analysis. Surv Ophthalmol. 2024; 69(3): 330-336.
2. Ludwig CA, Vail DA, Al-Moujahed A, Callaway NF, Saroj N, et al. Epidemiology of rhegmatogenous retinal detachment in commercially insured myopes in the United States. Sci Rep. 2023; 13(1): 9340.
3. Feltgen N, Walter P. Rhegmatogenous retinal detachment–an ophthalmologic emergency. Dtsch Arztebl Int. 2014; 111(1-2): 12-21.
4. Chiku Y, Hirano T, Hoshiyama K, Iesato Y, Murata T. (2023). Impact of local Covid-19 alert levels on rhegmatogenous retinal detachment. Jpn J Ophthalmol. 2023; 67(3): 255-263.
5. Saraf SS, Lacy M, Hunt MS, Lee CS, Lee AY, et al. Demographics and seasonality of retinal detachment, retinal breaks, and posterior vitreous detachment from the Intelligent Research in Sight Registry. Ophthalmol Sci. 2022; 2(2): 1-10.
6. Quiroz-Reyes MA, Babar Z, Hussain R, Loh ZC, Quiroz-Gonzalez E, et al. Management, risk factors and treatment outcomes of rhegmatogenous retinal detachment associated with giant retinal tears: scoping review. Int J Retina Vitreous. 2024; 10(1): 35.
7. Li H, Zhang M, Wang D, Dong G, Chen Z, et al. Blue light from cell phones can cause chronic retinal light injury: The evidence from a clinical observational study and a SD rat model. Biomed Res Int. 2021.
8. McCrann S, Loughman J, Butler J, Paudel N, Flitcroft DI. Smartphone use as a possible risk factor for myopia. Clin Exp Optom. 2020; 104(1): 35-41.
9. Mozaffarieh M, Sacu S, Benesch T, Wedrich A. Mental health measures of anxiety and depression in patients with retinal detachment. Clin Pract Epidemiol Ment Health. 2007.
10. Fabian ID, Abudy A, Kinori M, Skaat A, Glovinsky Y, et al. Diagnosis of posttraumatic stress disorder after surgery for primary rhegmatogenous retinal detachment. Retina. 2013; 33(1): 111-119.
11. Scott IU, Schein OD, Feuer WJ, Folstein MF. Visual hallucinations in patients with retinal disease. Am J Ophthalmol. 2001; 131(5): 590-598.
12. Kim Y, Moon S, Yim K, Seong S, Hwang J, et al. Psychological distress in patients with symptomatic vitreous floaters. J Ophthalmol. 2017.
13. Sabel BA, Wang J, Cárdenas-Morales L, Faiq M, Heim C. Mental stress as consequence and cause of vision loss: the dawn of psychosomatic ophthalmology for preventive and personalized medicine. EPMA J. 2018; 9(2): 133-160.
14. Ruran HB, Petty CR, Eliott D, Rao RC, Phipatanakul W, et al. Patient perceptions of retinal detachment management and recovery through social media. Semin Ophthalmol. 2023; 38(5): 498-502.
15. Al-Rashid ZZ, Malyshev AV, Lysenko OGI. Quality of life changes after surgical treatment of retinal detachment. Ophthalmol Rep. 2014; 7(2), 23-29.
16. Li J, Li C, Puts M, Wu YC, Lyu MM, et al. Effectiveness of mindfulness-based interventions on anxiety, depression, and fatigue in people with lung cancer: A systematic review and meta-analysis. Int J Nurs Stud. 2023; 140: 104447.
17. Pollard A, Burchell JL, Castle D, Neilson K, Ftanou M, et al. Individualised mindfulness-based stress reduction for head and neck cancer patients undergoing radiotherapy of curative intent: a descriptive pilot study. Eur J Cancer Care. 2017; 26(2).
18. Yu J, Han M, Miao F, Hua D. Using mindfulness-based stress reduction to relieve loneliness, anxiety, and depression in cancer patients: A systematic review and meta-analysis. Medicine. 2023; 102(37): e34917.
19. Clifton J, Domar AD. Psychological distress and infertility: prevalence, impact, and interventions. Elsevier. 2022; 163-181.
20. Galhardo A, Cunha M, Pinto-Gouveia J. A 7-year follow-up study of the Mindfulness-Based Program for Infertility: Are there long-term effects? Clin Psychol Psychother. 2019; 26(4): 409-417.
21. Patel A, Sharma PSVN, Kumar P. Application of mindfulness-based psychological interventions in infertility. J Hum Reprod Sci. 2020; 13(1): 3-21.
22. Grunberg VA, Geller PA, Durham K, Bonacquisti A, Barkin JL. Motherhood and me (mom-me): The development of an acceptance-based group for women with postpartum mood and anxiety symptoms. J Clin Med. 2022; 11(9): 2345.
23. O'Doherty V, Carr A, McGrann A, O'Neill JO, Dinan S, et al. A controlled evaluation of mindfulness-based cognitive therapy for patients with coronary heart disease and depression. Mindfulness. 2015; 6(3): 405-416.
24. Momeni J, Omidi A, Raygan F, Akbari H. The effects of mindfulness-based stress reduction on cardiac patients' blood pressure, perceived stress, and anger: a single-blind randomized controlled trial. J Am Soc Hypertens. 2016; 10(10): 763-771.
25. Zhang D, Lee EK, Mak EC, Ho CY, Wong SY. Mindfulness-based interventions: an overall review. Br Med Bull. 2021; 138(1): 41-57.

26. Driscoll MA, Edwards RR, Becker WC, Kaptchuk TJ, Kerns RD. Psychological interventions for the treatment of chronic pain in adults. Psychol Sci Public Interest. 2021; 22(2): 52-95.
27. Veehof MM, Trompetter HR, Bohlmeijer ET, Schreurs KM. Acceptance-and mindfulness-based interventions for the treatment of chronic pain: a meta-analytic review. Cogn Behav Ther. 2016; 45(1): 5-31.
28. Masuda A, Hayes SC, Sackett CF, Twohig MP. Cognitive defusion and self-relevant negative thoughts: Examining the impact of a ninety-year-old technique. Behav Res Ther. 2004; 42(4): 477-485.
29. Russell JF, Smiddy WE, Flynn HW. Five evidence-based answers for PVD, retinal breaks. Retina Specialist. 2021.
30. Nixon TR, Davie RL, Snead MP. Posterior vitreous detachment and retinal tear–a prospective study of community referrals. Eye. 2024; 38(4): 786-791.