COVID-19

AUSTRALASIAN PSYCHIATRY

Australasian Psychiatry
2022, Vol. 30(2) 235–238

DOI: 10.1177/10398562211057078
journals.sagepub.com/home/apy
SAGE

The impact of COVID-19 lockdown on the well-being of clients of a specialist personality disorder service

Parvaneh Heidari Spectrum Service for Personality Disorder, Richmond, VIC, Australia; Faculty of Medicine, Nursing and Health Sciences, Monash University, Clayton, VIC, Australia

Jillian H Broadbear Spectrum Service for Personality Disorder, Richmond, VIC, Australia; Faculty of Medicine, Nursing and Health Sciences, Monash University, Clayton, VIC, Australia

Lukas Cheney Spectrum Service for Personality Disorder, Richmond, VIC, Australia

Nitin P Dharwadkar Faculty of Medicine, Nursing and Health Sciences, Monash University, Clayton, VIC, Australia

Sathya Rao Spectrum Service for Personality Disorder, Richmond, VIC, Australia; Faculty of Medicine, Nursing and Health Sciences, Monash University, Clayton, VIC, Australia

Abstract

Objective: The aim of this study was to investigate the well-being of people with severe borderline personality disorder (BPD) during the first wave of COVID-19 social restrictions.

Method: Clients of an outpatient specialist personality disorder clinic (n = 77) were invited to the study. An online survey was conducted including a range of open-ended questions exploring well-being and the Coronavirus Anxiety Scale (CAS) which assesses 'coronaphobia'. Qualitative data were analysed using inductive content analysis with NVivo software. CAS data were analysed descriptively using SPSS version 25.

Results: Thirty-six surveys were completed (48% response rate). Many participants experienced significant challenges to their overall well-being during lockdown although some reported improvements in psychosocial functioning. Three participants (8.3%) experienced clinically significant 'coronaphobia'.

Conclusion: The self-reported physical and mental health of participants with BPD demonstrated resilience, suggesting that the capacity to maintain treatment via telehealth helped to mitigate many of the adverse aspects of social restrictions. This study was conducted during the first wave of social restrictions; subsequent studies will reveal longer-term effects of extended community lockdowns.

Keywords: anxiety, borderline personality disorder, COVID-19, coronaphobia, personality disorder, social restrictions

Borderline personality disorder (BPD) is a complex mental illness characterised by a pervasive pattern of instability in affect, interpersonal relationships and self-concept. Borderline personality disorder is also associated with frequent episodes of non-suicidal self-harm, feeling suicidal, feelings of emptiness, intense anger, emotional dysregulation, impulsivity and dissociative symptoms.[1,2] The majority of people diagnosed with BPD have co-occurring mood and anxiety disorders.[3,4] These BPD symptoms highlight the importance of investigating their well-being under COVID-19 lockdown conditions.

Melbourne, Australia endured one of the strictest and longest lockdowns internationally. People were required to stay at home apart from a short list of exceptions and were not permitted to receive visitors. The social restrictions also prevented the majority of in-person treatments of patients diagnosed with serious mental health problems.[5] Understanding the consequences of this unique experience may help policy makers and healthcare providers prepare for similar circumstances in the future. The aim of this study was to investigate physical and emotional well-being of people with BPD during the first wave of national stay-at-home restrictions.

Corresponding author:
Parvaneh Heidari, Spectrum Service for Personality Disorder, 110 Church Street, Richmond, Melbourne, VIC 3121, Australia.
Email: parvaneh.heidari@monash.edu

Methods

An online survey was conducted in a public outpatient specialist personality disorder clinic in Victoria, Australia, during May–June 2020. The clinic provides care for people diagnosed with severe personality disorder, the majority having a diagnosis of BPD.

Clients already receiving treatment services were included in the study (n = 77). Clients were aged between 18 and 65 years old with a diagnosis of BPD according to the DSM-5. Prospective participants were invited to participate via an email message explaining the purpose of study with a link to the online survey. The study was approved by the institutional ethics committee (LR20/037).

A qualitative descriptive survey format was used to ask participants open-ended questions regarding their mental health, physical health, quality of sleep and quality of their relationships (Supplementary Appendix B) as well as their experience of using telehealth to receive psychotherapy. The present study reports the findings regarding participants' physical, mental and social well-being. As the COVID-19 pandemic was a unique incident, an open-ended question format was used for data collection. Similar qualitative descriptive study designs are commonly used in health care, mental health and nursing research[6] where the aim is to gain firsthand knowledge of human experiences.[7,8]

The survey also included the Coronavirus Anxiety Scale (CAS),[9] a validated and reliable (α = 0.93) questionnaire measuring COVID-19 related fear and anxiety (coronaphobia). Coronavirus Anxiety Scale measures dizziness, sleep disturbance, appetite loss, tonic immobility and abdominal distress on a five-point Likert scale from zero (not at all) to four (nearly every day) based on symptoms experienced during the past two weeks. The total score can range from zero to 20. A threshold of scores ≥9 was proposed to differentiate people experiencing coronaphobia for people having a prior diagnosis of anxiety disorder.[9,10] CAS has been used in other studies[11] and adapted for use in Turkey,[12] Bangladesh,[13] Mexico[14] and Korea.[15]

Data analysis: Qualitative data were analysed using inductive content analysis[16] (Supplementary material). Frequency reported with respect to categories endorsement[17] and quotations were used to illustrate the findings. Coronavirus Anxiety Scale data were analysed using the Statistical Package for the Social Sciences (SPSS, version 25).

Results

Thirty-six clients completed the survey (48% response rate). The majority of participants were female (86.1%) and aged 28–37 years (Supplementary Appendix A).

Mental and physical health

When participants were asked about changes in their mental health under the stay-at-home restrictions, a variety of changes were reported (Table 1).

Out of 32 participants who responded to the question regarding the physical health, the majority reported that they were less physically active (n = 20, 62.5%). Seven (21.8%) participants reported no change and three (9.3%) were more physically active. Physical health changes that participants reported included increased smoking (n = 12; 36.3%), alcohol consumption and weight gain. Some reported stomach and bowel issues, poor appetite and higher blood pressure (Supplementary Table C).

Diet and eating patterns were highly variable, with nine of 31 participants (29.0%) reporting binge-eating, seven (22.5%) losing their appetite and eating less and three (9.6%) having fluctuations in their eating patterns.

Quality of sleep

Fourteen out of 29 participants experienced a worsening of quality sleep and insomnia (48.2%). Thirteen (44.8%) reported that their quality of sleep was unchanged during restrictions and two (6.9%) mentioned they experienced better quality sleep.

> *'Lack of routine has caused a big change in sleeping patterns…not enough sleep'* P18

Relationships with cohabitants

Of the 36 participants, eight lived alone (22.2%), 20 (55.5%) lived with family members, a partner (n = 4, 10.8%), friends, or housemates (n = 4, 10.8%). In terms of how they were managing their relationships with people with whom they lived, seven out of 27 respondents (25.9%) reported that their relationships were stable without any particular change and three (11.1%) reported improvement in their relationships.

> *'I think COVID19 has brought us closer together as we have more time to spend together.'* P25

Five (18.5%) participants reported that their relationships had deteriorated, whereas two (7.4%) reported although their relationships were already challenging at the beginning of the restrictions, they were managing well at the time of the survey.

> *'I have been more irritable and have had a shorter fuse during conflicts because I have had feelings of being trapped increase due to the isolation.'* P9

Relationships with non-cohabitants

Twelve out of 30 respondents to this question (40.0%) found their relationships with other people became more challenging during the restrictions and five (16.6%) mentioned that they felt less connected with others.

> *'Very challenging, I feel abandoned "out of sight out of mind". I feel that it is going to be hard to start socialising again.'* P8

Table 1. Mental health changes of people with BPD who continued to receive treatment via telehealth during COVID-19 lockdown (*n* = 32).

Themes	Categories	Please describe any changes in your mental well-being: Representative responses: (P: participant)	N (%)
Negative	More extreme emotions	I have experienced more periods of extreme emotion, which have been very difficult to regulate. P36	6 (18.7)
	More stressed	Severe anxiety, lots of stress P3	5 (15.6)
	More depressed	Things were starting to get worse for my depression, suicide attempts etc. COVID just made all this get even worse. P32	4 (12.5)
	Mental health has deteriorated	I took me years and years to be somewhat comfortable in the community, but now I think it will take a lot of work to get back to my normal. My mental health has developed into loss, grief, withdrawal, not feeling valued etc. P2	3 (9.3)
	Feeling more hopeless	I feel more hopeless and like less is available to me in terms of decompressing or nurturing my experience of community. P29	3 (9.3)
	Difficulty staying motivated	I feel very flat and unmotivated since the lockdown even though it hasn't changed my life much at all. P22	2 (6.2)
	Anxiety due to COVID-19	I have had consistent anxiety about all the information being exploited by the media regarding the virus P27	2 (6.2)
	More anxious when leaving the house	My anxiety at leaving the house has been heightened. P34	2 (6.2)
	Feeling of loneliness	Without the benefits of cuddles/shoulder to cry on I have struggled with processing the grief brought on by my mother's death. P10	2 (6.2)
	Hyperventilating, more dissociation, more suicide attempts, paranoid	Unstable, fear of heaps of things, paralysis, hopelessness, change in sleep, eating habits changed, mental fragility, depression, panic to leave house, insecure, dissociated more, hyperventilating a lot, new onset migraine. P16	1 (3.1)
Positive	Mental health has improved	I was starting to feel safer, less angry and less "down". Now I feel like I'm back at square one. P4	4 (12.5)
	Less violent	20% less violent P13	1 (3.1)
No change	–	No specific changes as I have challenges at the moment which haven't changed due to COVID-19. P7	3 (9.3)

Seven participants (23.33%) were trying to maintain their relationships through phone calls and/or texting. Three (10.0%) mentioned that their wider relationships remained stable during restrictions, while three (10.0%) said they had no relationships with others prior to the COVID-19 pandemic.

> *'Trying to keep in touch as much as possible, checking in on one another, making future plans to be excited about.'* P25

Coronavirus Anxiety Scale (CAS)

Three out of 36 clients (8.3%) had a CAS score of ≥9, suggesting that they were experiencing coronaphobia. Detailed responses of CAS are presented in Supplementary Table D.

Discussion

This study examined the holistic health of clients with BPD during the first wave of lockdown in Australia. The expectation was that social isolation would be particularly challenging for people with BPD due to specific features of the disorder such as self-harming behaviours, feelings of emptiness, fear of abandonment, interpersonal difficulties and emotion dysregulation. Although many experienced considerable challenges to their overall well-being during lockdown, an unexpected finding was that some participants reported improvements in their psychosocial functioning. The interpersonal triggers that drive many BPD-related behaviours were likely absent in these participants. It is noteworthy that participants were receiving psychotherapy and support via telehealth at the time that this survey was conducted, potentially mitigating some of the adverse effects of social isolation reported previously in people with serious mental illnesses.[18,19]

Complex interpersonal behaviours are symptoms of BPD. The majority of participants had a positive relationship with the people with whom they lived but found other relationships more challenging. A case study[20] reported

a similar finding where a person with BPD felt happy about their relationship with cohabitants but felt neglected and lonely due to having less contact with friends. A review article[18] reported a similar finding; people diagnosed with Cluster B personality disorders which include BPD may show more intense stress-related reactions to lockdown. However, while some participants missed their social connections, others enjoyed their time in lockdown, suggesting that for a few the reduction in interpersonal contact may have reduced their symptom expression.

The ongoing provision of BPD-appropriate psychotherapy via telehealth may have attenuated some of the most concerning expressions of BPD. This suggests significant benefits, in the short-term at least, for mental health services that adopt telehealth for the provision of treatment and support for their clients social connectedness is disrupted as has occurred during the pandemic.

Limitations

This study was conducted within a specialist personality disorder service and clients 'opted in', potentially introducing some bias in terms of client self-selection and impacting the generalisability of the findings to include all people with this diagnosis. Data were collected using an online survey with a cross-sectional design during the first national lockdown in Australia. Similar studies conducted to date also used cross sectional designs; the longer term consequences of social restrictions are yet to be reported.

Acknowledgements

We thank the participants of the study for their time on completing the survey.

Disclosure

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iDs

Parvaneh Heidari https://orcid.org/0000-0002-1043-1555
Jillian H Broadbear https://orcid.org/0000-0003-3342-5868
Sathya Rao https://orcid.org/0000-0001-9364-8831

References

1. Gunderson JG. Disturbed relationships as a phenotype for borderline personality disorder. *Am J Psychiatry* 2007; 164: 1637–1640.
2. *Diagnostic and statistical manual of mental disorders*. 5th ed. Arlington VA: Am Psychiatric Assoc, 2013.
3. Quirk SE, Berk M, Pasco JA, et al. The prevalence, age distribution and comorbidity of personality disorders in Australian women. *Aust New Zealand J Psychiatry* 2017; 51: 141–150.
4. Shah R and Zanarini MC. Comorbidity of borderline personality disorder: current status and future directions. *The Psychiatr Clinics North America* 2018; 41: 583–593.
5. Kahl KG and Correll CU. Management of patients with severe mental illness during the coronavirus disease 2019 pandemic. *JAMA Psychiatry* 2020; 77: 977–978.
6. Kim H, Sefcik JS and Bradway C. Characteristics of qualitative descriptive studies: a systematic review. *Res Nurs Health* 2017; 40: 23–42.
7. Sandelowski M. Whatever happened to qualitative description? *Res Nurs Health* 2000; 23: 334–340.
8. Neergaard MA, Olesen F, Andersen RS, et al. Qualitative description–the poor cousin of health research? *BMC Med Res Methodol* 2009; 9: 1–5.
9. Lee SA. Coronavirus anxiety scale: a brief mental health screener for COVID-19 related anxiety. *Death Stud* 2020; 44: 1–9.
10. Lee SA. Replication analysis of the coronavirus anxiety scale. *Dusunen Adam: The J Psychiatry Neurol Sci* 2020; 33: 203–205.
11. Asmundson GJG, Paluszek MM, Landry CA, et al. Do pre-existing anxiety-related and mood disorders differentially impact COVID-19 stress responses and coping? *J Anxiety Disord* 2020; 74: 102271.
12. Evren C, Evren B, Dalbudak E, et al. Measuring anxiety related to COVID-19: a Turkish validation study of the coronavirus anxiety scale. *Death Stud* 2020; ■■■: 1–7.
13. Ahmed O, Faisal RA, Sharker T, et al. Adaptation of the Bangla version of the COVID-19 anxiety scale. *Int Journal Mental Health Addiction* 2020; ■■■: 1–12.
14. Mora-Magaña I, Lee SA, Maldonado-Castellanos I, et al. Coronaphobia among healthcare professionals in Mexico: a psychometric analysis. *Death Stud* 2020; ■■■: 1–10.
15. Ahn MH, Lee J, Suh S, et al. Application of the stress and anxiety to viral epidemics-6 (SAVE-6) and coronavirus anxiety scale (CAS) to measure anxiety in cancer patient in response to COVID-19. *Front Psychol* 2020; 11: 604441. Brief Research Report.
16. Elo S and Kyngäs H. The qualitative content analysis process. *J Adv Nurs* 2008; 62: 107–115.
17. Fife W. *Counting as a qualitative method*. Switzerland AG: Springer, 2020.
18. Preti E, Di Pierro R, Fanti E, et al. Personality disorders in time of pandemic. *Curr Psychiatry Rep* 2020; 22: 80.
19. Melamed OC, Hahn MK, Agarwal SM, et al. Physical health among people with serious mental illness in the face of COVID-19: concerns and mitigation strategies. *Gen Hosp Psychiatry* 2020; 66: 30–33.
20. Chong SC. Psychological impact of coronavirus outbreak on borderline personality disorder from the perspective of mentalizing model: a case report. *Asian J Psychiatry* 2020; 52: 102130.