Pandemic Impacts on Cluster B Personality Disorders in the U.S. Navy: A Case Study in Context

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ABSTRACT This paper is a brief description of the impact that the SARS-CoV-2 global pandemic has had on both mental health and U.S. Navy policies through the narrative of a deployed enlisted sailor, medically evacuated from Japan. Although the introduction of vaccines and loosening of state-specific mandates have signaled a slow return to our "normal," pre-pandemic, way of life, there is now an opportunity to look back and understand how the situation impacted the presentation and outcome of certain cases. We believe that the sailor presented introduces a discussion about the impacts of heightened restrictions on some personality types. As the pandemic has continued to impact and reshape every facet of force health protection, we believe that understanding the impact of public health orders on individuals with specific personality disorders or traits will help us provide care and leadership counsel going forward. The discussion within our case report provides insight and an opportunity for healthcare providers to reflect.

The SARS-CoV-2 global pandemic impacted many areas of life and, in the military, experiences were further varied across the globe. To protect physical health, we isolated ourselves from one another, and this isolation affected mental health in a variety of ways. The policies and responses enacted by governments and large organizations to counteract the infectious spread of the SARS-CoV-2 virus and save lives on a large scale may have contributed to some negative mental health outcomes. Adults in the United States now report higher levels of anxiety and/or depressive symptoms.[1,2] Private citizens, however, were given free rein to manage, follow, or ignore restrictions as they desired, whereas those serving in the armed forces often had less choice. Unanticipated restrictions of this kind likely impacted those predisposed to mental illness, specifically those service members with personality disorders of the cluster B spectrum. An aspect of cluster B personality disorders—which include antisocial, borderline, histrionic, and narcissistic personality disorders—involves having limited appropriate coping mechanisms for isolation and strict restrictions with often dramatic responses to stressors.

Acting to protect our fighting forces and remain a global force for good during the outbreak of the SARS-CoV-2 virus, U.S. Navy leadership enacted NAVADMIN 64/20 on March 12, 2020. This stop movement order cancelled all nonemergent travel to include permanent duty station changes, temporary duty, and personal leave. There were also 14-day quarantines, although facilities and installations were closed to encourage physical distancing. Following NAVADMIN 64/20, commanding officers across the fleet applied regulations to address local concerns tailored for the area and personnel governed.

Public Health Orders in Japan further tightened restrictions on activities in the area, thereby significantly limiting social and public activities. U.S. Naval ships adjusted their standard operating procedures accordingly as well. Sailors experienced extended time underway, increased work hours, prolonged on-ship quarantines, and limited mobility in port. In contrast, sailors living in the United States were not restricted or isolated to the same degree as those stationed overseas. The differences in environment may have contributed to different and often more severe mental health presentations in sailors dealing with personality disorders overseas. Restrictions enacted were necessary from a public health standpoint, and we see our case study as an example of how this combination of external protections might impact a specific population of service members, those with cluster B personality disorders.

Why discuss this unique case at all or place it in the context of the pandemic? There are many individuals with personality disorders employed across the U.S. Military for a wide variety of reasons. In the case of patients with cluster B personality disorders, they may be particularly attracted to the rigid structure, which can serve as a replacement for ineffective parental figures. They may also appreciate the simplicity in being told what is "good" and "bad." Some previous research has supported an incompatibility with military service in those

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The patient information in this case study has been de-identified and the patient has given their permission for the case to be written. The paper has been cleared by the Uniformed Services University public affairs office for publication and contains public knowledge of U.S. Navy policies.

doi:https://doi.org/10.1093/milmed/usab441

who exhibit personality disorders when compared to controls; however, those functioning well with personality disorders would be difficult to identify as they may not present to mental health. The former earned less promotions, underwent more legal proceedings, were more likely to have unauthorized absences or desertions, and were more likely not to be recommended for re-enlistment.[3] Clinical studies have demonstrated that those with personality disorders exhibit difficulty adjusting to military life because of limited coping skills and some aversion to therapeutic options and leadership counseling.[3] These observable behaviors might reflect insecure and disorganized attachment styles with pathological internalized object relations impacting their ability to conform to the hierarchical structure of the military.

Our patient, a male in his twenties at his first duty station overseas was medically evacuated back to the United States after self-harming behaviors were discovered by command. Specifically, the patient cut his arm and painted a wall with the blood, denying any desire to die. His actions, consistent with primary process thinking, made it clear he required hospitalization and was no longer appropriate for overseas assignment. The patient had been intoxicated at the time of his self-harm and cited alcohol use as his primary coping mechanism for weeks prior to presentation.

Substance use disorder has become an issue for many during the pandemic, and the issue is multifactorial. The patient had previously enjoyed exercising, lifting weights, and exploring local areas; however, the limitation of these outlets because of pandemic protective orders had likely diminished the patient's sense of external control, and the team understood the public act of self-mutilation to be an attempt to regain this control. Outside of regaining control, it has been demonstrated that regular physical activity is associated with increased mood and improved ability to regulate stress.[4] We can see that limitations in the patient's access to alternate coping strategies may have contributed to increased stress and low mood, although substance use disorder was a significant factor.

Three months before his medical evacuation to San Diego in May 2020, the patient began seeing embedded mental health providers, seeking help for the first time for issues of low mood, anger, alcohol use, and difficulties at work. The patient was diagnosed initially with adjustment disorder with depressed mood, alcohol use disorder, antisocial personality traits, and borderline personality traits. His engagement with appointments was inconsistent, although it was encouraged by command. The patient eventually reported two instances of suicide preparatory behaviors during this time, involving a noose and a firearm, for which he did not immediately seek help or report prior to medevac. It was clear that the patient required a higher level of care than the local access provided.

The team learned that the etiology of the patient's presentation was complicated by geographical separation from friends and support in the states and recent loss, both associated with the pandemic. The patient was able to identify feelings of isolation from minimal close contacts or friends for months before medevac. His paternal figure, who was a close supporter of the patient, was admitted to a United States hospital with SARS-CoV-2 pneumonia weeks prior to his own hospital admission, increasing the patient's feelings of anxiety and stress. The patient's strong emotions toward the well-being of his family contrasted sharply with his expressed disdain and ambivalence toward them otherwise, possibly reflecting a difficult childhood and the loss of opportunities to repair these relationships.

Occupationally, the sailor had developed a contentious relationship with his command and superiors since arriving in Japan at his first duty station. Difficulty with authority figures, describing them as "tyrannical" and "selfish," may have reflected his own experience with authority figures growing up. The command expressed hope that the sailor would do well, and the leadership noted significant time had been spent talking with the sailor and helping them grow because of his potential. This command investment was perceived by the sailor as criticism and negativity. The narrative from the patient regarding his overbearing command was in marked contrast to the command's view of the sailor, reflecting a possible disconnect between his perception of interpersonal interactions and those of others. It may also reflect a frustration with social transactions that did not yield the desired results for him. Pandemic restrictions could not be adjusted, even in special circumstances, and that was difficult for the patient to tolerate. These dynamics were repeated with the inpatient treatment team as well.

While admitted, the patient displayed behaviors consistent with antisocial personality disorder, including lack of remorse or empathy and intense, unblinking eye contact when discussing socially inappropriate or violent behaviors, including the physical abuse of his younger brother. He was dismissive in response to guidance from providers and disparaging of motivational interviewing techniques, which might also have been a defense to regain a sense of control. The patient demonstrated a belief in his superior intellect over those around him and was noted to engage in the manipulation of others. To address symptoms of depression and difficulty sleeping, the patient engaged in pharmacotherapy with sertraline and trazodone, both antidepressants with different mechanisms of action—the latter has some sedating effects, with some subjective reported benefits in sleep and mood during his short stay. These medications were initiated in theater, where the available pharmacotherapy options for antidepressants and insomnia were limited. As the patient was tolerating them without side effects, these medications were continued and titrated to therapeutic dose and effect by the hospital team. There were no self-harming behaviors or suicidal statements made while in the hospital perhaps because of the combined efforts of the inpatient psychiatry team with crisis stabilization and a stable medication regimen. The patient was voluntary for treatment at a residential substance use program for his alcohol use disorder, severe, following admission.

There is developing literature describing how those with personality disorders are uniquely impacted psychologically by the restrictions of movement secondary to transmission mitigation of SARS-CoV-2.[5] Patients with narcissistic and antisocial personality disorders exhibit low agreeableness and were found to exhibit adverse psychological well-being, particularly symptoms of anxiety, depression, impulsivity, anger, emotional dysregulation, and suicidality. Socially, the patient had been coping with daily stressors well in Japan prior to the quarantine and restriction of activities. However, as outlets and social connections were limited, the patient began to struggle more with his stress. Feelings of isolation have been connected to psychological distress in other antisocial and narcissistic patients due to their limited opportunities for expressions of hostility and limited search for admiration from others.[5] In our presented case, the patient had fewer healthy coping outlets and avoided negative feelings through alcohol use, increased perception of conflict at work, and self-harming behaviors, such as cutting and making preparations for suicide.

Some studies suggest antisocial behavior could be accounted for by negative and conflictual parental behavior directed at adolescents.[6] Another even suggested low warmth and parental negativity predicted overall antisocial behavior.[6] It would follow that a patient with this pathology, newly restricted and isolated by their surrogate "parent," may lash out in an impulsive manner. Rather than attributing the quarantine restrictions to the worldwide pandemic or on the Navy, our patient displaced anger on his direct supervisor, who was the face of those restrictions and who functioned as the parental object. Unable to manipulate or feel in control of his external situation or his emotions, the patient physically took control of the situation by harming himself, which may have provided some temporary relief.

The military community is accustomed to adapting to change and meeting the needs of service members in their care. This case serves to highlight one paradigm response to our most recent challenges. We all respond differently to stress; however, identifying a personality disorder or even traits may help us navigate treatment plans and optimize performance in our sailors. Negative features of cluster B personality disorders include impulsivity and repeated suicidal/self-harming behaviors. Providing additional evidence-based coaching for mid-level leadership and other OCONUS supports to identify warning signs, facilitate increased safety planning, or provide engagement with dialectical behavioral therapy techniques in these situations may decrease the number of necessary medical evacuations and decrease the potential effect on the overall mission. In our case, command appeared to be utilizing all available support systems for this sailor, and it is worth noting that engagement is also required on the part of the individual. This case also serves as a reminder of the dangers of easy access to alcohol on U.S. bases, especially when healthy alternative coping strategies and human connections are limited. The presentation of the patient is multifactorial in nature, as evident from his history and presentation in the context of a global pandemic and resultant changes to his daily life while stationed overseas.

FUNDING

None declared.

CONFLICT OF INTEREST STATEMENT

None declared.

REFERENCES

1. Panchal N, Kamal R: The implications of COVID-19 for mental health and substance use. KFF 10; Februrary 2021. www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/; accessed March 2021.
2. Sherman AC, Williams ML, Amick BC, Hudson TJ, Messias EL: Mental health outcomes associated with the COVID-19 pandemic: prevalence and risk factors in a Souther US state. Psychiatry Res 2020; 293: 113476.
3. Gunderson EK, Hourani LL: The epidemiology of personality disorders in the U.S. Navy. Mil Med 2003; 168(7): 575–82. PMID: 12901471.
4. Childs E, de Wit H: Regular exercise is associated with emotional resilience to acute stress in healthy adults. Front Physiol 2014; 5: 161.
5. Preti E, Di Pierro R, Fanti E, Madeddu F, Calati R: Personality disorders in time of pandemic. Curr Psychiatry Rep 2020; 22(12): 80. PMID: 33170391; PMCID: PMC7652908.
6. Gabbard G: *Psychodynamic Understanding. Psychodynamic Psychiatry in Clinical Practice*. 5th ed. American Psychiatric Publishing; 2014. https://www-r2library-com.usu01.idm.oclc.org/Resource/Title/1585624438/ch0017s0217; accessed March 2021.