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Research Article

INVESTIGATION OF COVID-19 FEAR AND LIFE QUALITY AMONG BIPOLAR DISORDER PATIENTS FOLLOWED BY A COMMUNITY MENTAL HEALTH CENTER DURING THE COVID-19 PANDEMIC

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ABSTRACT

This study aims to determine and investigate COVID-19 fear level, quality of life, and follow-up-related data during the pandemic in patients with bipolar disorder in remission who were followed up at a Community Mental Health Center (CMHC). The study included 42 individuals who admitted to the CMHC unit between June and July 2022. Participants were assessed by using a sociodemographic data form, the COVID-19 Fear Scale, the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0), and the Clinical Global Impression Scale (CGI). The data were analyzed using independent groups T-test and Pearson correlation test. During the pandemic, no change was determined in the frequency of psychiatric hospitalizations in 95.2% (n=40), and manic and/or depressive episodes in 69% (n=29) of the patients. While 92.9% (n=39) of the patients reported no difficulty attending psychiatric follow-ups, 64.3% (n=27) stated that they did not experience COVID-19-related challenges accessing non-psychiatric services. The average COVID-19 fear score was 15.21±7.57, WHODAS 2.0 was 10.29±7.27, and CGI was 2.57±0.77. No significant relationships were found between the variables (p>0.05). In conclusion, the stability in episode frequency and hospital follow-ups during the pandemic highlights the importance of CMHC monitoring, emphasizing the need to enhance such services, especially during crises.

INTRODUCTION

COVID-19, a novel coronavirus disease that emerged in November 2019 and rapidly spread across the globe, was declared as a pandemic by the World Health Organization (WHO) in March 2020 (CDC Covid-19 Response Team, 2020). The pandemic significantly impacted on health, economy, and social life worldwide, and led to substantial increases in uncertainty and stress levels (Yalçın et al., 2021). Individuals with chronic illnesses were among the most vulnerable groups to the physical and psychological burdens brought on by the pandemic.

Studies have consistently reported that individuals with chronic health conditions faced heightened vulnerability during the COVID-19 pandemic—not only due to their increased risk of infection and COVID-19-related mortality, but also because of the indirect psychological

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burden imposed by the pandemic (Melamed et al., 2020). Quarantine measures, fear of infection, and social distancing policies created substantial barriers to healthcare access for these individuals, affecting both their physical and mental health (Wang et al., 2020; Xiong et al., 2020). Additionally, chronic illnesses were shown to impact not only the physiological course of COVID-19 but also individuals' psychological resilience, making them more susceptible to adverse mental health outcomes during this period (Holmes et al., 2020).

From the perspective of psychiatric disorders, the impact of the pandemic was particularly striking. It was suggested that individuals diagnosed with mood disorders and anxiety disorders might have experienced a worsening of symptoms due to the isolation, uncertainty, and disruptions to daily routines brought about by the pandemic (Rajkumar, 2020). In addition, the traumatic effects of the pandemic increased the risk of emerging mental health issues such as depression, anxiety, post-traumatic stress disorder, and alcohol or substance use disorders (González-Sanguino et al., 2020; Goularte et al., 2021; Xiong et al., 2020).

This period became even more critical for individuals diagnosed with severe mental disorders (SMD) such as Bipolar Affective Disorder (BAD), schizophrenia, and other psychotic conditions. Due to increased social distancing and quarantine measures, individuals with SMD faced significant challenges in accessing social support systems, leading to heightened feelings of loneliness, disruptions in circadian rhythms, and irregular sleep and eating patterns (Murray, Gottlieb & Swartz, 2021; Stefana et al., 2020). In patients diagnosed with Bipolar Disorder, it was noted that the isolation and restricted access to healthcare services during the pandemic might have increased the risk of suicidal behavior, placed a greater burden on caregivers, and elevated the likelihood of mood episode relapses (Fornaro et al., 2021; Stefana et al., 2020).

According to cross-sectional studies, quarantine measures were associated with increased severity of depressive symptoms in individuals with BAD and led to more pronounced disruptions in biological rhythms compared to patients with major depression and healthy individuals (Carta et al., 2021; Van Rheenen et al., 2020). However, there were also studies reporting no significant deterioration in individuals with BAD during the pandemic period (Karantonis, Rossell, Berk & Van Rheenen, 2021; Tundo, Betro' & Necci, 2021).

The COVID-19 pandemic profoundly affected individuals' health, social lives, and psychological resilience across the globe, with particularly significant consequences for vulnerable groups such as those with chronic or psychiatric conditions. In this context, our study examined the levels of fear related to COVID-19, quality of life, and the impact of the pandemic on psychiatric follow-up processes among individuals diagnosed with Bipolar Affective

Disorder (BAD) who were in remission and were being followed up at a Community Mental Health Center (CMHC). By exploring the experiences of this patient group at both individual and systemic levels, our study aimed to assess the effectiveness of CMHC services during crisis periods like the pandemic and to offer recommendations for their improvement. The research questions were listed below:

- What was the level of fear related to COVID-19 among individuals diagnosed with BAD who were in remission?
- How did the COVID-19 pandemic affect the quality of life of individuals in remission from BAD?
- Was there a relationship between quality of life and the level of fear associated with COVID-19?
- During the COVID-19 pandemic, did individuals with BAD in remission experience difficulties in continuing their psychiatric follow-up appointments?
- Was there a change in the frequency of manic and/or depressive episodes in individuals diagnosed with BAD during the pandemic?
- What was the role of Community Mental Health Center (CMHC) services in helping individuals with BAD in remission maintain regular follow-ups and psychological stability during the pandemic?
- How did social distancing measures, quarantine, and restricted access to healthcare services during the pandemic affect the overall mental health status of individuals in remission from BAD?

MATERIAL AND METHOD

Aim and Type of the Study

The aim of this study was to assess the level of COVID-19-related fear, quality of life, and follow-up data during the pandemic among patients diagnosed with Bipolar Affective Disorder (BAD) who were in remission and were receiving health care at a Community Mental Health Center (CMHC). This study was designed as a cross-sectional research.

Population and the Sample of the Study

Forty-two euthymic patients diagnosed with Bipolar Affective Disorder (BAD), who presented to the Community Mental Health Center (CMHC) of Dışkapı Training and Research Hospital between June and July 2022, were included in the study. The minimum sample size required to perform a correlation analysis with a large effect size (r=0.5), an alpha level of 0.05, and 80% power (1-β=0.80) was calculated as 29. Therefore, the inclusion of 42 participants was considered sufficient to detect large effects. At the time of the study, the CMHC functioned as an outpatient rehabilitation center affiliated with Dışkapı Training and Research Hospital, providing care for individuals with severe mental disorders, including schizophrenia, schizoaffective disorder, bipolar disorder, and other psychotic disorders. The center's professional team consisted of one faculty member, one nurse, one psychologist, one occupational therapist, one social worker, and two psychiatry residents. Of approximately 1,000 registered patients, 400 were being followed with a diagnosis of Bipolar Affective Disorder. Patients' mood states were assessed through clinical interviews conducted by case managers. These clinical evaluations were performed in accordance with the Structured Clinical Interview for DSM-5 (SCID-5). The case managers responsible for these assessments (residents, nurses, psychologists, and social workers) were professionals who had received training in and were authorized to administer the SCID-5 for severe mental disorders within the CMHC. The euthymic status of the patients was also supported by the Clinical Global Impression (CGI) Scale. During the study period, all literate individuals between the ages of 18 and 65, who were diagnosed with BAD, regularly attended their follow-up appointments at the CMHC, and were compliant with their medication regimens, were informed about the study. Written informed consent was obtained from those who agreed to participate. Patients who lacked of insight or who presented with psychotic symptoms were excluded from the study. No financial compensation was provided to the participants for their involvement in the study.

Data Collection and Analysis

Participants were assessed by a psychiatrist using a sociodemographic data form, and the severity of illness was evaluated using the Clinical Global Impression (CGI) Scale. Their quality of life was assessed by the clinician through the short form of the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0). Following this, participants were given the Fear of COVID-19 Scale to complete. The entire survey process took approximately 30 minutes. Evaluations of patients who were already being followed by the Community Mental Health Center (CMHC) and who continued to receive follow-up via telephone during the COVID-19 pandemic were conducted during the period when face-to-face appointments resumed and restrictions were lifted.

Data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 22.0. The normality of data distribution was assessed through skewness and kurtosis values.

For categorical (qualitative) variables, frequency (n), percentage (%), and standard deviation (SD) statistics were reported. Data analysis was performed using independent samples t-tests and Pearson correlation tests. A p-value of less than 0.05 was considered statistically significant.

Measurements

The sociodemographic data form (SDF)

The Sociodemographic Data Form was used to gather personal information from participants, including age, gender, education level, marital status, employment status, psychiatric history, and medication use. Additionally, the form assessed the number of illness episodes during the COVID-19 pandemic, whether there were any changes in the frequency of hospitalizations compared to the pre-pandemic period, and whether participants experienced difficulties attending CMHC follow-ups or accessing other medical departments for non-psychiatric complaints due to the pandemic. The development of this form was informed by previous studies in the literature (Bakioğlu, Korkmaz & Ercan, 2021; Castelpietra et al., 2021; Clerici et al., 2020; Pinkham, Ackerman, Depp, Harvey & Moore, 2020).

Fear of COVID-19 scale (FCV-19S)

The Fear of COVID-19 Scale (FCV-19S) is a 7-item, 5-point Likert-type self-report scale developed by Ahorsu and colleagues to assess the intensity of individuals' fear of the coronavirus (Ahorsu et al., 2020a). Scores on the scale range from 7 to 35, with higher scores indicating a greater level of fear related to COVID-19. The scale has a validated Turkish version, with established reliability and validity (Bakioğlu et al., 2021). In the Turkish adaptation study, the reliability coefficient was reported as .82, while in the current study, it was calculated as .91.

World health organization disability assessment schedule 2.0 (WHODAS 2.0)

The World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) is a disability assessment tool developed by the World Health Organization. It includes 12- and 36-item versions and can be administered in three formats: interviewer-administered, proxy-administered, and self-administered (Üstün et al., 2010). A Turkish validity and reliability study of the scale has been conducted on individuals with psychiatric disorders (Aslan Kunt & Dereboy, 2018). In the present study, the 12-item interviewer-administered version of the scale was used. Higher scores on the scale indicate greater impairment in quality of life, and the total score ranges from 0 to 48. In the Turkish adaptation study, the internal consistency coefficient for the 12-item interviewer-administered version was reported as .90, whereas in the present study, it was calculated as .75.

Clinical global impression scale (CGI)

The Clinical Global Impression Scale (CGI) was developed by Guy and colleagues to assess the severity of illness, degree of improvement, and intensity of side effects related to medications during follow-up (Guy, 1976). The scale is structured as a 7-point Likert-type instrument and does not include a specific cut-off score. The CGI comprises three subscales: severity of illness, global improvement, and side effects. In the present study, only the "severity of illness" subscale was used to assess the individual severity level of each patient. This subscale rates the patient's current condition on a scale from 1 to 7, where 1 = Normal, not at all ill; 2 = Borderline mentally ill; 3 = Mildly ill; 4 = Moderately ill; 5 = Markedly ill; 6 = Severely ill; and 7 = Among the most extremely ill patients. Although CGI is widely used in clinical practice in Turkey, a formal Turkish validation study has not yet been conducted.

Limitations of the Study

One of the main limitations of our study is that it was conducted in a single center, with a relatively small sample size, and relied on self-report data. Additionally, the study did not specify whether the participants were diagnosed with Bipolar I or Bipolar II Disorder. Although participants were clinically determined to be in a euthymic phase by their long-term case managers through clinical interviews, this status was not confirmed using a standardized rating scale, which can also be considered a limitation. However, considering that the participants were patients regularly followed at a single Community Mental Health Center (CMHC) over an extended period, the sample size and findings still provide valuable insights into the challenges faced by individuals with Bipolar Affective Disorder (BAD)—a severe mental illness—during the COVID-19 pandemic. Notably, much of the existing literature on the impact of COVID-19 in individuals with BAD focuses primarily on the early stages of the pandemic.

Ethical Considerations

The study was conducted in accordance with the Declaration of Helsinki, and ethical approval was obtained from the Ethics Committee of Dışkapı Training and Research Hospital (date: 06.06.2022, decision number: 139/19). Informed consent was obtained from all participants for both the administration of questionnaires and the publication of the study results.

RESULTS

Demographic and Clinical Characteristics of the Participants

More than half of the participants in our study were female (61.9%) and married (52.4%). Nearly half were high school (40.9%) or university (23.8%) graduates. Approximately 40.5% were housewives, and 50% reported having a physical illness. Detailed sociodemographic data are presented in Table 1 (Table 1).

When changes in psychiatric inpatient admissions over the past two years were evaluated, it was found that 95.2% (n=40) of participants reported no change, while 4.8% reported an increase. Regarding changes in the frequency of manic and/or depressive episodes, 69% (n=29) reported no change, 16.7% (n=7) reported an increase in episode frequency, and 14.3% (n=6) reported a decrease compared to previous years.

When, whether there was a difference in the severity of COVID-19 fear scores based on the presence or absence of a physical illness among participants were evaluated, no significant difference was found between the two groups ($t_{(42)} = -0.101$, $p > 0.05$).

In terms of access to psychiatric and other healthcare services during the COVID-19 pandemic, 7.1% of participants reported difficulties attending psychiatric follow-up appointments, while 35.7% experienced difficulties accessing other medical departments.

When the scores for COVID-19 fear severity and quality of life were evaluted, the mean fear score related to COVID-19 was determined to be 15.21±7.57, while the mean quality of life score was 10.29±7.27. According to the Clinical Global Impression (CGI) scale, the mean illness severity score of the patients was 2.57±0.77.

Information about the participants' sociodemographic and clinical characteristics is presented in Table 1 (Table 1).

Table 1. Demographic Information and Clinical Data of the Participants

Demographic information (N=42)	
Age ($\bar{X}$±SD)	46±10.58
Gender (%)	
Female (n=26)	61.9%
Male (n=16)	38.1%
Marital status (%)	
Married (n=22)	52.4%
Single (n=10)	23.8%
Divorced (n=5)	11.9%
Separated (n=1)	2.4%
Widowed (n=4)	9.5%
Education level (%)	
Primary school (n=12)	28.6%
Middle school (n=3)	7.1%

High school (n=17)	40.5%		
Collage/university (n=10)	23.8%		
Employment status (%)			
Unemployed (n=11)	26.2%		
Housewife (n=17)	40.5%		
Civil servant (n=7)	16.7%		
Retired (n=7)	16.7%		
Presence of physical illness (%)			
Yes (n=21)	50%		
No (n=21)	50%		
Change in number of hospitalizations (%)			
Increased (n=2)	4.8%		
No change (n=40)	95.2%		
Change in number of BAD episodes (%)			
Increased (n=7)	16.7%		
Decreased (n=6)	14.3%		
No change (n=29)	69.0%		
Difficulty attending psychiatric follow-up (%)			
Yes (n=3)	7.1%		
No (n=39)	92.9%		
Difficulty accessing other departments (%)			
Yes (n=15)	35.7%		
No (n=27)	64.3%		
Medication use (%)			
Depot antipsychotic (n=4)	9.5%		
Oral antipsychotic (n=38)	90.5%		
Mood stabilizer (n=38)	90.5%		
Antidepressant (n=6)	14.3%		
	Min-max	$\overline{X}$	**SD**
Fear of COVID-19 Scale	7-35	15.21	7.57
WHODAS 2.0	0-25	10.29	7.27
CGI	1-4	2.57	0.77

Note. BAD=Bipolar Affective Disorder; WHODAS 2.0=World Health Organization Disability Assessment Schedule 2.0; CGI=Clinical Global Impression Scale

Findings Related to Participants' Clinical Data

The correlations between illness severity, fear of COVID-19, and quality of life scores among participants are summarized in Table 2 (Table 2). No significant relationship was found between illness severity and fear of COVID-19 scores (r=-0.097, p>0.05). Similarly, no significant correlation was observed between illness severity and quality of life (r=0.241, p>0.125). In addition, there was no significant association between fear of COVID-19 and quality of life scores (r=0.092, p>0.05).

Table 2. Correlation between Quality of Life, Illness Severity, and Fear of COVID-19

		1	**2**	**3**
(1) WHODAS 2.0	**r**	1		
	p			
(2) Fear of COVID-19 Scale	**r**	0.092	1	
	p	0.564		
(3) CGI	**r**	0.241	-0.097	1
	p	0.125	0.542	

Note. WHODAS 2.0=World Health Organization Disability Assessment Schedule 2.0; CGI=Clinical Global Impression Scale

DISCUSSION

In our study, the level of fear related to COVID-19 and the quality of life of patients diagnosed with Bipolar Affective Disorder (BAD) who were being followed at our Community Mental Health Center (CMHC) were investigated. Additionally, changes in the frequency of illness episodes and hospital follow-ups during the COVID-19 pandemic were evaluated. Finally, the relationships between fear of COVID-19, illness severity, and quality of life were examined. The findings indicated that there were no significant changes in the frequency of mood episodes or psychiatric hospital admissions during the pandemic, and the majority of patients did not experience difficulties in continuing their follow-up appointments.

In our study, it was observed that half of the patients had comorbid physical illnesses. Additionally, the fact that nearly half of the individuals experienced difficulties in accessing other medical departments for the follow-up of their physical conditions highlighted an important issue that warranted attention during the pandemic. During the pandemic period, the follow-up of various conditions that require close monitoring—such as cardiovascular, endocrine, and neurological disorders—might have been disrupted (Keesara, Jonas & Schulman, 2020). Considering that, in addition to physical illnesses requiring follow-up, various psychiatric disorders—such as those examined in this study—also demand close monitoring, we believe that our findings might serve as a source of inspiration for future research. Contrary to previous studies, however, our study did not find a significant relationship between the presence of a physical illness and the severity of fear related to COVID-19 (Bakioğlu et al., 2021).

Psychopharmacological interventions played an essential role in the treatment of individuals diagnosed with severe mental disorders (SMD). However, there was also a critical need for community-based mental health practices that provided continuous psychosocial support, the development of individualized treatment and care plans, and the reintegration of individuals into society. At Community Mental Health Centers (CMHCs), which were established for this purpose, not only the individuals diagnosed with a disorder but also their social support networks were included in the treatment system, and a multidisciplinary approach was adopted. Given that our study was conducted within a CMHC, where patients were followed using a multidisciplinary approach, it was possible that the majority of participants did not experience significant difficulty in accessing non-psychiatric medical services. However, the fact that a noteworthy proportion of patients reported experiencing such difficulties outside the CMHC setting was significant in terms of case management and highlighted an area that warranted further attention. In a longitudinal study conducted by Dickerson et al., which compared patients diagnosed with schizophrenia and bipolar disorder to a control group, it was found that individuals with SMD had higher levels of stress and were more likely to neglect their hospital follow-up appointments compared to the control group (Dickerson et al., 2022). Although our study was cross-sectional, 92.9% of the participants reported that they did not experience difficulties in continuing their psychiatric follow-up appointments. The fact that psychiatric monitoring during the COVID-19 pandemic was carried out not only through in-person visits but also via telephone and, when necessary, home visits (in urgent cases and compliance with social distancing measures) might have contributed to the low rate of reported difficulties among patients.

Moreover, during the pandemic, it was found that there was no change in psychiatric hospitalization frequency for nearly all participants, and more than half reported no change in the frequency of manic and/or depressive episodes. A certain proportion reported a decrease in the number of episodes compared to previous years. The effective utilization of community-based mental health systems—particularly during challenging conditions such as the COVID-19 pandemic—may play a protective role by reducing patients' feelings of isolation and loneliness, thereby lowering the risk of relapse (Castelpietra et al., 2021; Clerici et al., 2020). In a study involving a total of 56 patients diagnosed with either BAD or Major Depressive Disorder, symptom severity, and mood changes were examined during the early phase of the pandemic in individuals with serious mental illness. The study found no significant differences compared to the pre-pandemic period. Surprisingly, participants reported a significant increase in their sense of well-being during the early phase of the pandemic (Pinkham et al., 2020). The finding that individuals with greater social resources before the pandemic reported increased well-being at the onset of the pandemic is consistent with the results observed in our study (Pinkham et al., 2020).

A higher level of social support appears to be associated with greater psychological resilience (Liu, Zhang, Wong & Hyun, 2020). In a comprehensive study conducted by Tundo et al., which included 194 patients diagnosed with BAD, participants were evaluated over a period that included the post-pandemic quarantine phase. The findings indicated that patients adapted well to the pandemic, and the negative impact of the pandemic on psychopathology was found to be low (Tundo et al., 2021). In 50% of the patients, the psychological responses observed were found to be similar to those of close friends and relatives without psychiatric disorders. Notably, one in three patients reported perceiving the quarantine period in a positive light (Tundo et al., 2021). In a study conducted during the early phase of the pandemic with 70 patients diagnosed with BAD, which evaluated fear of COVID-19, positive coping, and the severity of psychopathology, it was found that manic symptoms and fear of COVID-19 were higher during the early phase but decreased over time. Similarly, the use of positive coping strategies was also more prominent in the early phase and declined as time progressed (Koenders et al., 2021). In another study conducted with patients over the age of 50 diagnosed with BAD, no worsening of BAD symptoms was observed following the pandemic; on the contrary, a decrease in symptom levels was reported. However, feelings of loneliness and the use of passive coping strategies were found to be associated with symptom worsening (Orhan et al., 2021).

When examining the participants’ COVID-19 fear scores, it was noted that no cut-off point had been established in either the original development study or the Turkish validity and reliability study of the scale (Ahorsu et al., 2020a; Bakioğlu et al., 2021). However, in the Turkish validity and reliability study of the scale conducted on a community sample, the mean score was reported as 19.44±6.07 (Bakioğlu et al., 2021). In a study involving 43 patients with BAD and 24 healthy controls, the mean fear of COVID-19 scores were reported as 14.81±6.37 and 15.83±5.94, respectively. No significant difference was found between the two groups (Karantonis et al., 2021). Although the absence of a control group in our study prevented statistical comparisons in terms of significance, the fear of COVID-19 levels observed in our participants appeared to be lower than the community average. While it could have been speculated that this lower level was due to a lack of information about COVID-19, we did not consider lack of knowledge to be a primary factor, as patients with BAD regularly received information about COVID-19 during their follow-up at the CMHC, including in-person visits, phone calls, and/or home visits. However, it should be noted that the participants' level of knowledge was not measured before or after these informational interventions. Additionally, the passage of time might have led participants to recall their fear levels as lower than they actually were at the time. While there was limited literature examining the relationship between fear of COVID-19 and quality of life in individuals with psychiatric disorders, community-based studies had shown that fear of COVID-19 was related to mental health. Therefore, this issue should be explored in greater detail to better understand how individuals diagnosed with

BAD experienced the pandemic and to plan the types of support they might require (Ahorsu, Lin & Pakpour, 2020b; Fofana et al., 2020; Şimşir, Koç, Seki & Griffiths, 2022).

In line with the objectives of our study, the results regarding quality of life as measured by the WHODAS 2.0 revealed that the participants had a mean impairment score of 10.29 (SD=7.27). In the literature, there are varying opinions regarding the cut-off score for WHODAS. However, in the Turkish validity and reliability study of WHODAS 2.0, a cut-off point of approximately 1.5 was determined using ROC analysis (Aslan Kunt & Dereboy, 2018). In a study by Andrews et al., the mean impairment score on the quality of life among individuals with any mental disorder (including mood disorders, anxiety disorders, and substance use disorders) was found to be 6.3. Based on this, a cut-off score of 10 was proposed, suggesting that individuals scoring 10 or above may be experiencing clinically significant impairment in quality of life (Andrews, Kemp, Sunderland, Von Korff & Ustun, 2009). The fact that the mean score in our sample was considered borderline according to some studies and was above the cut-off point according to others might be interpreted as an indication that further research is still needed regarding quality-of-life assessments in individuals with psychiatric disorders.

In a study conducted on a community sample examining the relationship between fear of COVID-19 and quality of life as measured by the Short Form-12 (SF-12), increased fear was found to be associated with lower quality of life (Öztürk Çopur & Karasu, 2021). However, in another study where the quality of life in patients with BAD was assessed using the "Quality of Life in Bipolar Disorder Scale–Short Form," it was found that subjective quality of life was not associated with fear of COVID-19, changes in social rhythm, mood lability, or lifestyle changes. (Karantonis et al., 2021). Considering the conflicting findings in the literature on this topic, the results of our study—which did not find a relationship between fear of COVID-19 and quality of life—can be regarded as valuable. The relatively small sample size might have contributed to this outcome. Taking into account that no increase in the number of episodes or hospitalizations was observed among patients with BAD during the pandemic, the lack of a significant relationship between fear of COVID-19 and quality of life might be the result of stable and regular follow-up provided by healthcare professionals. Future studies are recommended to compare these findings with those of patients diagnosed with BAD who are not being followed at CMHCs (Karantonis et al., 2021).

CONCLUSION

In conclusion, this study aimed to evaluate the levels of COVID-19-related fear, quality of life, and follow-up processes during the pandemic among individuals diagnosed with BAD in remission and receiving care at a CMHC. The findings provided preliminary data supporting the potential protective role of CMHCs. Our study was among the limited number of studies offering data on fear of COVID-19 and quality of life in individuals with BAD followed at CMHCs in the post-pandemic period. To better understand how individuals with BAD were affected by the COVID-19 pandemic, further research that includes pre-pandemic data was deemed essential. Identifying the mental health needs of individuals with BAD was considered important not only for developing emergency strategies to respond to global stressors such as pandemics, but also for improving preparedness for similar situations in the future.

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