Psychosocial assessment among ophthalmic patients attending tertiary eye care centre during the lockdown in times of COVID-19 pandemic

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Purpose: The coronavirus disease (COVID-19) pandemic continues to play havoc in our lives. During the first “lockdown” in 2020, we were keen on assessing the anxiety levels of patients who sought ophthalmic care despite the lockdown. Public health actions, such as social distancing, were necessary to reduce the spread of COVID-19. As a result, most people felt isolated and lonely, thereby causing increased levels of stress and anxiety in them. We aimed to assess the anxiety levels using the Hamilton Anxiety Scale and personality assessment using the 57-point Eysenck’s Personality Inventory (EPI) questionnaire among patients visiting a tertiary eye care hospital during the lockdown period. Methods: Consecutive patients attending an ophthalmic tertiary care hospital during the COVID-19 pandemic and lockdown were approached to be a part of this prospective cross-sectional survey. Results: In total, 1,088 responses were analyzed during the 2-month study period with the mean age being 45.7 ± 16.9 years. The majority had completed graduation (78%) with 15 years or more of formal education. The purpose of the visit was an emergency consultation in 42% (n = 455), a review appointment in 42% (n = 457), and the remaining (16%, n = 176) came for a routine consultation. The majority of the patients (>90%) did not report experiencing any of the 14 sets of symptoms. A mild level of anxiety was noted in 1,086 (>99%) respondents, whereas only 2 (<1%) respondents showed mild–moderate levels of anxiety. Financial concerns such as affordability of medications (6% vs. 3%, P = 0.05) and fear of losing their job (16% vs. 11%, P = 0.02) were significantly more in those experiencing any anxiety compared to those with no anxiety. Conclusion: Our study revealed that patients visiting a tertiary ophthalmic center during lockdown were graduates, sought eye consultation primarily for emergency or a review, and had no major anxiety symptoms. In those with anxiety, the affordability of medicines and loss of jobs were the main concerns.

Key words: Coronavirus disease (COVID-19) pandemic, Hamilton Anxiety Score, lockdown, ophthalmology patients, tertiary eye care hospital

According to the American Psychological Association, anxiety is an emotion characterized by feelings of tension, worried thoughts, and physical changes such as increased blood pressure.[1] Anxious people usually have recurring intrusive thoughts or concerns, may avoid certain situations out of worry, and may also have physical symptoms such as sweating, trembling, dizziness, or a rapid heart rate.

The Corona Virus Disease-19 (COVID-19) pandemic has had a major effect on our lives. During the pandemic, many people were facing challenges that could have been stressful, overwhelming, and caused strong emotions in adults and children. Public health actions, such as social distancing, were necessary to reduce the spread of COVID-19. As a result, most people felt isolated and lonely, thereby causing increased levels of stress and anxiety in them.

A “complete” lockdown was declared by the Government of India on March 24, 2020, for a period of 21 days, and then subsequently extended by another 5 weeks to contain the spread of the Severe acute respiratory syndrome Coronavirus-2 (SARS-CoV-2) virus. This brought immense financial, logistic, and psychological challenges to our patients.[2,3]

During the lockdown period, most of the smaller eye clinics were shut. Only large-scale tertiary eye care hospitals such as ours were functioning with limited manpower following appropriate COVID-19 protocols to cater to the needs of people with eye problems during that time. During the lockdown period, some issues faced by the patients and their attendants included travel to the hospital, maintaining social distancing
in a public setting, mandatory screening, and questionnaires at hospital entry, and importantly, the fear of contracting the virus from the hospital environment.\[10\] Despite these concerns, there was still a need to visit the hospital, either for follow-up or for a new visually significant symptom, or a surgical procedure. This resulted in some level of stress and anxiety amongst patients visiting an eye hospital.

The initial diagnosis and severity of anxiety are usually based on risk assessment scores with various anxiety questionnaires such as the Zung Self-Rating Anxiety Scale, Hamilton Anxiety Scale (HAS), Beck Anxiety Inventory, Social Phobia Inventory, Penn State Worry Questionnaire, and Generalized Anxiety Disorder Scale.\[5–10\] Comparisons between the various anxiety questionnaires have shown the HAS to be a very brief and easy-to-use screening measure to detect the presence of clinically significant symptoms of anxiety.\[11\] This measure is widely used and easily obtained.

Studies have shown that personality may play an important predisposing, etiological role in anxiety.\[12,13\] Personality traits, in particular the combination of high neuroticism and low extraversion, may play an important interaction in anxiety. In a study among 466 young adults, it was noted that there exists an interaction between neuroticism and extraversion that predicted both global anxiety and depression 3 years later.\[12\] Kaplan studied the relationship between the five personality traits and social anxiety and found that high openness may protect against the higher social anxiety levels associated with low trust.\[13\]

Objectives
To assess the anxiety levels using HAS and personality assessment using the 57-point Eysenck’s Personality Inventory (EPI) questionnaire among patients visiting a tertiary eye care hospital during the lockdown period.

Study design
Consecutive patients attending an ophthalmic tertiary care hospital during the COVID-19 pandemic and lockdown period were approached to be a part of the study.

Methods
This prospective cross-sectional study was conducted at our tertiary eye care center, Bengaluru, South India, from April 2020 to May 2020. During these 2 months, all patients ≥ 18 years and those who filled the 14-point HAS and the EPI questionnaire were included in the study. This study adhered to the tenets of the Declaration of Helsinki and was approved by the Ethics Committee of our tertiary eye care center, (EC Ref. no: C/2020/06/06). Informed consent was obtained from all subjects. In addition, a survey form containing demographic details, educational status, financial status, locality of stay, profession, and questions regarding information on COVID-19 was administered to the patients in English and translated by the interviewer in the patient’s local language, if required.

Hamilton Anxiety Scale questionnaire\[14\]
The HAS was developed to measure the severity of anxiety symptoms. The scale consists of 14 items, each defined by a series of symptoms; it measures both psychic anxiety (mental agitation and psychological distress) and somatic anxiety (physical complaints related to anxiety). Each question on the HAS is scored on a scale of 0 (not present) to 4 (severe). Thus, a possible range between 0 and 56 can be obtained. Based on the score, 4 levels of severity of anxiety have been identified. A score ≤17 indicates mild anxiety, 18–24 indicates mild-to-moderate anxiety, 25–30 indicates moderate-to-severe anxiety, and >30 indicates severe anxiety.

Eysenck’s Personality Inventory (EPI) Questionnaire\[15\]
EPI is a very simplistic type of personality measurement scale. The EPI measures two pervasive, independent dimensions of personality, Extraversion–Introversion and Neuroticism–Stability, which account for most of the variance in the personality domain. Each form contains 57 “Yes–No” items with no repetition of items. The inclusion of a falsification scale provides for the detection of response distortion. The traits measured are Extraversion–Introversion and Neuroticism. Three scores are obtained after filling the EPI.

• The “L score” is out of 9. It measures how socially desirable you are trying to be in your answers. Those who score 5 or more on this scale are probably trying to make themselves look good and are not being totally honest in their responses.
• The “E score” is out of 24 and measures how much of an extrovert you are.
• The “N score” is out of 24 and measures how neurotic you are.

Outcome measures
Responses to 14 questions from the HAS\[14\] were the primary outcome measure. A dichotomous composite variable was generated to determine anxiety using responses from the HAS such that the presence of any of the 14 parameters was taken as the presence of anxiety. Factors influencing this composite anxiety variable were used for statistical analysis. Responses from the EPI\[15\] were combined based on interpretation guidelines to determine four personality subtypes, that is, phlegmatic (e.g., calm and even-tempered), melancholic (e.g., reserved, pessimistic, and moody), sanguine (e.g., easygoing, responsive), and choleric (e.g., restless, aggressive, impulsive).

Statistical analysis
All continuous variables are presented as means with standard deviation, and categorical variables are presented as proportions (n, %). Group differences between categorical variables were assessed using the Chi-square or Fischer’s exact test. Similarly, differences in continuous variables across two groups were assessed using the Student’s t-test or the Wilcoxon’s rank-sum test for non-parametric distributions and using the analysis of variance (ANOVA) or Kruskal–Wallis test when comparing across more than two groups. A univariate and multivariable logistic regression analysis was used to find factors predicting the composite anxiety variable, after adjusting for personality type and education level.

All data were entered in Microsoft Excel and analyzed using STATA 12.1 I/c (Stata Corp, Fort Worth, Texas, USA) and all P values <0.05 were considered statistically significant.

Results
We included demographic data from 1,088 of the 1430 adult patients, who visited our hospital during the 2-month study period of a government-mandated lockdown when our tertiary eye care center was functional using the updated national guidelines. The mean age of the patients was 45±16.7 years. In
total, 563 (52%) males and 525 (48%) females were included in the survey. A majority had completed graduation 78% (n = 854) with 15 years or more of formal education. The median distance covered to reach the hospital was 17 km (range = 1–500 km) and using a personal vehicle (either owned or hired) was the most common mode of transport in 75% of the respondents (n = 818).

The purpose of the visit was an emergency consultation in 42% (n = 455), a review appointment in 42% (n = 457), and the remaining (16%, n = 176) came for a routine consultation. On further inquiry, 1,006 (93%) respondents said that they were less anxious to visit the hospital and the remaining 82 (7%) respondents were stressed to visit the hospital. Overall, 95% of patients (n = 1,003) reported worsening of their eye symptoms as the main reason for their visit. A few patients reported difficulties with procuring the prescribed medications due to the lockdown and hence traveled to the hospital (n = 51, 5%). When queried about the consultation methods, the respondents would prefer in future, face-to-face consultation was the most preferred mode of interaction for 85% of patients (n = 925), whereas the remaining were agreeable for teleconsultation (n = 163, 15%).

After evaluating the hospital records of the respondents who visited the hospital, we noted that about 60% of patients (n = 653) had visited our hospital more than 6 months ago, whereas 435 (40%) patients had visited within the previous 6 months. Of these, 33 patients (8%) were on active treatment and had visited us the previous month. A significant systemic history that included conditions such as diabetes, hypertension, thyroid dysfunction, and previous cancer therapy was reported in 11% (n = 120). Of all patients, 18% (n = 196) had a prior ocular surgical history and had come for a follow-up check. Another, 7% (n = 76) had a significant medical history of needing either topical, oral medication, or intravitreal injections, and 2% (n = 22) of these were on immunosuppressive therapy.

About three-fourths of the respondents were currently employed full-time, with half of them working from home during the pandemic, and approximately 12% (n = 130) were worried about losing their existing jobs. Also, those with a graduate degree were less likely to be worried about losing their job (odds ratio [OR] = 0.67, 95% confidence interval [CI] = 0.47–0.96, P = 0.03) compared to those without a graduate degree. The belief that a hospital visit will increase the risk of contracting COVID-19 was not different between graduates (n = 110, 10%) and non-graduates (n = 29, 9%) (P = 0.47). Those without a graduate degree were significantly more fearful of losing their existing job (n = 50, 15%) compared to those with a graduate degree (n = 117, 11%) (P = 0.03). On logistic regression, those with a graduate degree were less likely to be worried about losing their jobs (OR = 0.67, 95% CI = 0.47–0.96, P = 0.03) compared to those without a graduate degree. On analyzing the personality traits with education, there were no significant differences. Our study also showed that significantly greater proportion of non-graduates (n = 29, 9%) were relying on information from social media for COVID-19-related information compared to graduates (n = 57, 5%) (P = 0.02).

**EPI scale**

1,088 respondents who answered the EPI questionnaire, the “lie score” ≥5 was noted in 546 respondents and, hence, were excluded from further analysis. In the remaining 542 cases, “choleric” personality was noted in 95 (17%) patients, “melancholic” personality in 140 (26%) patients, “phlegmatic” in 153 (28%) patients, and “sanguine” (27%) personality in 144 patients. Table 2 shows Comparison of working conditions in 153 (28%) patients, and “sanguine” (27%) personality in 144 patients. Table 2 shows Comparison of working conditions

**HAS score**

Hamilton Anxiety Score was recorded in all 1430 patients. Table 1 shows overall responses from the HAS. Overall, the majority of the patients (>90%) did not report experiencing any of the 14 sets of symptoms. Any form of anxiety (i.e., at least one of the symptoms) was seen in 282 patients (20%) of whom tension 8% (n = 118) and fear 6% (n = 84) were the most common subtypes. Financial concerns about the affordability of medications (6% vs. 3%, P = 0.05) and fear of losing a job (16% vs. 11%, P = 0.02) were significantly more in those experiencing any anxiety compared to those with no anxiety at all. There were no statistical differences in any of the 14 responses in the HAS with respect to personality type (results not shown in tables). On multivariable logistic regression analysis, we found that those fearful of losing their jobs were 56% more likely to be anxious (OR = 1.56, 95% CI = 1.1–2.3, P = 0.02). Personality type (OR = 0.97 compared to phlegmatic, 95% CI = 0.86–1.1, P = 0.65) did not influence anxiety, whereas financial concerns about affordability of medications (OR = 1.71, 95% CI = 0.9 – 3.1, P = 0.07) lead to marginal increment in anxiety. There was no difference in the psychological symptoms (i.e., the presence of any one anxiety symptom at least) between the gender (P = 0.88).

The belief that hospital visit will increase the risk of contracting COVID-19 during the visit was not different between graduates (n = 110, 10%) and non-graduates (n = 29, 9%) (P = 0.47). Those without a graduate degree were significantly more fearful of losing their existing job (n = 50, 15%) compared to those with a graduate degree (n = 117, 11%) (P = 0.03). On logistic regression, those with a graduate degree were less likely to be worried about losing their jobs (OR = 0.67, 95% CI = 0.47–0.96, P = 0.03) compared to those without a graduate degree. On analyzing the personality traits with education, there were no significant differences. Our study also showed that significantly greater proportion of non-graduates (n = 29, 9%) were relying on information from social media for COVID-19-related information compared to graduates (n = 57, 5%) (P = 0.02).

**Relationship between EPI scale and HAS score**

All 542 respondents had an anxiety scale below ≤17 (range: 0–6), suggestive of a mild form of anxiety. No higher grades of anxiety were noted in the study. Table 3 shows the EPI measurement scale and the range of HAS.

Further sub-analysis showed that there was no difference in the psychological symptoms (i.e., the presence of any one anxiety symptom at least) between those with a minimum graduate degree (n = 207, 19%) vs. those without a graduate degree (n = 240, 22%) (P = 0.32). On multivariable logistic regression analysis, after adjusting for personality type
and education level, we found that those fearful of losing their job were 56% more likely to be anxious (OR = 1.56, 95% CI = 1.1–2.3, P = 0.02). In separate models adjusting for personality type, financial concerns about the affordability of medications (OR = 1.71, 95% CI = 0.9–3.1, P = 0.07) lead to increased anxiety though this was only marginally significant. Additionally, those with a graduate degree were 15% less likely to experience psychological symptoms compared to those without a graduate degree (OR = 0.85, 95% CI = 0.6–1.2, P = 0.32) but this was not statistically significant.

Discussion

This questionnaire-based study assessed the psychological status of patients who visited an ophthalmology outpatient during the lockdown period using the HAS/EPI. The result of this survey suggests that a majority of patients had mild-level anxiety while visiting a tertiary eye care hospital for an eye check-up. Choleric personality was the least common personality trait seen in our study. Patients with different personality traits have a mild form of anxiety.

In the current survey, >90% of patients did not experience specific forms of anxiety such as tension, irrational fear, insomnia, depression, behavioral issues, and anxiety itself. However, a composite score showed that about 20% were experiencing some form of anxiety or the other. This was not driven by their inherent personality trait and a fear of losing their job was the most important factor driving the heightened anxiety responses during the pandemic. Financial concerns about the affordability of medications also lead to anxiety, but this was only marginally significant. These subgroups may require counseling, support, and reassurance to tide over the crisis. In view of the very large sample and non-influential role of the underlying disease, these findings may be generalizable to the entire community, and not just healthcare (or eye care) seeking patients. Those with eminent employment loss are more prone to psychological disturbances, irrespective of their personality trait, underlying disease state, or COVID-19 perceptions. Given that millions have already suffered job losses, this is an urgent matter and government agencies should take notice of the deep-seated mental impact from such fallouts of COVID-19. These concerns should be discussed and addressed by policymakers to prevent long-term repercussions.

A majority of those visiting the hospital had a worsening of their eye condition, which explains the risk they took to travel during the lockdown. The most preferred a face-to-face consultation because they were experiencing severe symptoms or needed an emergency consultation or a review visit for ongoing treatments.

Relatively few patients were worried about contracting COVID-19 during their hospital visit, suggesting high levels of

| Questions                                                                 | Not Present | Mild | Moderate | Severe | Very Severe |
|--------------------------------------------------------------------------|-------------|------|----------|--------|-------------|
| Anxiety, Worry, irritability, fearful anticipation                        | 1348 (94%) | 62 (4%) | 17 (2%) | 1 (<1%) | 2 (<1%)     |
| Tension, Restlessness, stress, inability to relax                       | 1309 (92%) | 60 (4%) | 57 (4%) | 0      | 1 (<1%)     |
| Fear, Irrational phobia, excessive worry                                 | 1346 (94%) | 59 (4%) | 25 (2%) | 0      | 0           |
| Insomnia, Fatigue, inability to sleep, nightmares, night terrors         | 1423 (99%) | 3 (<1%) | 0      | 4 (<1%) | 0           |
| Intellectual symptoms, Poor concentration, memory impairment            | 1425 (100%) | 1 (<1%) | 4 (<1%) | 0      | 0           |
| Depressed mood, Decreased interest in activities, diurnal swing, early waking | 1422 (99%) | 3 (<1%) | 1 (<1%) | 4 (<1%) | 0           |
| Muscular symptoms, Aches and pains, stiffness, twitching, teeth grinding | 1394 (97%) | 29 (2%) | 7 (<1%) | 0      | 0           |
| Sensory symptoms, Tinnitus, blurred vision, hot/cold flushes, weakness   | 1426 (100%) | 4 (<1%) | 0      | 0      | 0           |
| Cardiovascular symptoms, Tachycardia, palpitations, chest pain, fainting, throbbing | 1430 (100%) | 0 | 0 | 0 | 0 |
| Respiratory symptoms, Chest pressure/constrictions, choking, sighing, dyspnea | 1430 (100%) | 0 | 0 | 0 | 0 |
| Gastrointestinal symptoms, Swallowing difficulties, abdominal pain, nausea, weight loss | 1430 (100%) | 0 | 0 | 0 | 0 |
| Genitourinary symptoms, Frequency/urgency of micturition, amenorrhea, impotence | 1430 (100%) | 0 | 0 | 0 | 0 |
| Autonomic symptoms, Dry mouth, flushing, pallor, sweating, giddiness, headache | 1430 (100%) | 0 | 0 | 0 | 0 |
| Behavior at interview, Fidgeting, restlessness, tremors, sighing, pallor, straining | 1430 (100%) | 0 | 0 | 0 | 0 |
### Table 2: Comparison of working conditions and COVID-19-related perceptions overall and between four different personality types

| Variable                                           | Total (n=1,430) | Phlegmatic (n=464) | Sanguine (n=379) | Melancholic (n=333) | Choleric (n=254) | P |
|----------------------------------------------------|-----------------|--------------------|------------------|---------------------|------------------|---|
| Will visiting the hospital make you less anxious/stressed? | 1319            | 427 (92%)          | 351 (93%)        | 310 (93%)          | 231 (91%)        | 0.79 |
| How concerned are you about your eye condition?    |                 |                    |                  |                     |                  |    |
| Very concerned                                     | 77 (5%)         | 29 (6%)            | 14 (4%)          | 18 (6%)            | 16 (6%)          | 0.71 |
| Concerned                                          | 1312 (92%)      | 420 (91%)          | 354 (93%)        | 307 (92%)          | 231 (91%)        |    |
| Neutral                                            | 41 (3%)         | 15 (3%)            | 11 (3%)          | 8 (2%)             | 7 (3%)           |    |
| Work-related questions                              |                 |                    |                  |                     |                  |    |
| Currently, working?                                | 1050 (73%)      | 341 (73%)          | 279 (74%)        | 245 (73%)          | 185 (73%)        | 0.99 |
| Working from home?                                 | 797 (56%)       | 245 (53%)          | 223 (59%)        | 187 (56%)          | 142 (56%)        | 0.37 |
| Fear of losing a job?                              | 167 (12%)       | 54 (12%)           | 44 (12%)         | 42 (13%)           | 27 (11%)         | 0.91 |
| Does your profession require you to work outside your home? | 1412 (99%) | 458 (99%)          | 372 (98%)        | 332 (100%)         | 250 (98%)        | 0.29 |
| No                                                 | 1412 (99%)      | 458 (99%)          | 372 (98%)        | 332 (100%)         | 250 (98%)        |    |
| Yes, less frequently                               | 3 (<1%)         | 2 (<1%)            | 0                | 0                   | 1 (<1%)          |    |
| Yes, very frequently                               | 15 (1%)         | 4 (<1%)            | 7 (2%)           | 1 (<1%)            | 3 (1%)           |    |
| COVID-related perceptions                          |                 |                    |                  |                     |                  |    |
| Do you fear contracting disease during hospital visit? | 139 (10%)      | 52 (11%)           | 31 (8%)          | 29 (9%)            | 27 (11%)         | 0.42 |
| Do you feel people will be harassed & bullied if they declare their illness? | 105 (7%) | 33 (7%)            | 33 (9%)          | 24 (7%)            | 15 (6%)          | 0.60 |
| Do you have enough trust in your medical professional to reveal if you have any symptoms? (% Yes) | 1422 (99%) | 462 (100%)         | 376 (99%)        | 331 (99%)          | 253 (100%)       | 0.88 |
| Do you think social media is a reliable source of COVID-19-related information? | 86 (6%)         | 31 (7%)            | 13 (3%)          | 24 (7%)            | 18 (7%)          | 0.10 |

### Table 3: EPI measurement scale

| Type of personality | No. of respondents (n=542) | Range of HAS score |
|---------------------|----------------------------|-------------------|
| Choleric            | 95                         | 0-6               |
| Melancholic         | 140                        | 0-4               |
| Phlegmatic          | 153                        | 0-4               |
| Sanguine            | 144                        | 0-4               |

EPI, Eysenck's personality inventory

confidence in the hospital authorities following standardized guidelines and enforcing preventive measures.

In a study by Lindeke-Myers et al. on patients’ perceptions regarding continuing ophthalmic care during the COVID-19 pandemic interestingly found that 60% of patients attending the eye clinic believed that severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) exposure at the eye clinic was extremely unlikely or unlikely. Amongst patients at high risk for vision loss from lapses in care, many expressed concerns regarding the effect of the pandemic on their ability to receive timely care. The study also suggested that the fear of SARS-CoV-2 exposure was associated with a roughly four-fold increase in the odds of patients lost to follow-up. Anxiety, sleeplessness, fear of contracting the virus, frustration, and irritability are some effects of long-term lockdowns during pandemics.

Misinformation and sharing of fake news through social media cause anxiety. The uncertainty and ambiguity add to an individual’s sense of unease, leading to a loss of hope and initiative. People who have active symptoms of the disease hesitate to disclose or seek help as they anticipate social stigma. Rehman et al. showed that Indian citizens who did not have enough household and food supplies to sustain themselves during the lockdown were most affected. Family affluence is negatively correlated with stress, anxiety, and depression. Students and healthcare professionals experienced stress, anxiety, and depression more than others. In a study on police personnel on duty in India, the psychological impact during lockdown included significant anxiety, stress, and depression.

Mental health remains a major concern all around the world. Challenges that professionals face would be to help people cope with a new and emerging scenario with a modified lifestyle (self-isolation, social distancing, and quarantine). A lot of effort is needed to weed out conspiracy theories and disinformation about the origin, scale, signs, symptoms, transmission, prevention, and treatment of COVID-19. Mackolil and Mackolil brought forward some important issues during the lockdown that included an increase in domestic violence, lack of personal space in large families, and boredom. Parents are bound to be stressed about the security of their jobs as well as their children’s education. Sleep disturbances, extended screen time, and lack of self-efficacy activities are expected. "Idle time" can risk overthinking, ruminating, and losing hope. Ophthalmologists new in their career or those who have set up a new practice can suffer from the stress and fear of losing their jobs or treating patients during the COVID-19 pandemic and lockdown. On a positive note, some may use their “free time” productively by picking up new hobbies or acquiring new skills.

Although a number of studies have shown an interaction between personality traits and anxiety levels, our study
failed to show any relationship between the two aspects during the COVID-19 lockdown period. A higher lie score and exclusion of these patients from the study could have been responsible for this. The inclusion of all respondents for analysis may have provided an alternate outcome.

**Conclusion**

To conclude, this is perhaps the first study showing the psychological impact of the COVID-19 pandemic on out-patient health care (specifically eye care) seeking patients in India. The standardized methodology used and the use of a well-established anxiety scale to obtain responses from such a large cohort of patients make this study very unique and valuable. COVID-19 has been around for over a year and shows no signs of abating. It is very important that we approach psychosocial problems holistically with ample mental health support for us and our patients.

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**Conflicts of interest**

There are no conflicts of interest.

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