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Psychological impact of COVID-19 lockdown on staff and residents of nursing and care homes in Belgium and EHPADs France

Aspect médico-psychologique relatif à l'épidémie du coronavirus: mise en place d'une stratégie de soutien pour le personnel soignant par les médecins coordinateurs dans les maisons de repos et de soins en Belgique ou Ehpad en France et impact psychologique pour les résidents de ces maisons de repos et de soins privées et publiques

Carine Duray-Parmentier[1]
Jean-Baptiste Lafontaine[2]
Noémie Nielens[1]
Pascal Janne[3]
Maximilien Gourdin[4]

[1] Centre de psychothérapie de Namur, Namur, Belgique
<carine.durayduray@gmail.com>

[2] Maison médicale de La Plante, Namur, Belgique

[3] Faculté de Psychologie, Université catholique de Louvain, Ottignies-Louvain-la-Neuve, Belgique

[4] Département d'anesthésiologie, Université catholique de Louvain, CHU UCL Namur, Yvoir, Belgique

Correspondance : C. Duray-Parmentier

Abstract. More than a third of the world's population is currently living under lockdown due to the coronavirus pandemic. Lockdown measures have been in place in many countries for several weeks. The health authorities are waging war against COVID-19 and have to provide information to the public on it while facing many unknowns about the virus. What impact does this have on mental health? What impact can lockdown have upon a population? What psychological impact will this lockdown have on elderly people living in nursing and care homes in Belgium and EHPADs France? We are not aware of any French-language research which has been published on the psychological aspects of the coronavirus among the population. We will try, through this article, to approach the psychological impact upon nursing staff and residents within nursing homes.

Key words : coronavirus, COVID-19, pandemic, elderly people, care homes, Ehpad, caregivers

Résumé. Plus d'un tiers de l'humanité est actuellement soumis à des mesures de confinement du fait de la pandémie de coronavirus. Le confinement a été instauré dans de nombreux pays pour plusieurs semaines. Les autorités sanitaires sont sur le pied de guerre face à un virus encore mystérieux et pour lequel ils sont amenés à en informer la population tout en étant confronté à beaucoup d'inconnues concernant la COVID-19. Dès lors, qu'en est-il de la santé mentale ? Que peut engendrer une situation de confinement auprès de la population à placer en quarantaine ? Quel impact psychologique ce confinement va-t-il avoir sur nos aînés hébergés en maisons de repos et de soins en Belgique ou en Ehpad en France ? Actuellement, nous n'avons pas encore connaissance d'articles francophones déjà publiés sur les aspects médico-psychologiques liés au coronavirus auprès de la population. Nous allons tenter, au travers de cet article, d'aborder la question médico-psychologique du personnel soignant au sein des maisons de repos et de soins et l'impact psychologique des résidents.

Mots clés : coronavirus, Covid-19, pandémie, personnes âgées, maisons de repos, Ehpad, personnel soignant

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Introduction

More than a third of the world's population is currently under some form of lockdown due to the coronavirus pandemic. Many countries have asked their residents to isolate themselves in their homes. The quarantine (or lockdown) has been in place for several weeks, with individuals only being allowed to go out under exceptional circumstances. Decisions on implementing quarantine measures should be made by governments on the best available evidence (studies of other epidemics that can be found in scientific journals

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such as the *Lancet* or the *New England Journal of Medicine)* [1]. The health authorities are waging war against COVID-19 and have to inform the public about it while at the same time being faced with many unknowns about the virus. What impact does it have on mental health? What impact can lockdown have upon a quarantined population? What psychological impact will this lockdown have on elderly people in private and public nursing homes (maison de repos, MR) and nursing and care homes (maison de repos et de soins, MRS) in Belgium and nursing homes (hébérgement pour personnes âgées dépendantes, EHPAD) and long-term care units (unité de soins de longue durée, USLD) France? Feelings of loneliness and isolation are experienced more intensely. The situation necessarily exacerbates anxieties which, when not in a lockdown situation, are generally diluted through everyday acts and relationships. Will the psychological repercussions of lockdown depend on how long it lasts? Do they increase after ten days of lockdown? It would appear to be important that the public authorities be able to give a clear deadline for how long it will last. In general, anxieties develop from fears that one may form about ailments and contagiousness of the coronavirus. However, anxieties also arise with regard to our health in general, that of our loved ones, and more particularly with regard to what we have done with our lives up to that point. At present, we are not aware of any French-language articles already published on the psychological aspects of the coronavirus in the population. In this article, we will try to address the psychological impact on nursing staff in MRS and residents within MRs.

Psychological aspects of lockdown

Psychological impact of quarantine on residents of nursing homes

MRs in Belgium and EHPADs in France have long functioned by adopting a "home for life" approach. The current health crisis has turned these "homes for life" into "homes for death". The entire vision of support for the elderly and geriatric care is being called into question. Accommodation for the elderly (both MRS and EHPAD) will have to adapt in the future to respond more effectively to any new epidemic. Lockdown is often an unpleasant experience for those who undergo it. Separation from loved ones and the loss of freedom already associated with living in a care home is felt all the more keenly and reinforced, and uncertainty about the disease and the boredom of no longer seeing loved ones create dramatic effects for more or less still able-bodied elderly people living in an institution [2]. On the front line, carers work hard to minimise this impact on their residents and sometimes have to make difficult decisions in total isolation. The public authorities have had to reconsider the conditions of accommodation for the elderly, following the increase in the number of deaths in these homes in both France and Belgium. Beyond the degree of contagion and the mortality rate of the coronavirus, the current crisis is also the consequence of a chronic under-investment in healthcare facilities. Professionals in MRS and EHPADs much like their peers in hospitals, have repeatedly sounded the alarm without being heard [3]. The first findings are that lockdown seems to not only endanger the social bond but also the bond of attachment [4]. The fact that elderly people can no longer see their relatives makes their mental health even more fragile. And anything that destabilises an individual's temporal and social reference points will increase their anxiety [1]. For elderly people, who should be protected as much as possible from the coronavirus by restricting visits, isolation is not without consequences. It is known that this situation can lead to depression or psychological decompensation. Especially since several studies (from the *Lancet,* 14/03/2020) [1] have shown that remaining socially active after the age of 60 is protective against the risk of dementia. In people who are already very vulnerable, several doctors have warned of "failure to thrive" [5], a state of psychological distress that can be fatal. For others, the challenge is to preserve their autonomy, as the loss of muscle caused by reduced physical activity or poor nutrition can lead to them becoming frail. Moreover, the reduced recourse to healthcare, between the fear of contracting the virus at the doctor's surgery and remote consultations not always being appropriate for this population, leads to elderly people visiting A&E with chronic illnesses that are more severely decompensated than usual, such as heart failure [3, 6].

Developing support for care staff in MRS and EHPADs

In January 2020, the World Health Organization announced that the coronavirus outbreak was a public health emergency of international concern. Public and private MRS and EHPADs treat people suffering from physical or mental disabilities (Alzheimer, mental deficiencies, autism), some of whom are very old. Residents of these facilities are vulnerable populations at higher risk of adverse outcomes. These people are also more likely to be infected because they live in close contact with other people. Consequently, MRS and EHPADs have had to take special precautions to protect not only their residents, but also the nursing staff [7]. Coordination of systems and services to provide long-term care have been established with relevant

authorities such as the Ministry of Health, Social Protection and Social Justice, in order to ensure continuity of care in MRS in Belgium and EHPADs in France and also to provide additional support if a case of coronavirus is confirmed in an elderly person living in a facility for the elderly. A list of MRs in Belgium (sample taken from the Namur region) as well as any private or public facilities, was compiled in order to identify the coordinating doctors were for these facilities. For the private facilities, coordinating doctors were appointed to coordinate the COVID-19 protocols.

Support strategies for care staff in MRs in Belgium and EHPADs France

The MRs in Belgium and Ehpads in France suffered from an acute lack of protective equipment (FFP2 masks, protective aprons, visors, etc.) with increasing risk situations and ever more suspected cases. In Belgium, faced with increasing number of staff absences due to fears over contamination, and for want of anything better, MRs "cobbled together" visors, fabric masks, overcoats and goggles that they received through donations from individuals or volunteers *via* the medical posts of the various provinces or the public social welfare centres. The coordinating doctors requested some form of priority for testing, as did hospital staff, given the risk of lethality of the virus on the residents. Therefore, the Federal Ministry of Health in Belgium and the French Ministry of Health indicated that essential care staff in the MRs or EHPADs would be tested as a priority in the event of respiratory disorders, so that they could be quickly resume their caring duties in the event of a negative test. MRs which are locked down are then cut off from the outside world. Once a COVID cluster has taken hold, social distancing can lead to distress and even despair for the older person. Little publicised to date, the issue of intermediate facilities needs to be analysed [8]. In order to support nursing staff, infection control in long-term care facilities in the context of COVID-19 led to the introduction of various measures, including social distancing, within the facility to limit the spread of the virus. Among other things, it was decided to restrict the number of visitors and to prohibit access to families during lockdown except for residents in palliative care. A protection protocol was established in such cases so that the family could accompany the dying person. However, this was done on a case-by-case basis, and these decisions varied from region to region, as many MRs continue to operate behind closed doors during the lockdown. Within the facility, it was recommended that a distance of at least one metre be maintained between residents and that residents and carers be encouraged to avoid contact (handshakes, hugs or kisses). Early identification, isolation and treatment of COVID-19 positive cases is essential to limiting the spread of the virus. Therefore, in collaboration with the coordinating doctor of the MRs it was planned, following the example of health decisions taken in other countries, to separate the MRs into two sectors: "COVID" and "non-COVID" sectors. Caregivers were then to apply precautions to avoid contact and droplet transmission when caring for the resident, entering the resident's room or being within one metre of the resident. Specific medical equipment was assigned to health staff dealing with clinical COVID cases and could be exchanged with uncontaminated sections. In the Walloon region (Belgium), the Walloon Agency for Quality of Life (AVIQ) chose to divide 66,700 tests into two groups: 50% of the tests were referred to MRs that represented large clusters, in other words MRs that already had 50 or 60 residents who were either possible or confirmed cases of COVID-19, and the remaining 50% were directed to the smallest clusters in MRs, i.e. those that had fewer than six possible or confirmed cases. According to AVIQ officials, in Belgium, half of the MRs in Wallonia are considered to be "large clusters": establishments with a large number of patients or staff members who are or may be contaminated. In MRs and EHPADs, the objective is to more quickly detect residents and nursing staff who are unaware of being contaminated because they are asymptomatic, in order to be able to organise work better and enable facilities which are less affected by the coronavirus to remain so. For Belgium as a whole, 3,806 MR residents tested positive for COVID-19 in April 2020, out of a total of 25,055 tests: 1,076 were symptomatic and 2,730 asymptomatic. MRs have paid a heavy price since the start of the coronavirus epidemic, with 3,678 estimated/confirmed deaths, out of a total of 6,917 deaths in Belgium, according to the latest figures released on 14 April 2020 by the health authorities [9].

Psychological impact on nursing staff in MRs and EHPADs

Stress factors among nursing staff in MRs and EHPADs

The epidemic, like those that have preceded it elsewhere in the world (SARS, Ebola, H1N1, etc.), has significant and lasting psychological repercussions for both healthcare workers and the rest of the population. It is important to anticipate and care for nursing staff within the different hospital facilities, MRs and EHPADs and mental health establishments. The fear of being infected, of dying and of infecting others, reinforced by the uncer-

tainties surrounding the epidemic (symptoms, mode of contamination) activate stress factors during lockdown. The duration of lockdown beyond ten days and a prolongation beyond what was initially announced increases the psychological impact of the lockdown (*e.g.* fear of financial loss). According to Dr. Abgrall and her team at the Paris Medical and Psychological Emergency Unit (CUMP) [10], symptoms of acute and long-lasting stress such as anxiety, sleep disorders, loss of appetite, fatigue, irritability, anger, difficulty paying attention, gloom and depression may occur. These symptoms are comparable to symptoms of "post-traumatic stress". A Chinese study on the effects of the coronavirus epidemic estimated that the symptoms are comparable to those of vicarious traumatisation (trauma by proxy). This includes profound changes experienced by carers who have established empathic relationships with COVID-19 patients. Articles in the *Lancet* on the psychological impact of lockdown report symptoms of "acute stress" or "post-traumatic stress", including for children, although lockdown is not considered a traumatic situation according to the DSM-5 [1, 11-14].

Specific support systems for carers

It is important to provide specific support facilities for carers (nurses, care assistants, hospital doctors and GPs), including for staff who are quarantined, which is accessible remotely and open to all staff. Above all, frontline carers should be protected, by encouraging them to take breaks, by organising team rotation and by bearing in mind the protective factors highlighted in the Chinese study (training, voluntary work), without overlooking the fact that the psychological impact on these carers may manifest itself in a delayed manner, after the health crisis [15]. The durability of the effects of lockdown suggests that psychological support arrangements should be maintained beyond the lockdown period. In Belgium (as in France), the Federal Public Health Service and various psychosocial managers have set up a "Psychosocial Coordination Committee", known as the CCPS. The aim is to emphasise rational and unambiguous communication by all the services involved in the different provinces: communication campaigns, telephone counselling, and the external service for prevention and protection at work (SEPPT). The "Copsycovid19.be" website is a collective of Belgian psychologists and therapists trained in counselling, offering free short-term psychological support through remote consultation to people experiencing difficulties in the current health crisis situation, citizens and professionals in the social-health sector and, for doctors and doctors-in-training, the creation of a freephone number. A web page entitled "Psychological support for doctors during the COVID-19 crisis" is also available. France has also set up similar structures for healthcare personnel. The 107 network, *Réseau Santé Wallon* in Belgium, made a first-line service available to people made vulnerable by the health crisis situation: coopsy.be [16]. On 6 April 2020, the AVIQ and the Walloon Federation of Mental Health Services (FéWaSSM) launched a psychological support service designed to support healthcare professionals and assistants who work on the front line in hospitals, psychiatric facilities, MRs, services for people with disabilities or in fragile situations, and planning centres. This free service consists of psychologists, psychiatrists, social workers and other professionals, who provide not only listening services but also first-line psychological care and referrals for longer-term follow-up if necessary [17].

Psychological impact on elderly people in MRs

Over-mortality of elderly people in MRs and EHPADs

Over-mortality among the elderly is explained by the fact that they often suffer from several chronic diseases: diabetes, cardiovascular pathologies or cancer which make the body more vulnerable. According to another study published in the *New England Journal of Medicine,* a high proportion of severe to critical cases and a high mortality rate were observed in elderly COVID-19 patients. Rapid disease progression was noted in those who died, with a median survival time of five days after hospital admission. Dyspnoea, lymphocytopenia, comorbidities including cardiovascular disease and chronic obstructive pulmonary disease, and acute respiratory distress syndrome were predictive of poor outcome. Close monitoring and prompt treatment were required for high-risk elderly patients. Another study conducted by researchers at the *London School of Economics* found that the rate of COVID-19-related deaths in nursing homes in five countries studied ranged from 42% to 57% of total deaths attributed to this infection in those countries, according to preliminary data. In Belgium, this rate is 42%, Italy 53%, Spain 57%, France 45% and Ireland 54%, according to data collected in the first half of April 2020. There is little information on many countries. In addition, registration systems related to coronavirus in nursing homes vary between countries and even regions. Furthermore, the fact that very few countries systematically test people in nursing homes (residents or care staff) complicates estimates of the number of infections and deaths. According to the authors of this research, given this

lack of testing, it would seem that the best way to estimate the impact on mortality of the coronavirus in these facilities would be to compare mortality data from the period of the pandemic with mortality from previous years at the same time of year. As a result, the French National Institute of Statistics (INSEE) published data on 10 April 2020 showing that in March 2020, for example, there were 11.9% more deaths in EHPADs than in March 2019. There were therefore 10.4% more deaths in the total population aged over 70 [18-21].

Psychological support systems for older people

The health crisis linked to COVID-19 has disrupted the daily life of many residents of MRs and EHPADs. What strategies are in place to deal with the lockdown of our elderly and, above all, the exacerbation of loneliness? Not all elderly patients with COVID-19 die. What happens to the survivors? The mortality rate is just the tip of the iceberg. Studies on COVID-19 and older people should explore what is not yet apparent. Isolation, which resulted from the policy to minimise the danger linked to the coronavirus, itself entails particular risks for the elderly, because great difficulty is that we do not yet have the scientific capacity to determine the benefit-risk balance of lockdown and the psychological impact. Currently, both politicians and health professionals on the ground have tried to deal with the most urgent issues: managing the crisis from a health and logistical point of view, but from a psychological point of view, the data are still almost non-existent.

Failure to thrive in the elderly in nursing homes

Failure to thrive remains a psychopathological phenomenon that is still poorly understood in geriatrics. This concept appeared in French medical literature in the 1950s and was described by the geriatrician Jean Carrié as "*a process of involution and senescence brought to its most complete state*" [22]. It therefore refers to the perception of a state in which the elderly person seems to be consciously letting themselves slide towards their own death. Medically, it is a state of rapid decompensation of the general condition following an acute illness. We could therefore define the failure to thrive by a state of great physical and psychological destabilisation marked by anorexia, malnutrition, adipsia (refusal to drink or hydrate), a refusal to stand up, a refusal to communicate, the subject asks to be "left alone", a confused and depressive state with somatic manifestations, with a probably unexpressed desire for death [23]. Specific to advanced age, the failure to thrive is therefore a rapid deterioration in general condition, triggered by an acute medical (infectious, vascular, viral, such as COVID-19), surgical or psychological condition, from which it is separated by a period in which the elderly person appears to be in good condition. This syndrome evolves over a few days or weeks at the most and can lead to death in the absence of therapeutic management and often, in spite of this, in a picture of functional decline and severe depression [24]. From this point, the elderly person witnesses the collapse of their entire mental and physical being, demonstrating their extreme frailty. They are considered to be "slipping towards death" [25]. Thus, it is important to remain cautious about this possible clinical response in the elderly person who has experienced prolonged quarantine. Will failure to thrive be collateral damage in the months following decommissioning? This is surely a factor to be observed in the coming months.

The concept of failure to thrive post-lockdown, following the coronavirus pandemic

At present, little is known about the psychological consequences of extended lockdown (beyond 14 days) as a result of the coronavirus pandemic in elderly subjects. However, it could be imagined that the consequences would be the same as any other traumatic situation that might have occurred in different contexts. It would be interesting to observe the evolution of the reactions of cohorts of elderly subjects who have survived COVID-19 isolation in MRs and EHPADs. Carers' attention could also be drawn to the principle of "bonding". As a result of being deprived of this bond (to the family, to familiar staff, to the general practitioner)for a certain period of time, the elderly person may become insecure and show agitated or depressed behaviour [4]. Furthermore, for the nursing staff, dealing with an elderly person who fails to thrive is not an easy task, as the image of someone experiencing this can be traumatic. The carer may feel that the older person projects attitudes of rejection or overprotection in the face of the violence of the condition and their total dependence on the carer. In this context, the caring relationship is essential. Comforting care is essential. Like the "good enough mother" described by Winnicot [26, 27], good enough care should be rigorously supported in geriatrics and perhaps, primarily, during AND after the isolation experienced by the elderly person. Physical care is of great value when a patient fails to thrive: holding and handing provide psychological and physical support at this time of life. This support allows moments of psychosomatic integration as well as a libidinal reinvestment of the body. A few words describing the treatment or a comment evoking a few trivial events makes it possible to make the link

between bodily sensations and the outside world and thus to encourage the resumption of thought.

Conclusion

The psychological impact of lockdown measures is broad, substantial and likely to be long-lasting. The psychological impact of the lockdown, both for the nursing staff and for elderly people over the age of 70, will certainly depend on the duration of the lockdown. We therefore need to review all our knowledge about the support provided to elderly people and geriatric care in nursing homes and learn how to respond more effectively to any new epidemic both socially and psychologically. The lack of studies on the psychological impact of lockdown on elderly people and carers in institutions in Europe suggests that politicians and medical experts have not been prepared for this health crisis and, by default, have had to react urgently by putting strategies in place. We certainly need more time and more in-depth statistical studies to compare with those carried out previously on shorter epidemics in smaller geographical areas, such as SARS in 2003, Ebola in Africa or the more recent H1N1 in Europe, in order to analyse and compare the psychosocial consequences of this pandemic. Furthermore, studies on COVID-19 seem to be generally oriented towards case statistics from different countries, presumably in order to measure the upward and downward curves of the pandemic's evolution in order to set up strategies to emerge from lockdown at a later stage. To conclude, we think it would be wise to compare, in each MR, the resources put in place at the time of the crisis both by the nursing staff within the MR or EHPAD and for the residents during the health crisis [1]; the psychological impact of the entire setting after lockdown should be observed.

Key points

- COVID-19: More than a third of the world is currently under lockdown due to the coronavirus pandemic.
- What impact will this have on mental health for the elderly, MRs, EHPADs, and nursing staff?
- What impact can lockdown situations have upon the population being quarantined?
- The mental health needs of nursing staff in nursing homes and the psychological impact on residents needs to be addressed.

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Question à l'auteur

Q1 Merci de nous transmettre la date à laquelle vous avez consulté le site des références [8], [14], [16], [17] et [21].