



**Superior
Health Council**

PSYCHOSOCIAL CARE DURING THE COVID-19 PANDEMIC

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and Environment

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ADVISORY REPORT OF THE SUPERIOR HEALTH COUNCIL no. 9589

Psychosocial care during the Covid-19 pandemic

In this scientific advisory report, which offers guidance to public health policy-makers, the Superior Health Council of Belgium provides recommendations on psychosocial care during the Covid-19 pandemic for health care providers and authorities.

This version was validated by the Board on
6 May - 2020¹

SUMMARY

The SHC has drafted an opinion on the psychological issues that may result from the Covid-19 pandemic, how they may evolve and what we know about the means to be implemented in order to tackle them in the mid- to long-term.

This opinion aims to set forth a situational analysis of the literature on the matter and that on collective emergency situations, in order to advise the authorities on the measures to be taken to optimise psychosocial management. The recommendations relate to both the general population and healthcare providers, as well as other support services. The isolation measures taken have affected the population as a whole, even if their impact (and therefore the risk of acute stress and long-term consequences) has been more significant for certain individuals. Nonetheless, these recommendations must be translated differently for each target group.

The SHC recommends that psychosocial aspects should be taken into account throughout the duration of the pandemic, not only to reduce mental health issues within the population, but also in order to promote better monitoring of its directives as relate to the pandemic.

To this end, it will be necessary, on the one hand, to undertake the work required to predict, identify and treat mental health issues; and on the other hand to reduce distress levels within the population. The aim is to strengthen individual and collective resilience. This will require clear, coherent and transparent communication, and the use of a sufficiently diverse range of media. It is important to call on community spirit, rather than coercion and repression, which have adverse effects on mental health and compliance with instructions.

At the start of the pandemic, emphasis must be placed on the effective deployment of resources (assessment and sorting of requirements according to the resources available). Easy-access care must be made available, that individuals can refer to as necessary (with particular attention to problems relating to bereavement and for certain more vulnerable groups, as well as for healthcare providers). Psychosocial support must particularly aim to promote natural recovery and autonomy, and to identify and guide those who need support.

¹ The Council reserves the right to make minor typographical amendments to this document at any time. On the other hand, amendments that alter its content are automatically included in an erratum. In this case, a new version of the advisory report is issued.

These targeted, adapted and scaled psychological interventions must then remain available. The longer the pandemic lasts, the higher the risk. It is important to monitor and manage certain signs (domestic violence, stigmatisation, loneliness, etc.).

Assessment will come to the fore after the pandemic, and it will be essential to prepare for a possible new pandemic; focussing on individual and collective resilience and investing in training for professionals.

Reactions to crisis situations vary greatly between individuals. Many people will encounter stress reactions which will, in the majority, be temporary. It is necessary to treat these stress reactions (including with online intervention) in order to reduce the risk of problems at a later date, but also to strengthen compliance with the measures taken to combat the virus. As for trauma, this will be managed by specifically trained professionals.

These issues must be managed, taking into account the risk factors that determine their occurrence and evolution:

- Predisposing factors: age, female sex, low socio-economic status, low social support, low sense of control, previous psychological issues, etc.
- Trigger factors: fear of the pandemic, quarantine, long periods of uncertainty, threat to life, etc.
- Maintenance factors: duration of isolation, personal factors such as individual capacity to tackle the circumstances, social support, community reaction and recognition, confidence in the information supplied, financial support and recovery, attention in the media, etc.

Loneliness is also a risk factor for mental health issues. Individuals currently living separately from their family run the highest risk. Social distancing measures will impact the well-being of the population as a whole.

There are no dominant factors, but it is frequently a combination of factors that causes certain groups to become particularly fragile: individuals who are very fearful of COVID-19, those who have been admitted to intensive care, those who feel threatened, who have no job or income security, who present with pre-existing vulnerability made more acute by the impact of COVID-19, parents of young children, women, young people, individuals living alone, those who have no or very little social contact, low skilled individuals (including university students, and students who are working). Increased psychopathologies have also been noted in women with young children, migrants, individuals with previous psychiatric issues, and adolescents, among others.

The care sector also deserves particular attention, including after the crisis.

Furthermore, it will be necessary to be aware of the long-term effects on the population as a whole. Work stoppages can be anticipated, not only following infections due to the virus, but also caused by other consequences such as the additional workload, the consequences of isolation, lack of employment or financial security. However, returning to work and employment in general play an important role in the prevention of mental health issues and wider health problems, as well as in relaunching society as a whole. It is therefore essential to support programmes that target a return to work and training.

Finally, while there is a lack of data concerning the impact of the strict measures taken concerning mourning rituals, the SHC is of the opinion that it is important to work on a well considered and scalable bereavement process. Professional support is also recommended in the event of a complicated bereavement.

Keywords and MeSH descriptor terms²

Mesh terms*	Keywords	Sleutelwoorden	Mots clés	Schlüsselwörter
Disease Outbreak	Epidemic	Epidemie	Epidémie	Epidemie
Mental Health	Mental Health	Geestelijke gezondheid	Santé mentale	Psychische Gesundheit
Psychological trauma	Psychotraumatology	Psychotraumatologie	Psychotraumatologie	Psychotraumatologie
Health Personnel	Reintegration	Werkhervatting	Réintégration	Wiedereingliederung
	Health Care Providers	Zorgverleners	Prestataires de soins	Leistungserbringer im Gesundheitswesen
Resilience, Psychological	Psychosocial intervention	psychosociale interventies	Intervention psychosociale	Psychosoziale Intervention
	Resilience	Veerkracht	Résilience	Belastbarkeit

MeSH (Medical Subject Headings) is de thesaurus van de NLM (National Library of Medicine) met gecontroleerde trefwoorden die worden gebruikt voor het indexeren van artikelen voor PubMed <http://www.ncbi.nlm.nih.gov/mesh>

List of abbreviations used

- ASD Acute stress Disorder
- EMDR Eye movement desensitization and reprocessing
- PTSD Post-Traumatic Stress Disorder

² The Council wishes to clarify that the MeSH terms and keywords are used for referencing purposes as well as to provide an easy definition of the scope of the advisory report. For more information, see the section entitled "methodology".

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I INTRODUCTION AND ISSUE

This advisory report deals with the psychological impact that can be expected as a result of the corona-crisis. This document discusses what effects are to be expected, what their diagnosis, course and prognosis will look like in the medium and long term, and what we know about useful ways of dealing with them. It is not a manual on how the government should act during and after the corona crisis, but an exploration of the existing literature and knowledge on the subject. Annex 1 contains the original question presented to the working group.

II METHODOLOGY

After analysing the request, the Board and, when appropriate, the Chair of the working group identified the necessary fields of expertise. An *ad hoc* working group was then set up which included experts in psychology, psychiatry, occupational medicine, virology. The experts of this working group provided a general and an *ad hoc* declaration of interests and the Committee on Deontology assessed the potential risk of conflicts of interest.

This advisory report is based on a review of the scientific literature published in both scientific journals and reports from national and international organisations competent in this field (peer-reviewed), as well as on the opinion of the experts.

As part of the systematic research, the working group defined some specific search terms and inclusion terms with which articles were searched within the Cochrane Library and PubMed. Preference was given to reviews or articles with peer review from 2000 to the present and which investigated psychological impact in a traumatogenic situation. Details of the search terms used and the process of the working group are given in Annex 2.

These guidelines in this report have been chosen at the highest possible level of evidence. Anecdotal evidence is not included in the scientific evidence, although they are numerous. Figures and reports from the field of work were included insofar as they followed the scientific principles and provided added value for the further elaboration of the recommendations. This report is not a meta-analysis and no full level-of-evidence determination of each recommendation was made.

In addition, attention must be paid to the uniqueness of the current pandemic and the working group calls for these recommendations to be kept under review in light of the changing situation. Much used evidence is based on insights from single events. At this moment it is not clear whether this comparison is valid. The recommendations are similar to those already published from China³ and follow the principles reflected in the report on the terrorist⁴ attacks of 22 March 2016.

Once the advisory report was endorsed by the working group, it was ultimately validated by the Board. However, in order to make these recommendations available in a timely manner, it should be noted that the usual internal validation procedures of the SHC have been adapted.

A few comments on this report:

- These recommendations apply to all adults (including the elderly). For each of these groups an adapted translation is needed from the core insights behind these recommendations. It is not the responsibility of the working group to determine what this actually looks like. The authors are available for further advice.

³ Jun Zhang, Wu, Zhao, & Zhang, 2020

⁴ SHC 9403 2017

- As far as children and young people are concerned, the science is still in its infancy. Some aspects are certainly similar, while other aspects will be experienced differently by children and young people. Making recommendations specifically for this target group was not the objective of this mandate. Nevertheless, between the start of the pandemic and 20 April 2020, we searched for scientific insights. These were found to be insufficient to distil a recommendation.
- On the basis of these recommendations and systematic research, an evaluation can be launched. This does not fall within the remit of the working group, but the authors are available for further advice during the evaluation phase.
- The recommendations apply to both the general population and psychosocial actors. The latter have certain specific characteristics during this pandemic. By 'care sector' we mean both care and welfare workers, including bereavement counsellors and undertakers. We do not distinguish between the different (support) services within the sector because there is no indication that they have a different impact. The general rule also applies within the care sector: the more people are confronted with the impact and consequences of the corona crisis, the higher the risk of acute stress reactions and long-term consequences.
- This report does not explicitly address a number of factors that make certain groups more vulnerable to the effects of the corona crisis, such as housing, financial space and the presence of complex family situations. This does not mean that the working group does not expect these factors to have an impact – on the contrary.
- A collective emergency often involves victims. During the corona pandemic, there is an important distinction:
 - direct or indirect **victims** are people who have died as a result of the COVID-19 disease and their relatives;
 - **those affected** experience consequences of the corona crisis. Unlike other collective emergencies, here all Belgians were affected by the strict measures imposed during the lockdown-light. The victims were also affected, of course.

III ELABORATION AND ARGUMENTATION

1 Phasing of psychosocial care

The review provides a number of overarching findings that are important for all phases. For example, the literature shows that it is advisable to strategically tackle the psychosocial part of a pandemic as well. This in view of its impact both on the course of the pandemic (e.g. compliance guidelines) and on the mental health of the population. The prevention, detection and treatment of mental health should be an important component within the approach to public health⁵.

In addition, there is a general need for clear, transparent and coordinated communication. Truthful communication should also be a priority within complexity and / or progressive insight⁶. Conflicting reports and/or discussions about policy decisions taken, or the perception that is created about them, reinforce distress feelings within society⁷. It is therefore crucial to communicate in a united and solid manner with due attention to specific communication challenges such as framing, stigma and discrimination⁸. Media literacy and media preferences in the population should also be taken into account. In order to be able to reach as many people as possible in a uniform way, a variety of media should be used in the communication approach⁹. A clear division of roles in the field of communication and tasks is required¹⁰. During the pandemic it must above all be possible to appeal to a sense of community, solidarity and voluntarism. Coercion and repression have perverse effects, both on mental health and on adherence to advice¹¹.

Finally, it is appropriate to focus on the general perpetuation and active reinforcement of individual and collective resilience to deal with this exceptional situation. It is this resilience that plays a significant role in reducing the risk of toxic stress and associated health problems both in the general population and in specific target groups¹².

1.1 The start of a pandemic

At the start of a pandemic, the focus should be on the efficient deployment of resources. An assessment and triage of psychological needs tailored to the currently available resources is required¹³. It is crucial to ensure that the right balance is found between attention to psychological/psychiatric needs, without lapsing into a forced generalised offer of treatment (cf. resilience above). Low-threshold, step-by-step care should therefore be set up, including online help and initial psychological help by professionals in basic and first-line care whom people can look up themselves whenever they feel the need¹⁴. Particular attention should be paid to traumatic loss experiences as a mental challenge that many will face in this pandemic: on the one hand because there are many 'unexpected' deaths and on the other hand because

⁵ IASC, 2020; Qiu J; Shen B, Zhao M et al, 2020; WHO, 2020

⁶ Here we refer to reporting that can be considered contradictory while actually reflecting the unfolding reality. Experts also learn from COVID-19 while the infection is raging over our population.

⁷ Leung M et al, 2005; Cowling J et al, 2010

⁸ Leung M et al, 2003; Bourne D, 2005; Gardner P & Moallem P, 2005; Reynolds DL et al, 2008; Cowling J et al, 2009; Peng EY et al, 2010; Brooks S et al, 2018).

⁹ Bourne D, 2005; Brooks S et al, 2018; Park J, Lee E, Park N & Choi Y, 2018

¹⁰ Bourne D, 2005; Leung M et al, 2005; Cowling J et al, 2010; Gouli P et al, 2010; von Gottenberg et al, 2016

¹¹ Leung M et al, 2005; Mauder RG et al, 2006; Cowling J et al, 2010; Brooks S et al, 2020

¹² HGR Nederland, 2006; Cowling J et al, 2010; De Soir E, Knarren M, Zech E, Mylle K, Kleber R, Van der Hart O, 2012; Sallouma A, Choib M & Smith C, 2019; Losada-Balter A et al, 2020

¹³ CPI, 2015; WHO, 2015; Jaloh MF, Bunnel RE et al, 2015; Duan L & Zhu G, 2020

¹⁴ Jaloh MF, Bunnel RE et al, 2015; Qui J, Shen B, Zhao M et al, 2020

the circumstances and lockdown measures make it difficult to say goodbye according to the usual cultural habits¹⁵.

Certain groups deserve special attention because they are particularly vulnerable due to various factors. These include young people, the elderly and people in a vulnerable situation such as people living in poverty, people with disabilities and people with a background of migration¹⁶. People with pre-existing mental problems have a higher risk of infections such as pneumonia and often also have more difficult access to their usual treatment by the chaos of a pandemic and lockdown measures¹⁷. It is important to support families because they can provide an initial social buffer¹⁸.

The continuity of regular mental health care comes under pressure in a pandemic and deserves extra attention¹⁹. The care itself is also extra vulnerable and, above all, needs correct information and clarity of role²⁰. People who are in the front line need to be closely monitored from the start in terms of stress, mental strain and avoidance behaviour. These include, for example, care personnel, such as care staff and specific people working in specific departments with intimate contact with the sick²¹. They are not only confronted with the consequences of a pandemic, but often have to work in changing circumstances (e.g. team composition, change of shift, etc.) and even in situations for which they are not adequately trained. This leads to additional uncertainty and an increased risk of distress²². Backup systems should be used, but above all physical and mental safety should be guaranteed²³. A specific vulnerable group are those who survive the disease and in particular care staff who contract the disease²⁴.

1.2 During the pandemic

After the initial confrontation with the impact of the pandemic, it remains important to further facilitate the expansion and strengthening of psychosocial care. Psychological interventions must continue to be made available in a targeted and adapted manner²⁵. It is also important for care providers to keep access to psychological/psychiatric care as available as possible and to focus on their experiences, problems they face in order to try to avoid avoidance behaviour²⁶. Continuity of care and attention to the confrontation with traumatic loss remain important points of attention²⁷.

The longer the pandemic lasts, the greater the risk of overburdening society. Attention to certain signs of this should be present in the monitoring. For example, an increase in domestic

¹⁵ Bournes, 2005; Walsh F, 2007; WHO, 2015; Bartone P et al, 2019

¹⁶ Leung M et al, 2005; Jalloh MF, Bunnel RE et al, 2015; Garner P & Moallef P, 2015; Hashem B et al, 2017; Qui J, Shen B, Zhao M et al, 2020

¹⁷ Yaot H, Chen J & Yi-Yeng, 2020

¹⁸ Gardner P & Moallef P, 2015; Papadimos R et al, 2018

¹⁹ CPI, 2015; EMCDDA, 2020

²⁰ Leung M et al, 2003; Gardner P & Moallef P, 2015; Hashem B et al, 2017; Jalloh MR, Li W, Bunnell RE et al, 2018; Qui J, Shen B, Zhao M et al, 2020

²¹ Greenberg N, Docherty M et al, 2018; Cénat JM et al, 2019

²² Lee AM et al, 2007; Peng EY et al, 2010; De Soir E, Knarren M, Zech E, Mylle K, Kleber R, Van der Hart O, 2012

²³ Bournes D, 2005; Khalid I et al, 2016; Dionne G, Desjardins D, Lebau M et al, 2018

²⁴ Lee AM et al, 2007; Gardner P & Moallef P, 2015

²⁵ Duan L & Zhu G, 2020; Qiu J; Shen B, Zhao M et al, 2020

²⁶ Barnes N et al, 2015; Dekel R, Nuttman-Schwartz O & Lavi T, 2016; ; Khalid I et al, 2016; Labrague L, Hammad K, Gloe S et al, 2017; Brooks S et al, 2018; Dionne G, Desjardins D, Lebau M et al, 2018; Park J, Lee E, Park N and Choi Y, 2018; Brooks S et al, 2020; Chen Q, Liang M, Li Y et al, 2020

²⁷ Walsh F, 2007; Barnes N et al, 2015; Dekel R, Nuttman-Shwartz R & Lavi T, 2016; Cénat JM et al, 2019; Yaot H, Chen J & Yi-Yeng, 2020

violence, stigmatisation of certain target groups, expressions of loneliness, etc. are important signals that must be picked up on and dealt with in a timely manner²⁸. The risk of possible secondary trauma increases²⁹.

1.3 After the pandemic

In the period following a pandemic, evaluation is particularly important. Above all, society needs to prepare for a possible following/new pandemic in which, on the basis of the evaluation, improvements need to be made to the approach, policy and also training of professionals³⁰ (if useful and relevant). It remains crucial to focus on individual and collective resilience³¹. Psychosocial health is crucial within the health of a society and all possible tools for this should be mapped out. A coherent crisis prevention plan and plan of action for the next pandemic should be developed³². Within the healthcare sector, training and development must be fully deployed so that this crucial sector is prepared to act in crisis situations.³³

2 Natural recovery and self-reliance

During a collective emergency, the emphasis should be on natural recovery and self-reliance. Psychosocial care should aim to promote this. The lack of evidence about the effect of preventive intervention does not mean that psychosocial care should be absent from the acute phase. This is evident from experience in the field. When care providers stimulate natural recovery and self-reliance in that period, this benefits the health of those affected in the longer term. As also pointed out in SHC advisory report opinion 9403³⁴, it is particularly important to facilitate access to care providers by avoiding an excessively formalised system and by leaving people completely free (respect for autonomy).

The best approach is to respond to the immediate practical, social and emotional needs of those affected. For example: offering a sympathetic ear, helping to reunite with relatives, helping to tackle practical problems and informing people about the impact that the event may have on their well-being. Care providers can be alert to those in need of therapeutic treatment and point the way there.

3 A challenge for the adaptive capacity

The reactions in the (sub)acute phase – although they can be violent – can generally be regarded as normal reactions to an abnormal event. People are very different in the way they react to a collective emergency. As far as we know, many people have to deal with stress reactions during the collective emergency, some of them very severe. As a rule, the associated health problems are temporary in nature. Most people are resilient and recover within a short time. In the longer term, the most common reactions after a collective emergency are:

- Fear,
- Dejection,

²⁸ IMPACT, 2014; Cowling J et al, 2009; Brooks S et al, 2018; Park J, Lee E, Park N & Choi Y, 2018; Prasso S, 2020

²⁹ Walsh F, 2007

³⁰ Lee AM et al, 2007; De Soir E, Knarren M, Zech E, Mylle K, Kleber R, Van der Hart O, 2012; Liu X et al, 2012; CPI, 2015; WHO, 2015

³¹ Walsh F, 2007; Duan L & Zhu G, 2020; Prasso S, 2020

³² Jalloh MF, Bunnel RE et al, 2015; Duan L & Zhu G, 2020; Qiu J; Shen B, Zhao M et al, 2020

³³ Bournes D, 2005; De Soir E, Knarren M, Zech E, Mylle K, Kleber R, Van der Hart O, 2012; Jalloh MF, Bunnel RE et al, 2015; Dekel R, Nutteman-Swhartz R & Lavi T, 2016; Labrague L, Hammad K, Gloe S et al, 2017; Brooks S et al, 2018; Dionne G, Desjardins D, Lebau M et al, 2018; Cénat JM et al, 2019; Duan L & Zhu G, 2020; Greenberg N, Docherty M, Gnanapragnasam S & Wessely S, 2020

³⁴ SHC 9403 2017

- Intrusive re-experience,
- Substance abuse (such as alcohol and drugs),
- Physically unexplained complaints.

Estimates of how often these reactions occur vary widely. According to the literature on disaster situations, it is claimed that in Western countries twenty to fifty per cent of those affected will suffer from such complaints one year after the collective emergency³⁵. This does not mean that those affected will also notice an increase in psychiatric disorders such as depression, anxiety disorders, post-traumatic stress disorder (PTSD) or addiction. Such an increase can be observed in certain groups, including mothers with young children, evacuees, people with the status of migrant, people with previous psychiatric problems and adolescents¹².

On the basis of the above, the members of the working group derive that during the corona pandemic a substantial proportion of those affected will sooner or later suffer from what we refer to as acute stress disorder (ASD). ASD can turn into PTSD. PTSD occurs when certain forms of severe stress disorder – such as re-experience, avoidance and increased irritability – persist for more than one month after the event or develop more than one month after the event³⁶.

In adults, the chance of developing PTSD after exposure to a traumatic event is, on average, about ten per cent³⁷. But some studies show higher odds, even above thirty per cent. Increased symptoms are also common in young people in the first months³⁸. The incidental percentages found differ greatly between studies. They depend, among other things, on the type of event and the investigation procedures used. For example, questionnaires show higher percentages than clinical interviews³⁹.

Most of those affected regain their balance without the help of professional care providers¹². Those affected by a collective emergency must make a strong appeal to their adaptability and resilience.

It appears that symptoms and effects are normally worst in the period immediately after the collective emergency⁴⁰ and then usually gradually diminish, sometimes interrupted by short periods of stagnation or even increase. Most complaints lose their sharpness within one to one and a half years. Sometimes they remain constant for a long time or get worse⁴¹. In a sizeable minority of those surveyed – about 20 to 25 per cent of those affected – the complaints persist for months to years. Furthermore, a clear link between the severity of the symptoms in the short term and those in the medium and long term has been demonstrated⁴².

³⁵ Bromet & Havenga, 2002; Havenga & Bromet, 2003

³⁶ American Psychiatric Association, 2013

³⁷ Breslau et al., 1998; De Vries & Olff, 2009

³⁸ Bonanno et al., 2010; Norris et al., 2002

³⁹ Engelhard et al., 2007

⁴⁰ Rubonis & Bickman, 1991

⁴¹ Bartone, Ursano, Wright, & Ingraham, 1989; McFarlane, Polcansky, & Irwin, 1987; Wang et al., 2000

⁴² Norris, Friedman, & Watson, 2001

Existing WHO, APA, NICE, ISTSS and NHMRC guidelines⁴³ recommend trauma-focused cognitive behavioural therapy and EMDR (eye movement desensitisation and reprocessing) as techniques for dealing with acute stress disorder. The NICE and WHO guidelines recommend that in this lockdown situation, in which face-to-face psychological counselling is impossible, other solutions such as online counselling or group interventions should be creatively sought. In China, experiments have already been carried out with the development of online psychological crisis care⁴⁴. By dealing with toxic stress reactions, the risk of problems at a later stage decreases. In addition, people are then more inclined to comply with the measures imposed to contain the virus⁴⁵.

4 One-off psychosocial interventions?

The preventive effect of early psychological interventions has not been sufficiently researched, but it is clear that one-off debriefing has no preventive value for PTSD symptoms⁴⁶. Low-threshold group interventions can be deployed. The aim of interventions in the acute phase of a collective emergency is to reduce stress complaints, ASD and the risk of PTSD.

5 Leave the expert work to the specialists

Advisory report No. 9403 of the Superior Health Council (2017) concerning the recommendations on the prevention and management of psychosocial residual injuries after individual or collective emergencies stated that the treatment of trauma experiences should be provided by trained and competent professional care providers who meet a certain profile (see Annex 3 concerning the required level of training of trauma therapists)⁴⁷.

6 Causes of psychosocial complaints

What factors play a role in the onset and course of the conditions in question? We divide the factors into three categories⁴⁸:

- Predisposing factors: people's degrees of vulnerability differ. One person gets the complaints sooner than another;
- Provocative factors: this concerns the circumstances that trigger the complaints in susceptible people, in this case the collective emergency;
- Sustaining factors: these are factors that cause the symptoms to persist and hinder recovery.

6.1 Predisposing factors

- **Age:** Children of school age sometimes have more complaints than adults after collective emergencies. In young children, the response of the caring parent to the collective emergency plays an important role. The more severe the reaction of the

⁴³ WHO: Word Health Organisation; APA: American Psychological Association; NICE: National Institute for Health and Clinical Excellence; ISTSS: International Society for Traumatic Stress Studies; NHMRC: Australian National Health and Medical Research Council.

⁴⁴ Zhang et al., 2020

⁴⁵ Leung et al., 2005

⁴⁶ Rose, Bisson, Churchill, & Wessely, 2002

⁴⁷ SHC 9403 2017

⁴⁸ Gezondheidsraad, 2005; Mayou & Farmer, 2002; Sharpe, 2002; van den Berg, Grievink, Ijzermans, & Lebret, 2005

parent(s) and the disruption of family and surroundings, the more serious the effects on the child⁴⁹.

- **Gender:** Women and girls have more complaints than men and boys after a collective emergency. Mothers with young children are at extra-high risk, especially when there is an unknown, uncertain threat⁵⁰.
- **Socio-economic status:** There is strong evidence that the consequences of collective emergencies are more detrimental to people's health if their socio-economic status is lower⁵¹. This could be explained by the fact that people with a higher socio-economic status have more resources to deal with the consequences. Foreign research has shown that people with a low socio-economic status are more likely to be affected by a collective emergency in the place where they live.
- **Culture and ethnicity:** Adult members of ethnic minorities often have more complaints and problems after a collective emergency than people belonging to the dominant culture⁵².
- **Neuroticism:** There are indications that neuroticism – the tendency to worry and quickly become anxious – increases the chance of problems and complaints after a collective emergency⁵³, as opposed to a solid, stable personality.
- **Sense of control over life:** There are indications that people who feel they have little or no influence on their own lives have more complaints after a collective emergency⁵⁴.
- **Social network, social support:** If people have few social contacts, they are more vulnerable after a collective emergency⁵⁵.
- **Previous psychological damage as a result of shocking events:** People who have already experienced shocking events – such as an accident, a rape or the loss of a loved one – and who have suffered psychological damage as a result are more vulnerable after collective emergencies. The same goes for people who have been under stress for a long time⁵⁶.
- **Complaints prior to the collective emergency:** People with a history of unexplained physical symptoms or psychopathology (anxiety, depression, PTSD or other psychiatric problems) are more likely to develop such disorders even after a collective emergency⁵⁷.

6.2 Provocative factors

Provocative factors are specific circumstances that trigger complaints in people who are sensitive to them. The most important provocative factor is the intrusiveness with which one has been confronted with the collective emergency, for example because someone has been in mortal danger, has been in prolonged uncertainty about the fate of loved ones or has been

⁴⁹ Norris et al., 2002; McFarlane et al., 1987; Vogel & Vernberg, 1993; Bromet & Dew, 1995; Gurwitch & Sullivan, 1998; Gallo et al., 2019

⁵⁰ Bromet & Havenaar, 2002; Havenaar & Bromet, 2003; Norris et al., 2002; Silver et al., 2002; van den Berg et al., 2005; Vogel & Vernberg, 1993; Bromet et al., 1982; Havenaar & Van Den Brink, 1997; Havenaar et al., 1996

⁵¹ Havenaar & Van Den Brink, 1997, Norris et al., 2002

⁵² Norris et al., 2002

⁵³ Norris et al., 2002

⁵⁴ Gibbs, 1989; Prince-Embury, 1992

⁵⁵ Norris et al., 2002

⁵⁶ Bromet & Havenaar, 2002; Havenaar & Bromet, 2003

⁵⁷ Bromet et al., 1982; Havenaar & Bromet, 2003; IJzermans et al., 2005; Norris et al., 2002; Silver et al., 2002; van den Berg et al., 2005

in quarantine. People who are very afraid of the pandemic are more vulnerable to provocative factors⁵⁸.

People who are (or have been) in mortal danger are most likely to suffer long-term psychological damage, especially PTSD⁵⁹.

Furthermore, it has become clear that the more someone experiences such situations, the greater the chance of psychological damage. A large meta-analysis carried out in 1991 on the terrorist attacks also shows that more psychopathological symptoms are found in the survivors as the number of fatalities increases⁶⁰.

6.3 Maintaining factors

- **Evacuation and quarantine:** Prolonged evacuation may be an important risk factor. It is assumed that the long distance from the evacuation site to the collective emergency area, the loss of home or work, adaptation problems in the new environment, loss of social support and stigmatisation play a role in this. Prolonged quarantine may have similar effects. If long-term housing elsewhere is unavoidable, such negative effects will have to be taken into account⁶¹.
- **Somatic attribution:** Where there is continuing uncertainty about exposure to toxic substances or radiation and the resulting damage to health, people may continue to attribute their health complaints to that exposure, even in the absence of that relationship⁶². This gives the idea that one cannot influence the complaints oneself, and that hampers recovery.
- **Personal factors:** The lack of adequate perception and *coping* is one of the personal factors that perpetuate complaints. The way in which someone is able to assess their own ability to cope with the situation has a strong influence on further developments⁶³. An active approach to the problems protects against psychological complaints⁶⁴. The working group is therefore of the opinion that interventions should at all times lead to the activation of those affected.
- **Social support:** Social support can act as a buffer between stress factors and the development of a disorder⁶⁵. The extent to which a person receives emotional and practical support after the collective emergency, or the positive perception of it, is therefore an important factor. People who did not have a good social network before the collective emergency, suffer more afterwards. It is also possible that one has experienced this support previously, but that it slowly decays as the duration increases. That is another point of interest.

⁵⁸ Bromet & Havenga, 2003; Gurwitch, Sullivan, & Long, 1998; Havenga & Bromet, 2003; Norris et al., 2002; Rubonis & Bickman, 1991; Silver et al., 2002; van den Berg, Grievink, Ijzermans, & Lebret, 2005; Vogel & Vernberg, 1993

⁵⁹ Bromet & Havenga, 2003; Gurwitch, Sullivan, & Long, 1998; Havenga & Bromet, 2003; Norris et al., 2002; Rubonis & Bickman, 1991; Silver et al., 2002; van den Berg, Grievink, Ijzermans, & Lebret,

⁶⁰ Rubonis & Bickman, 1991

⁶¹ Brooks , Webster, & Smith, 2020

⁶² Havenga, Cwikel, & Bromet, 2002; Bertazzi, 1989

⁶³ Norris et al., 2002

⁶⁴ Silver et al., 2002

⁶⁵ Bromet & Havenga, 2002; Havenga & Bromet, 2003

- **Community response:** The way in which the community to which one belongs responds to the collective emergency is important. After all, support and attention, recognition and respect have a protective effect. Remembrance ceremonies and monuments can contribute to processing and recovery⁶⁶.
- **Confidence in information made available, in experts and authorities:** This factor is likely to have a positive effect on recovery⁶⁷. Winning and maintaining the trust of those affected must therefore be a high priority for authorities.
- **Financial aid schemes and their finalisation, rapid reconstruction and resettlement:** This factor promotes the recovery of those affected. If those affected receive no financial aid and reconstruction is difficult, this is not conducive to their recovery.
- **Attention in the media:** The media can play an important role, both positive and negative, in providing information on the consequences of a collective emergency. Much media attention for the dramatic aspects of a collective emergency can reinforce the increased compassion in society with victims but can also lead to an increase in fear⁶⁸.

The working group emphasises that these factors are a paradigm. The hypothesis is that the complaints only become chronic if both predisposing and provocative and maintaining factors apply to a person. There are differences of opinion about the weight of the various factors. Risk factors for psychological complaints after collective emergencies have been investigated more often, but the quality of the research is poor. The size of the groups studied is often small, control groups are lacking or inadequate, or there are other methodological weaknesses that undermine the conclusions.

The above overview is mainly based on reviews of risk factors after collective emergencies⁶⁹ and it is not clear how this can be interpreted for psychosocial problems in the current pandemic. Less is known about predisposing factors than about provocative and maintaining factors, because adequate data from before or during a collective emergency are often lacking.

7 Special attention to loneliness

Research shows that loneliness, solitude and social isolation are risk factors for mental problems, illness and death, whether by suicide or not⁷⁰. Conversely, it also seems that poorer health or health problems can lead to solitude⁷¹. People who currently live separated lives from their families or loved ones run a higher risk of mental health problems such as depression and anxiety⁷², and of suicide⁷³. For this reason, the World Health Organization recently changed the term 'social distancing' to 'physical distancing', a term with a less strong connotation of loneliness and isolation.

⁶⁶ Post, Nugteren, & Zondag, 2002

⁶⁷ Havenaar & Bromet 2002

⁶⁸ Mertens, Gerritsen, Salemink, & Engelhard, 2020

⁶⁹ Bromet & Havenaar, 2002; Galea, Nandi, & Vlahof, 2005; Gidron, 2002; Gurwitch, Sullivan, & Long, 1998; Havenaar & Bromet, 2003; Havenaar & Van Den Brinck, 1997; Norris, Friedman, & Watson, 2002; Norris et al., Silver, Holman, McIntosh, Poulin, & Gil-Rivas, 2002; van den Berg, Grievink, Ijzermans, & Lebret, 2005; Vogel & Vernberg, 1993

⁷⁰ Rico-Uribe et al., 2018; Valtorta et al., 2016; Elovainio, 2017

⁷¹ Victor et al., 2005

⁷² Smith & Victor, 2018

⁷³ Calati, 2020

The chances are that, during and after the corona pandemic, the whole population evaluates its own well-being less positively than under normal circumstances. This is related to the strict measures for social contact. During the 2003 SARS outbreak in Canada, 38.5% reported loneliness and 60.6% social isolation during the quarantine imposed there⁷⁴. The effects appear to be even more pronounced in children and adolescents in a recent British study: 83% of the children and adolescents surveyed who reported mental health problems prior to the corona pandemic indicated that they felt even worse during the lockdown measures⁷⁵. They have less access to mental health care and the support of their friends, despite the higher use of social media. Although social media do indeed offer a form of connection, they are also a source of (too) much, sometimes false, information and stress, especially for people who are on their own and are less able to communicate about this with others.

Quarantine measures and the resulting isolation lead to an increase in domestic violence, child abuse, child exploitation and neglect⁷⁶. This became apparent during the Ebola crisis in West Africa in 2014-2016 and now also during the corona crisis in China.

There is also a stigma in potential and confirmed patients, as well as in healthcare workers, who, because of the risk of infection, have to remain in isolation from their relatives.

People who live alone or have to isolate themselves due to the exceptional circumstances score higher on the General Health Questionnaire than people living with housemates. That questionnaire gauges mental health problems, with a higher score for a higher risk of complaints. This outcome emerged at the time of the SARS epidemic⁷⁷, the COVID-19 outbreak in China⁷⁸ and recent unpublished results of the University of Antwerp corona study (2020) (see Annex).

8 Vulnerable groups and moments

Various sources indicate that individual differences in health outcomes depend on unique risk factors, including the contextual characteristics of the event, the physical distance to which one is exposed, the distance in the aftermath, gender, age during the event, ethnicity, socio-economic status, mental illness, the loss of a loved one, the disruption of the social fabric (social relationships can improve after a collective emergency, especially in one's own family; however, the overwhelming body of evidence points to the erosion of personal relationships and community spirit)⁷⁹.

Research shows that there does not appear to be a single dominant predictor for psychological complaints and recovery. It involves a combination of factors⁸⁰. Some groups are vulnerable. The working group follows the enumeration that can be found in the scientific literature and the existing guidelines. We observe an increase in psychopathology in mothers with young children, evacuees, migrants, people with previous psychiatric problems and adolescents⁸¹.

⁷⁴ Reynolds et al., 2008

⁷⁵ Lee, 2020

⁷⁶ Lee, 2020

⁷⁷ Nickelle et al., 2004; Lee et al., 2007

⁷⁸ Dai et al., 2020

⁷⁹ Brewin et al., 2000; Bonanno et al., 2010; Gezondheidsraad, 2006; Norris et al., 2002; Ozer et al., 2003

⁸⁰ Brewin et al., 2000; Wohlfarth, Winkel, & van den Brink, 2002; Ozer, Best, Lipsey, & Weiss, 2003; Bonanno et al., 2010

⁸¹ Wang et al., 2020

A number of groups have an increased risk of long-term problems (see review in annex):

- people with a great fear of COVID-19;
- people who are (have been) admitted to intensive care;
- people who feel threatened/overwhelmed;
- people who are insecure about their job or income;
- people with a pre-existing increased vulnerability⁸² to the impact of COVID-19;
- parents with young children;
- women;
- young people;
- single people;
- people who have no or very little social contact;
- the low-skilled (including university students, and working students).

9 Extra attention for our care and welfare providers⁸³

The care sector deserves specific attention with regard to the impact of the corona pandemic. In China and Italy, we can already see that the corona crisis is particularly severe for the healthcare professions. To begin with, this group runs a real risk of infection. Medical and care staff have to cope with a very heavy work rhythm, an unexpected new job content and confrontational situations. It takes extreme concentration to protect yourself and at the same time treat ailing patients. In addition, they are confronted with suffering and dying, and must quickly make difficult decisions about life and death⁸⁴. In China and Italy, care staff dropped out, not only due to contamination with corona, but also due to acute stress.

The results of a multicentre study among 1,563 medical staff at Nanfang Hospital, (Guangzhou, China) show a prevalence of depression (50.7%), anxiety (44.7%), insomnia (36.1%) and symptoms of fear of illness (73.4%)⁸⁵ during the corona crisis.

A Chinese study of 4,600 care providers⁸⁶ showed that the main concerns of care providers are the contamination of colleagues, the contamination of family members, the operation of personal protective equipment and medical violence. In more than 40% of cases, a sharp increase in stress was observed, especially among those who had had first-line contact with COVID-19 patients and their family members.

A cross-sectional study of 150 care providers who worked in the context of the MERS outbreak in Jeddah (Saudi Arabia) showed that it was mainly the ethical dimension of the job that kept care providers at work. The feelings that were most prominent were related to personal safety and that of colleagues and family. They experienced it as supportive to feel a positive attitude in the workplace, to see infected colleagues recover and to notice that their own situation became safer through better protection. Recognition for their efforts, both from their own management and from the population, was also felt to be important.

After the corona crisis, additional staff losses are also to be expected due to long-term mental health problems such as burn-out, depression and anxiety disorders. This is already apparent

⁸² We also refer here to patients with pre-existing (serious) psychiatric disorders. Here there may be an exacerbation of the existing problems, as well as the development of new challenges. An appropriate monitoring, diagnostics and follow-up is required.

⁸³ This group is meant in the broadest possible sense. It also includes technical or support services (intra- and extramural) but also, for example, undertakers.

⁸⁴ Godderis, Boone, & Bakusi, 2020

⁸⁵ Liu et al., 2020

⁸⁶ Dai et al., 2020

from figures from China and from previous epidemics with SARS and MERS⁸⁷. A knock-on effect is created: when colleagues drop out, the workload for healthcare staff increases further. Previous influenza pandemics have shown that there can be a drop-out rate of forty to seventy per cent of hospital staff, on the one hand because of illness caused by the virus itself or because of acute mental problems⁸⁸.

Although there is enough literature available that discusses the stressors for care providers in a crisis situation, there is little to be found about traumatisation among this target group. We know too little about the factors that encourage traumatisation. It seems plausible that it is advisable to limit the known stressors as much as possible. Preventive psychosocial support is also desirable.

10 Work and mental health

We must be aware of the long-term consequences for the health of all workers. Staff loss is to be expected, not only due to coronavirus infections, but also due to stress, frustration and isolation due to quarantine⁸⁹. It is likely that the different groups of employees, disabled people and job-seekers will react differently, not only as a result of the pandemic but also of the economic recession that awaits us⁹⁰. For health professionals, psychological effects are to be expected as a result of the high work pressure during the crisis. For employees, their mental health is more likely to be affected by isolation and quarantine. Finally, excessive workload, job insecurity and loss of income for workers can lead to psychological problems⁹¹.

Commitment to return to work, job counselling and a social safety net are important health-enhancing investments during a recession, which at the same time will help revitalise the economy⁹². The Superior Health Council therefore advises investing in (re)training of employees and programmes that increase the chances of finding a job.

From previous pandemics and recessions we can conclude that the return to work and work in general are important for the revival of society. Moreover, work is the most important factor in the prevention of mental health and other health problems. During the economic crisis in the 1990s, for example, Spain spent little on social protection, which increased the number of suicides along with unemployment. Sweden, on the other hand, spent about four times more on social support programmes, so suicide rates did not increase there⁹³.

11 Resumption of work

There is no literature on work resumption procedures, the (re)opening of the companies that had to stop their activities during the lockdown or the return to normal operation for companies that adjusted their operation. Nor are there any insights into the impact on employees who ended up in (long-term) temporary unemployment during and after the lockdown or had to suspend their search for work. So we cannot cite research in contexts comparable with the corona pandemic.

Sufficient research has, however, been conducted into resumption of work and risk factors for long-term incapacity for work⁹⁴. In addition to age and gender, the assessment of one's own health and chances of returning successfully are important determinants. The duration of the

⁸⁷ Maynou & Saez, 2016

⁸⁸ Maunder et al., 2006

⁸⁹ Godderis et al., 2020; Maunders et al., 2006

⁹⁰ Maynou & Saez, 2016

⁹¹ Brooks et al., 2020

⁹² Godderis & Luyten, 2020

⁹³ Stuckler, Basu, Suhrcke, Coutts, & McKee, 2009

⁹⁴ Goorts et al., 2019

incapacity for work is crucial, because the longer the absence from work, the more difficult it becomes to return due to anxiety and also due to the creation of balances at home and at work.

12 Collective loss processing

The working group notes that loss and mourning during the pandemic are strict and deviate from the usual rituals. Because of the lockdown measures, people who have to say goodbye to a deceased loved one are now forced to do so at a distance. In addition, the impact for care and welfare providers is significant. Finally, we also refer to the patients who are present in the wards at the time of death. Because this type of loss and mourning is unknown and there is no empirical research available on how this situation affects the mourning process, there is a lack of evidence-based guidelines or protocols on mourning during pandemics. After all, the way of saying goodbye, the preparation of the funeral as well as the mourning rituals are adapted to the risk of infection. The impact (speed of the number of deaths) and the consequences for the authorities involved, such as lack of storage space, also have an impact on the mourning process.

However, literature research indicates that mourning increasingly has a social and far-reaching component, especially when the loss affects larger communities⁹⁵. Because of pillarisation and the disappearance of ‘the big stories’ – with their accompanying rituals – people seek support in new shared and symbolic processing. The social aspect of this is magnified in the case of ‘national tragedies’ such as this pandemic. According to research, experiencing emotions together reduces stress, while creating emotional unity. A sense of belonging also contributes to building community resilience – the necessary resilience of a community to deal with adverse situations⁹⁶.

According to the working group, it is advisable to work on a well-considered and phased mourning process. In the first place, and from when this is medically possible, people should be given the opportunity to commemorate their loss with loved ones, and national recognition should be given to the special way in which people have said goodbye in these exceptional circumstances.

A problem with the various phase layouts in the literature on mourning and loss processing is that the variety of people’s reactions makes demarcation difficult. At most, very global phases can be distinguished, such as beginning, middle and end⁹⁷. The first hours, days and sometimes weeks after the death there is shock and disbelief; the next of kin is psychologically anaesthetised and paralysed. Feelings gradually take over. The grieving person cries and is sad. Some time later there are reactions such as gloominess, depression, protest and sometimes anger. The next of kin processes the loss by gradually allowing it to dawn on them that the loved one is dead. The intensity of negative feelings gradually decreases. Eventually – usually after about a year – the next of kin resume their daily life and form new bonds⁹⁸.

Only a minority of the bereaved seek professional help⁹⁹. It is, however, recommended in the case of complicated mourning; when a person experiences intense mourning reactions during six months that are accompanied by serious problems in everyday functioning. Examples are an intense and disruptive longing for the deceased, difficulty in accepting the loss and the feeling that life is empty and meaningless¹⁰⁰.

⁹⁵ Walter, 2015

⁹⁶ Walsh, 2007

⁹⁷ Van den Bout, Boelen, & De Keijser, 1998

⁹⁸ Van den Bout, Boelen, & De Keijser, 1998

⁹⁹ Stroebe, Schut, & Stroebe, 2005

¹⁰⁰ Prigerson et al., 2009

IV CONCLUSIONS

The corona pandemic will have long-term consequences for the health of all, not only due to coronavirus infections, but also due to stress, frustration and isolation due to quarantine :

- On the basis of the above, the members of the working group derive that during the corona pandemic a substantial proportion of those affected will sooner or later suffer from what we refer to as ASD. For a minority, ASD can turn into PTSD. PTSD occurs when certain forms of severe stress disorder – such as re-experience, avoidance and increased irritability – persist for more than one month after the event or develop more than one month after the event.
- Loneliness, solitude and social isolation are risk factors for mental problems, illness and death, whether by suicide or not. People who currently live separated lives from their families or loved ones run a higher risk of mental health problems such as depression and anxiety, and of suicide. The chances are that, during and after the corona pandemic, the whole population evaluates its own well-being less positively than under normal circumstances. This is related to the strict measures for social contact.
- Quarantine measures and the resulting isolation lead to an increase in domestic violence, child abuse, child exploitation and neglect.
- There is also a stigma in potential and confirmed patients, as well as in healthcare workers, who, because of the risk of infection, have to remain in isolation from their relatives.
- Job insecurity and loss of income for workers can lead to psychological problems.

V RECOMMENDATIONS

To address these risks, the SHC makes the following recommendations:

In brief :

1. Align psychosocial care with phases of the pandemic. Be pro-active, not reactive. Adapt communicationstrategies whenever necessary.
2. Reinforce natural adaption processes by activating already existing resources in an individual and/or system.
3. Monitor psychosocial impact (up to at least 6 months after the pandemic to insure inclusion of delayed psychosocial responses).
4. Treat psychosocial dysfunctioning as soon as possible.
5. Offer high quality treatment. Provide training to ensure adequate ressources to respond to psychosocial dysfunctioning.
6. Install a monitoring/dispatchingssystem to ensure adequate dispatching, (impact)evaluation and follow-up.
7. Target persons/groups at risk.
8. Use familiar pathways or persons of trust to bring help to individuals.
9. Do not minimise the impact of quarantine, lockdown or fear of covid-19.
10. Breach social isolation and focus on facilitating feelings of social cohesion.

1) For authorities

- **The prevention, detection and treatment of mental health should be an important component within the approach to public health.** It is advisable to strategically tackle the psychosocial part of a pandemic as well. This in view of its impact both on the course of the pandemic (e.g. compliance guidelines) and on the mental health of the population.
- Be attentive to **communication** :
 - Confidence in information made available, in experts and authorities is likely to have a positive effect on recovery. Winning and maintaining the trust of those affected must therefore be a high priority for authorities.
 - There is a general need for clear, transparent and coordinated communication. Truthful communication should also be a priority within complexity and / or progressive insight. Conflicting reports and/or discussions about policy decisions taken, or the perception that is created about them, reinforce distress feelings within society. It is therefore crucial to communicate in a united and solid manner with due attention to specific communication challenges such as framing, stigma and discrimination. Media literacy and media preferences in the population should also be taken into account. In order to be able to reach as many people as possible in a uniform way, a variety of media should be used in the communication approach. A clear division of roles in the field of communication and tasks is required.
 - The media can play an important role, both positive and negative, in providing information on the consequences of a collective emergency. Much media attention for the dramatic aspects of a collective emergency can reinforce the increased compassion in society with victims but can also lead to an increase in fear.
 - Although social media do indeed offer a form of connection, they are also a source of (too) much, sometimes false, information and stress, especially for people who are on their own and are less able to communicate about this with others.

- **Active reinforcement of individual and collective resilience** : resilience plays a significant role in reducing the risk of toxic stress and associated health problems both in the general population and in specific target groups. Most of those affected regain their balance without the help of professional care providers.
 During the pandemic it must above all be possible to appeal to a sense of community, solidarity and voluntarism. Coercion and repression have perverse effects, both on mental health and on adherence to advice. Support and attention, recognition and respect have a protective effect. It is important to support families because they can provide an initial social buffer.
 The longer the pandemic lasts, the greater the risk of overburdening society. Attention to certain signs of this should be present in the monitoring. For example, an increase in domestic violence, stigmatisation of certain target groups, expressions of loneliness, etc. are important signals that must be picked up on and dealt with in a timely manner. The risk of possible secondary trauma increases.
- **Investing in social protection** : Commitment to return to work, job counselling and a social safety net are important health-enhancing investments during a recession, which at the same time will help revitalise the economy. If those affected receive no financial aid and reconstruction is difficult, this is not conducive to their recovery. From previous pandemics and recessions we can conclude that the return to work and work in general are important for the revival of society. Moreover, work is the most important factor in the prevention of mental health and other health problems. The SHC therefore advises investing in (re)training of employees and programmes that increase the chances of finding a job.
- **Efficient deployment of mental health care resources**. At the start of a pandemic, assessment and triage of psychological needs tailored to the currently available resources is required. It remains important to further facilitate the expansion and strengthening of psychosocial care. Psychological interventions must continue to be made available in a targeted and adapted manner. Certain groups deserve special attention because they are particularly vulnerable due to various factors. Low-threshold, step-by-step care should therefore be set up, including online help and initial psychological help by professionals in basic and first-line care whom people can look up themselves whenever they feel the need. It is crucial to ensure that the right balance is found between attention to psychological/psychiatric needs, without lapsing into a forced generalised offer of treatment (cf. resilience above).
- **Supporting care providers** : The care sector deserves specific attention with regard to the impact of the corona pandemic. People who are in the front line need to be closely monitored from the start in terms of stress, mental strain and avoidance behavior. It is advisable to limit the known stressors as much as possible. Preventive psychosocial support is also desirable. Care providers need correct information and clarity of role. Backup systems should be used, but above all physical and mental safety should be guaranteed. Within the healthcare sector, training and development must be fully deployed so that this crucial sector is prepared to act in crisis situations
- **Work on a well-considered and phased mourning process** for relatives of people who have died, service patients and care and support providers. In the first place, and from when this is medically possible, people should be given the opportunity to commemorate their loss with loved ones, and national recognition should be given to the special way in which people have said goodbye in these exceptional circumstances.

- In the period following a pandemic, society needs to prepare for a possible following/new pandemic in which, on the basis of the evaluation, improvements need to be made to the approach, policy and also training of professionals (if useful and relevant). It remains crucial to focus on individual and collective resilience. Psychosocial health is crucial within the health of a society and all possible tools for this should be mapped out. A coherent crisis prevention plan and plan of action for the next pandemic should be developed.
- In addition, attention must be paid to the uniqueness of the current pandemic and the working group calls for **these recommendations to be kept under review** in light of the changing situation.

2) For care providers

- Promotion of **natural recovery and self-reliance**. The way in which someone is able to assess their own ability to cope with the situation has a strong influence on further developments. An active approach to the problems protects against psychological complaints. Interventions should at all times lead to the activation of those affected.
- Care providers can be **alert to those in need of therapeutic treatment** and point the way there. A number of groups have an increased risk of long-term problems.
- The aim of interventions in the acute phase of a collective emergency is **to reduce stress complaints, ASD and the risk of PTSD**. Existing WHO, APA, NICE, ISTSS and NHMRC guidelines recommend trauma-focused cognitive behavioural therapy and EMDR as techniques for dealing with acute stress disorder. The NICE and WHO guidelines recommend that in this lockdown situation, in which face-to-face psychological counselling is impossible, other solutions such as online counselling or group interventions should be creatively sought. In China, experiments have already been carried out with the development of online psychological crisis care. By dealing with toxic stress reactions, the risk of problems at a later stage decreases. In addition, people are then more inclined to comply with the measures imposed to contain the virus.

The treatment of trauma experiences should be provided by trained and competent professional care providers who meet a certain profile (see Advice SHC 9403).

- Particular **attention should be paid to traumatic loss experiences** as a mental challenge that many will face in this pandemic. Only a minority of the bereaved seek professional help. It is, however, recommended in the case of complicated mourning; when a person experiences intense mourning reactions during six months that are accompanied by serious problems in everyday functioning. Examples are an intense and disruptive longing for the deceased, difficulty in accepting the loss and the feeling that life is empty and meaningless.

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With this list of references we also refer to the overview in excel in the appendix where you will find the other sources used as guidelines already published.

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VII COMPOSITION OF THE WORKING GROUP

The composition of the Committee and that of the Board as well as the list of experts appointed by Royal Decree are available on the following website: [About us](#).

All experts joined the working group ***in a private capacity***. Their general declarations of interests as well as those of the members of the Committee and the Board can be viewed on the SHC website (site: [conflicts of interest](#)).

The following experts were involved in drawing up and endorsing this advisory report. The working group was chaired by **Elke VAN HOOF**; the scientific secretary was Sylvie GERARD.

BAL Sarah	Clinical psychology	UGent
BLAVIER Adélaïde	Clinical psychology	ULG
CALMEYN Marc	Psychiatry, psychotherapy	PZ Onze-Lieve-Vrouw-College
DE SOIR Erik	Crisis psychology	KMS, KHID, VHYP
GODDERIS Lode	Occupational medicine	KULeuven
MOMMEREENCY Gijs	Clinical psychology	UZ Gent
VAN DEN CRUYCE Nele	Social sciences	VUB
VAN HOOF Elke	Clinical psychology	VUB
VANDAMME Annemie (Anne-Mieke)	Virology, epidemiology	Rega Instituut (KU Leuven)

The following administrations and/or ministerial cabinets were heard:

FORTUIN Astrid Psychosocial Manager FPS Public Health

This advisory report was translated by an external translation agency.

VIII APPENDIXES

Appendix 1*: Project form

Proposition de projet d'avis : Prise en charge psychosociale dans le cadre de la crise Covid-19

La crise du Covid-19, ainsi que les mesures de confinement prises pour y faire face, ont créé de nombreux besoins en santé mentale. Il est en effet non seulement important d'assurer la continuité des soins pour les personnes qui en besoin, mais il faut également faire face à de nouvelles demandes issues de la crise en elle-même, des mesures prises (confinement) et des conséquences économiques et sociales de celles-ci ; et ce tant au niveau de la population générale, que de groupes cibles particuliers comme les professionnels de la santé.

Le secteur de la santé mentale s'organise pour faire face à cette crise et un certain nombre d'initiatives sont déjà menées pour répondre à ces besoins, tant par le secteur lui-même sur le terrain que par les autorités régionales et fédérales. Il est cependant nécessaire de renforcer les collaborations et la concertation afin de mener ces actions de manière uniforme et d'être complet dans la réponse donnée. Ainsi, il est nécessaire d'avoir un plan de crise avec des accords de collaboration entre secteurs et en tenant compte de l'impact des mesures prises dans un secteur sur les autres ; à la fois au niveau opérationnel (entre les secteurs et leurs réseaux et institutions dans une région donnée) et au niveau politique (entre les secteurs de compétence fédérale tels que les soins de santé et les secteurs de compétence régionale tels que l'aide à la jeunesse, les soins aux personnes handicapées, à l'enfance et à la famille, les PMS...).

Un soutien scientifique est nécessaire pour élaborer ce plan de crise, s'assurer de la pertinence des mesures prises en urgence et préparer les réponses à apporter à moyen et long terme. Les besoins en santé mentale directement liés à cette crise seront en effet encore présents longtemps, et il est important de réfléchir dès maintenant à la manière de gérer ces aspects psychosociaux à plus long terme. En collaboration avec le SPF Santé publique, le CSS désire donc élaborer un avis qui vise, sur des bases scientifiques, à déterminer quels seront les besoins en terme de prise en charge psychosociale et les moyens d'action à moyen et long terme à mettre en place ; ainsi que de s'assurer que les mesures actuellement prises sont appropriées.

Il s'agira d'établir une base scientifique, puis de réfléchir aux mesures réalisables en Belgique et de hiérarchiser les priorités.

Pour cela, le CSS pourra notamment s'appuyer sur les recommandations récemment publiées par l'OMS pour la prise en compte des besoins de santé mentale durant la crise et sur un article (Brooks et al., 2020) qui a récemment fait un état des lieux des risques psychosociaux liés au confinement et des mesures recommandées pour y faire face.

Implications du projet pour la santé publique

Plusieurs problématiques de santé publique ont été identifiées concernant la santé mentale, dans le cadre du covid-19 :

- Nécessité de soutenir les professionnels de la santé et ainsi s'assurer de l'opérationnalité durable du personnel soignant et médical dans les hôpitaux, les centres psychiatriques et les maisons de repos.
- Assurer la continuité des soins, notamment pour les patients les plus vulnérables (dépression, trauma, troubles chroniques, tendances suicidaires, dépendances...), les enfants et adolescents en situation de crise (avec une attention particulière pour les jeunes placés dans le cadre de l'aide à la jeunesse et les âges de transition), les personnes marginalisées et isolées.
- Réduire les effets nuisibles du confinement (effets sur la santé mentale, difficultés liées au télétravail imposé, isolement des personnes en centres ou structures d'aide, soutien aux proches aidants, ...)

Appendix 2: PRISMA Flow Diagram

First PRISMA Flow Diagram

Ongoing: extra contributions from working group + snowball method

Search terminology

(title and abstract search, “and”, “mesh”)

original search terminology search Cochrane and Pubmed

Psychological distress / Emotional distress

Anxiety / anxiety disorder

PTSD

Trauma

Coping mechanisms/ Dealing with / coping with

Outbreaks

Epidemic

COVID19

MERS

SARS

Flue

Ebola

Disasters

Terror

war

Inclusion criteria

Article or guideline (published, preference for reviews)

Timing: 2000 - 2020

English/French

Exclusion criteria

Non psychosocial impact / focus

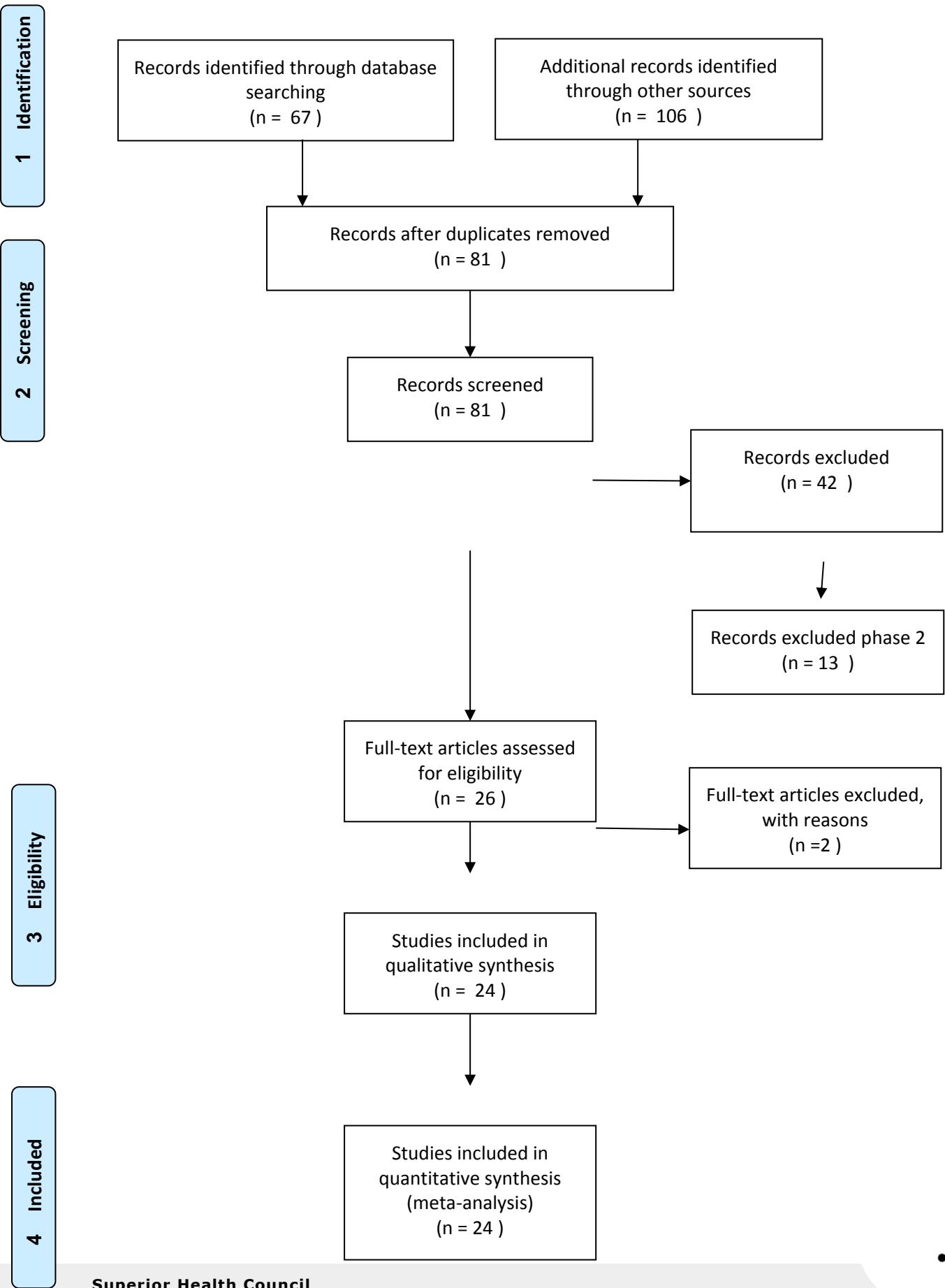
Non trauma related (single or chronic incident)

Fase2 Single incidents

Expert opinion or articles without reference to research/statistics

Ebola - unless regarding foreign helpers

Scale of research limited to local event/specific culture



Second PRISMA flow diagram

Ongoing: extra contributions from working group + snowball method

Search terminology

(title and abstract search, “and”, “mesh”)

Search terms search in Cochrane and Pubmed

Mental health disorder

Depression

Mourning/grief/bereavement

children/youth/elderly

Psychological Resilience

Community resilience

Individual resilience

Inclusion criteria

Article or guideline (published, preference for reviews)

Timing: 2000 - 2020

English/French

Exclusion criteria

Non psychosocial impact / focus

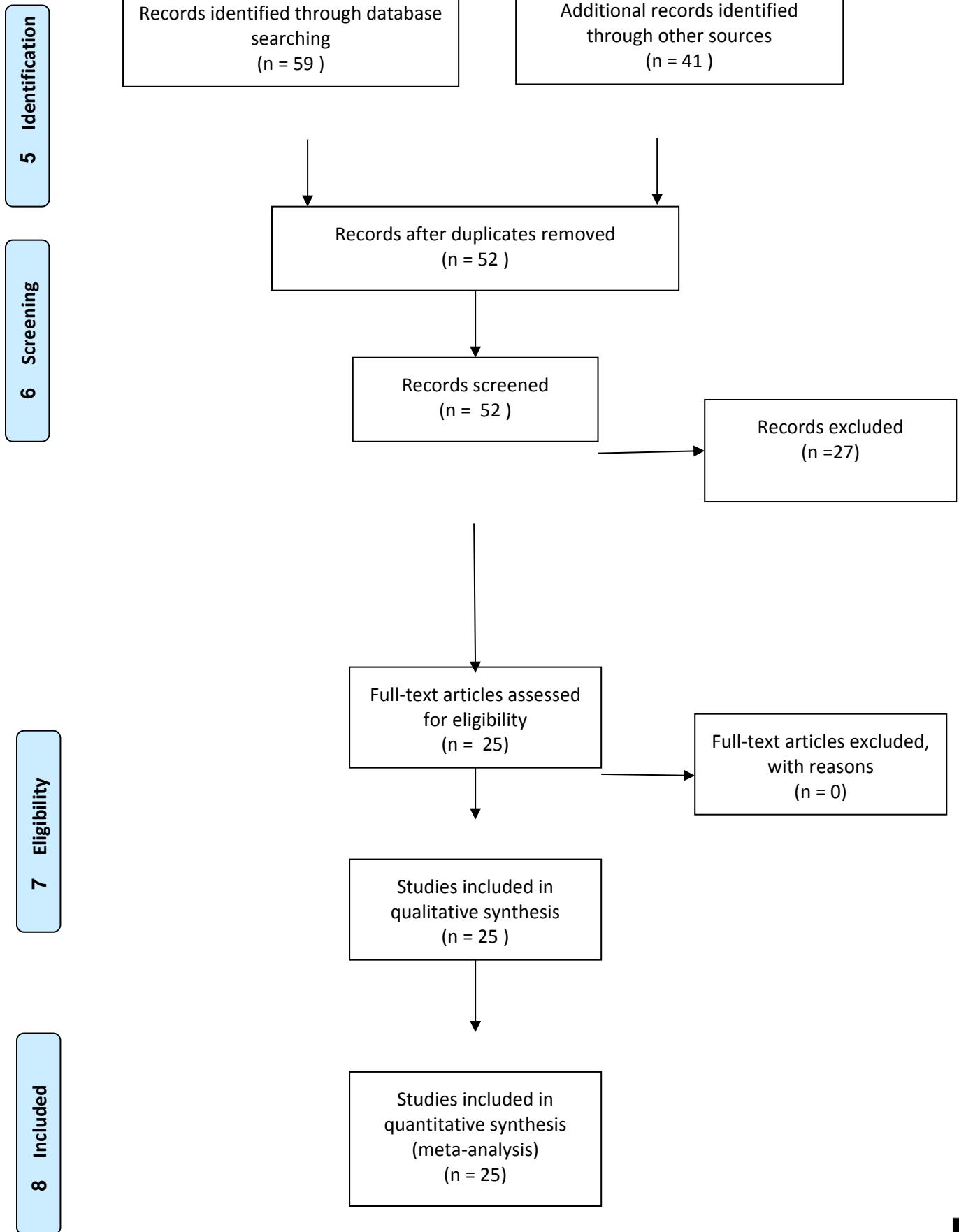
Non trauma related (single or chronic incident)

Single incidents

Expert opinion or articles without reference to research/statistics

Ebola - unless regarding foreign helpers

Scale of research limited to local event/specific culture



Schematization in Excel by type of prevention and stage in pandemic

Meta analysis of literature can be found in Excel file

Sheet 1 : articles

Sheet 2 : guidelines

Sheet 3 : previous advice national health council

Sheet 4 : references (referred to by line number)

Appendix 3: trauma care quality criteria

Opleiding van de betrokken professionele hulpverleners

Eerstehulpverleners

De personen die direct na of tijdens een traumatógene gebeurtenis of episode optreden, in steun van zorgverleners of first responders, hoeven niet noodzakelijk psychologen te zijn, maar moeten wel een gepaste opleiding in Eerste Psychologische Zorgen bij Ongevallen (EPsyHBO) hebben gehad. Een aantal van hen zijn onmiddellijk beschikbaar binnen de netwerken of teams voor collegiale hulpverlening zoals die bestaan binnen de brandweer, de politie, de ziekenhuizen, enz. De EPsyHBO bij acuut getroffenen hoeft niet meteen van psychotherapeutische aard zijn. Als de hulpverlener ter plaatse is en in de veronderstelling dat hij niet zelf getraumatiseerd of emotioneel uit evenwicht is door de impact van de gebeurtenissen, moet hij/zij in de eerste plaats oog te hebben voor de praktische en concrete problemen van getroffenen en een kader helpen scheppen waarbinnen crisisopvang mogelijk wordt.

Deze hulpverleners moeten echter opgeleid zijn om psychosociale steun te verlenen in crisissituaties. Daarom zou een opleiding voor EPsyHBO hoog op de agenda moeten staan voor het ondersteunend personeel van ziekenhuizen en woonzorgcentra.

Het is ook belangrijk dat de hulpverleners die in de eerste lijn optreden een opleiding krijgen om hen te behoeden voor psychologische letsen. Volgens de aanbevelingen van de AEPSP is het daarom cruciaal om in de opleidingen van deze hulpverleners te focussen op preventie van professionele stress en hun vermogen aan te scherpen om emotionele, psychologische en lichamelijke symptomen na de confrontatie met schokkende gebeurtenissen en de symptomen posttraumatische stress/dissociatie te herkennen.

Huisartsen en eerstelijnszorg

De expertise in de eerstelijnszorg (huisartsen, eerstelijnspsychologen en bijvoorbeeld de Centra voor *Algemeen Welzijnswerk* (CAW) in Vlaanderen of Centra Geestelijke Gezondheidszorg (CGG), alsook andere professionele hulpverleners zoals kinesitherapeuten of ergotherapeuten) moet worden vergroot om enerzijds tijdens de weken na de gebeurtenis proactief hulp en begeleiding bij het herstelproces te kunnen bieden en anderzijds vast te stellen wanneer het nodig is om iemand door te verwijzen naar gespecialiseerde zorg. Aangezien de persoon autonoom en vrij zijn therapeut kan kiezen, is het immers mogelijk dat hij zich tot zijn huisarts wendt en dat die, als hij niet voldoende op de hoogte is van de specifieke kenmerken van traumabehandeling, misschien ongeschikte behandelingen zal toepassen (overdreven zware geneesmiddelenbehandelingen, nadelig ziekteverlof).

Het is meer bepaald belangrijk dat huisartsen een betere opleiding over de symptomen van dysfunctionele stress, PTSS, verstoerde rouw en burnout alsook over de mogelijkheden voor behandeling uiteg krijgen. Uit de studie over de ramp van Gellingen (2006) was al gebleken dat de symptomen van deze stoornis vaak apart werden aangepakt en behandeld door de huisarts in plaats van als één geheel (Versporten et al., 2006). Dit rapport raadde aan om “artsen bewust te maken van de mogelijke impact van collectieve noodsituaties en rampen op de lichamelijke en geestelijke gezondheid. Zo zouden ze alert kunnen zijn op traumagerelateerde symptomen, pathologische situaties kunnen opsporen en kunnen doorverwijzen naar professionele hulpverleners - psychologen of psychiaters die opgeleid zijn voor interventies in verband met posttraumatische letsels”. Voorts stelde het rapport dat “de artsen moeten kunnen beschikken over informatie in verband met de mogelijke impact van een dergelijke ramp op de geestelijke gezondheid en op het daarmee gepaard gaande gedrag. Ze moeten weten dat deze schadelijke effecten zelfs op lange termijn kunnen optreden. Het is nodig zich te buigen over de te nemen maatregelen om de huisartsen te ondersteunen (cursussen, spreekbeurten, brochures enz.)”.

Therapeuten voor psychologisch trauma

Voor gespecialiseerde zorg bestaat in België momenteel geen officieel erkende opleiding voor de behandelaars van psychologisch trauma. Deze situatie geeft aanleiding tot een wildgroei aan diverse beproefde en minder of niet beproefde therapiemethodes. De KUL^{101[1]} organiseert als enige universitaire instelling een postgraduate opleiding van twee jaar. In de lijn met de gangbare toelatingsvoorwaarden voor postgraduaat psychotherapie opleidingen (aan de KU Leuven) wordt de kandidaatstelling voor deze opleiding beperkt tot houders van de volgende diploma's: Master in de psychologie (met afstudeerrichting klinische psychologie en minstens zes maanden stage hebben gevolgd), Master in de pedagogische wetenschappen (die de afstudeerrichting orthopedagogiek en minstens zes maanden stage hebben gevolgd) of Arts/Master in de geneeskunde (en tevens psychiater of psychiater in opleiding, vanaf het derde jaar). De VUB organiseert i.s.m. BIP (Belgisch Instituut voor Psychotraumatologie) een postacademische opleiding in psychotraumatologie. De ULB^{102[2]} en de UMons^{103[3]} organiseren een interuniversitair getuigschrift in victimologie en Psychotraumatologie, dat gericht is op een breed publiek. Tot slot beschikt de ULg^{104[4]} in de faculteit Psychologie over een universitaire dienst die specifiek gespecialiseerd is in psychologisch trauma en dit onderwerp doceert aan de studenten van de master klinische psychologie. Er bestaat ook een interuniversitair getuigschrift in klinische victimologie aan de ULg, maar dat is evenmin specifiek gericht op klinische psychotraumatologie en focust meer op de psychocriminologische en de wettelijke benadering, zodat het meer onder de criminologie dan onder de klinische behandeling van slachtoffers valt. De andere bestaande opleidingen in het domein van de psychotraumatologie situeert zich in de commerciële sector, mikt doorgaans op een breed publiek en is niet gebonden aan de gangbare kwaliteitsvereisten voor hogescholen en universiteiten.

^{101[1]} Katholieke Universiteit Leuven

^{102[2]} Université Libre de Bruxelles

^{103[3]} Université de Mons

^{104[4]} Université de Liège

De behandeling van de personen moet echter absoluut gebeuren door opgeleide en competente professionele hulpverleners. Het is immers belangrijk om hen te beschermen tegen personen zonder opleiding die willen helpen, maar ook tegen personen die voordeel willen halen uit de situatie. Daarom zou het goed zijn als er een lijst zou bestaan van bevoegde professionele hulpverleners of structuren bij wie/waar personen die hulp nodig hebben, terecht kunnen. De autonomie van personen, de relatie tussen de therapeut en zijn patiënt en de therapeutische alliantie die daaruit volgt, mag echter niet uit het oog worden verloren. Uit deze elementen volgt dat die bevoegdheid vooral ter informatie wordt meegedeeld en de keuzevrijheid van de patiënten niet mag beperken. Een andere aanbeveling is de kwaliteit van zorg en de patiënttevredenheid in kaart te brengen. Dit kan via het reeds vermelde registratiesysteem (zie punt 2.2).

Met het oog op accreditering van de professionele hulpverleners die een traumaopleiding hebben gevolgd heeft de NtVP (*Nederlandstalige Vereniging voor Psychotrauma*) een advies opgesteld over de certificering van therapeuten in psychologisch trauma. Dat bevat een omschrijving van het competentieprofiel van de gezondheidswerker en van de opleidingseisen.

Volgens het rapport van deze werkgroep moet een therapeut in psychologisch trauma

- *een basisopleiding van klinisch psycholoog, orthopedagoog, seksuoloog of psychiater hebben;*
- *minimaal twee jaar ervaring in de behandeling van traumagerelateerde stoornissen en/ of minimaal tien patiënten met traumagerelateerde stoornissen kunnen voorleggen;*
- *minimaal zes opleidingssessies in erkende opleidingsinstellingen hebben gevolgd en minimaal vijftien uur supervisie hebben uitgevoerd;*
- *kunnen bewijzen te beschikken over de competenties in het competentieprofiel.*

Volgens dit competentieprofiel omvat het expertisedomein van de traumatherapeut het psychodiagnostische onderzoek, het beoordelen van de resultaten daarvan en het toepassen van *evidence based* psychologische behandelmethodes (bijvoorbeeld zoals vermeld in de *Guidelines for Trauma Treatment* van de *International Society for Traumatic Stress Studies*) om de gezondheidstoestand na een traumatische gebeurtenis te herstellen. Deze taken vereisen enerzijds specifieke competenties (in verband met de psychologische diagnose, de indicatie en de behandeling) en anderzijds algemene professionele competenties (persoonlijke ontwikkeling, kennis van het netwerk, kennis van de richtlijnen, oog hebben voor diversiteit enz.).

In bijlage het volledige eisenpakket van psychologen en psychiaters in Nederland die een erkenning als psychotraumatoloog willen bekomen van de Nederlandstalige Vereniging voor Psychotrauma (op basis van een brede consensus tussen alle betrokken beroepsorganisaties).

De HGR raadt aan om dit competentieprofiel als basis te gebruiken voor het vastleggen van voorwaarden voor goedkeuring en erkenning van de professionele hulpverleners die bevoegd zijn om trauma's te behandelen. Deze erkenning kan uitgaan van de coördinatiestructuur, met steun van het comité van experts. Gezien de noodwendigheden beveelt de werkgroep nochtans aan om de groep van psychotrauma therapeuten uit te breiden naar

psychotherapeuten met een langdurige psychotherapie opleiding én een opleiding in minstens twee verschillende vormen van evidence-based behandeltechnieken, met minstens een basisdiploma van bachelor in de humane wetenschappen.

Erkenning als psychotraumatoloog - Nederlandstalige Vereniging voor Psychotrauma

Deskundigheid

De deskundigheid van de NtVP-psychotraumatherapeut omvat algemene kennis over psychotrauma, het verrichten van psychodiagnostisch onderzoek, het beoordelen van de resultaten daarvan en het toepassen van psychologische behandelingsmethoden ten aanzien van een persoon met het oog op diens gezondheidstoestand na het meemaken van een of meerdere traumatische gebeurtenissen. Daarnaast heeft hij/zij recente werkervaring in het behandelen van cliënten met psychotrauma en daaraan gerelateerde stoornissen. De Psychotraumatherapeut voldoet aan de vooropleidingseisen met een registratie als gezondheidspsycholoog, psychotherapeut, klinisch psycholoog of psychiater.

In het competentieprofiel zijn in hoofdlijnen de volgende eisen opgenomen:

Psychodiagnostiek

De Psychotraumatherapeut NtVP is in staat om normale van verstoerde verwerkingsreacties te onderscheiden.

De Psychotraumatherapeut NtVP heeft kennis van:

- o de kenmerken van uiteenlopende traumatische ervaringen;
- o de mogelijke gevolgen en de uitingsvormen van de traumatische ervaringen
- o de mogelijke samenhang van posttraumatische klachten met andere problematiek op de DSM5 asl en/of asII én de rol van culturele, sociale, leeftijd- en genderaspecten;
- o de invloed van cognitieve- en geheugenprocessen op en na traumatische ervaringen en de verstoring van het gevoel van veiligheid op de klachtpresentatie.

Hij besteedt in het diagnostisch proces specifiek aandacht aan het inschatten van de gevolgen voor systeem, werk en omgeving en de wisselwerking tussen trauma en deze gebieden en het inschatten van de risico- en beschermingsfactoren; vraagt tijdens het diagnostische proces met voldoende rust, empathie en begrenzing naar traumatische ervaringen en traumagerelateerde klachten en gaat professioneel om met mogelijke reacties; is in staat om een gevalideerde vragenlijst en een klinisch interview met betrekking tot de diagnostiek van psychotraumaklachten te hanteren; besteedt expliciet aandacht aan de comorbiditeit van PTSS (zoals depressie, overige angststoornissen, dissociatieve stoornissen, verslaving, lichamelijk onverklaarde klachten, persoonlijkheidsstoornissen), differentiaaldiagnose en de interactie met lichamelijke stoornissen.

Indicatiestelling

De Psychotraumatherapeut NtVP is in staat om een diagnose te stellen, een onderbouwde indicatie voor behandeling te stellen en een behandelingsplan op te stellen.

De Psychotraumatherapeut NtVP heeft overzicht over beschikbare specifieke psychologische behandelingsmethoden voor traumagerelateerde stoornissen, alsmede over andere vormen

van behandeling, waaronder psychofarmaceutische behandeling; is in staat om in te schatten welke problematiek prioriteit heeft in de behandeling en welke plaats een op verwerking gerichte behandeling inneemt; is op de hoogte van de bestaande evidence en clinical based richtlijnen voor het behandelen van PTSS; geeft uitleg over de behandel mogelijkheden, de te verwachte effecten, resultaten, risico's en bijwerkingen van een behandeling; maakt met de cliënt en/ of het systeem afspraken ter voorbereiding op de behandeling en, indien nodig, om ontregeling te voorkomen; heeft kennis van de sociale kaart met betrekking tot psychotraumazorg en is staat om deze instellingen te consulteren en, indien nodig, cliënten te verwijzen (bijvoorbeeld in crisissituaties of als de cliënt medicatie nodig heeft); heeft oog voor de diversiteit aan doelgroepen (vluchtelingen, beroepsgerelateerde problematiek, slachtoffers huiselijk geweld, etc.).

Behandeling

De Psychotraumatherapeut NtVP voert traumagerichte behandelingen op professionele wijze uit.

De Psychotraumatherapeut NtVP: is in staat om betrokkenen te informeren over normale en verstoerde verwerkingsreacties na een traumatische gebeurtenis door: uitleg te geven over de mogelijke relatie tussen de traumatische gebeurtenis en de symptomen (psycho-educatie); praktische adviezen te geven om minder last te hebben van symptomen; te motiveren voor een traumagerichte behandeling; stabiliserende technieken toe te passen interventies met betrekking tot terugvalpreventie uit te voeren.

Hij beheert tenminste twee methoden van evidence based therapie met betrekking tot traumagerelateerde stoornissen op een gevorderd niveau en is daarbij in staat in te schatten wanneer een bepaalde traumagerichte behandeling geïndiceerd is of de voorkeur verdient en is in staat om argumenteerd af te wijken van het standaardprotocol indien onvoldoende vooruitgang wordt geboekt of te verwijzen naar een meer geëigende behandeling, die men zelf niet kan bieden.

Ethische en morele kwesties

De Psychotraumatherapeut NtVP is bekend met morele en ethische dilemma's (zoals het "false memory" fenomeen, illegaliteit bij asielzoekers, sociale marginalisatie van trauma slachtoffers (b.v. veteranen, vluchtelingen), culturele fenomenen m.b.t. opvoeding, eerwraak, daderschap, etc.), en weet hiermee zowel in het diagnostische proces als in het behandelproces op een vakkundige manier mee om te gaan.

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