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Research Article

TranSMuteiting: Programme for Prevention of Mental Disease in the Bereaved Person

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Abstract

Context: In their lifetime, human beings experience different grieving episodes, which may be facilitated or hindered intrinsic or extrinsic factors. The Mental Health and Psychiatry Specialist Nurse (MHPSN) can play a decisive role in the monitoring of the bereaved by boosting factors that facilitate the process and minimizing risk factors for Prolonged Grief Disorder (PGD). This support can encourage adaptive grieving processes, reducing associated morbidities and resulting in health gains.

Objective: To reflect on the identification of Prolonged Grief Disorder in the bereaved, in a Primary Health Care context, as a setting for the promotion of mental health, and to develop a mental health intervention programme (TransSMutar) anchored in the Disease Prevention Model with a focus on promoting strategies that enhance adaptive grief.

Methodology: Bibliographic research was used, as well as reflection on empirical experience within a practical context.

Results: The establishment of the TranSMuteiting programme contributes to the goals established by the WHO (2013/2030) and reinforces the importance of an evidence-centered practice.

Conclusion: In the context of Primary Care, the development of selective responses is essential, and the role of the Mental Health and Psychiatry Specialist Nurse is crucial. The MHPSN's interventions with the bereaved, through structured support, could pave the way for the development of necessary and relevant area of intervention, which is still at an early stage in a community context.

Keywords: *Grief; Mental Health; Health Promotion; Nursing Interventions*

Theoretical Reference

Different forms of loss which are not always expressed verbally surround human suffering [1]. Loss, an integral part of life, is a construct of grief, the characteristic reaction to a real or symbolic significant loss, which implies an adaptive response with somatic, affective, cognitive, behavioral and spiritual reactions that characterize the grieving process [1]. The term grief is therefore used to indicate a variety of psychological processes, brought about by the loss of a loved one, whatever the results [4]. The experience of loss can trigger behaviours that respond to the multifactorial effect it causes on the person and this is called the grieving process [18].

The grieving process allows for the transformation of the experience so that what is essential can be internalized and the griever to move on [19]. Grief as a process involves several phases that can last from weeks to months, or even years, and involves carrying out adaptive tasks. The literature points to a diversity of grief models that present the work associated with grief in a view of phases, tasks, processes, components, orientation, axes and stages. Within that diversity there is a standardized view of an evolutionary path.

Prolonged Grief Disorder (PGD) arises when a person experiences a prolonged disorganization that prevents them from resuming activities with the same quality that preceded the loss [9,14,21]. Manifestations of PGD are, according to Worden [21]: expression of intense feeling that persists long after the loss; somatizations, radical changes in lifestyle that lead to isolation; depressive episodes, low self-esteem, and self-destructive impulses.

The relevance of PGD led the World Health Organization (WHO) to include PGD in the International Classification of Diseases. Prolonged grief is classified in chapter 6, code QE62, of the international classification of diseases (ICD-11). Within PGD, we can find several sub-types of grief that can be grouped into: traumatic grief (unexpected loss); inhibited grief (delayed, postponed, frozen); chronic grief (dependent); exaggerated mourning; unspeakable mourning (deprived of rights, removed) [2].

The following criteria are required for a PGD diagnosis [14]: chronic and persistent longing, yearning and longing for the deceased (which cannot be satisfied by others); the person must present four of the following aspects intensely, several times a day: difficulty in accepting death; inability to trust others; excessive bitterness or anger related to the death; difficulty moving on; numbness/detachment; feeling of empty and meaningless life without the loved one; bleak future; agitation. These symptoms must last for at least six months and be a disorder that causes significant clinical impairment in social, occupational, or other important areas of functioning.

In a community context grief cuts across all areas of intervention, although there is clearer evidence in mental health [14]. In a practical context, experience suggests a high prevalence of bereaved persons that have been prescribed anxiolytics and benzodiazepines. From this, it is clear that an approach to the bereaved person that seeks to promote mental health is crucial in the community. Standard 03/2019 of the Portuguese Directorate General for Health [8] reaffirms the requirement of a structured response to the bereaved on behalf of the NHS, in an attempt to disseminate good practices and guarantee patient safety, and to pay special attention to bereaved people deemed to be at risk of developing Prolonged Grief Disorder.

The literature [1,9,14,21] indicates that between 10% and 20% of bereaved people experience maladaptive grief. It also shows an increase in mortality and morbidity after bereavement [1,2,13], with increases in accidents, cardiovascular diseases, infectious diseases and suicide, as well as increases in the consumption of alcohol, tobacco, tranquilizers and hypnotics and in extreme cases, psychiatric disorders [15]. Although the literature suggests that the bereaved person can progress to the resolution of the bereavement between 6 to 12 months, there is evidence of an increase in mortality and morbidity after bereavement and that at least 30% of bereaved people experience prolonged bereavement and need support in the field of mental health [8,12,15].

According to Stakes [16] the determinants of mental health are factors associated with different aspects of health and can be both causes of mental health status or its consequences. These can be considered as: improvement factors, which increase people's positive mental health resources; supportive factors, which help people strengthen their resilience in the face of adversity and protective factors, which decrease the likelihood of developing a mental disorder. The determinants of mental health can be grouped into four domains: individual factors and experiences, social interactions, social structures and resources and cultural values.

In the literature [1,5,8,18], the following are identified as protective factors for PGD: the existence of a secure attachment, due to the ability to better organize and integrate (new) information; the quality of the bond, a relationship without conflicts and without pending issues; the performance of rituals, important for the separation and farewell process; helps to close the cycle; type of death, death

from chronic illness without suffering, in which there is the possibility of saying goodbye to the loved one and resolving pending issues; grief recognized by the bereaved and society, values one's own pain and the pain of the other, is empathetic, allows the person to live the grieving process, sometimes guided by loss, sometimes towards recovery [5,17], keeping a healthy bond, without necessarily having a definitive breakup and resilience, as an expression of action after the death of a loved one, the ability to be resilient and create possible alternatives.

PGD risk factors are grouped into personal, interpersonal, and circumstantial [1,5,8,18]. The following personal risk factors are identified:

i) The female gender;

ii) Elderly group;

iii) Young age of the deceased;

iv) Psychiatric history, including suicidal ideation and/or previous suicide attempts and substance use;

v) Previous significant losses that continue to generate significant grief symptoms;

vi) Insecure attachment style, translated into an attitude of hypervigilance, lack of trust in interpersonal relationships, hostility and concern related to the lack of availability of the other in case of need;

vii) Immature defensive styles, such as denial and distortion of external reality, as well as avoidant and ruminative coping strategies;

viii) Intense reactions of anger and guilt;

ix) Neuroticism, which includes manifestations of depression, hostility, and anxiety;

x) Inability to make sense of the loss.

Interpersonal risk factors:

i. Loss of a child and loss of a spouse;

ii. Co-dependent, conflictual, and ambivalent relationship;

iii. Distress, caused by unresolved issues;

iv. Lack of family support;

v. Family dysfunction.

In the circumstantial risk factors are included:

i. Sudden and violent death, catastrophic situations involving multiple losses;

ii. Lack of preparation for death, related to insufficient communication;

iii. The deteriorating state of the patient;

iv. The perception of medical malpractice;

v. Increased difficulty in providing care related to the intensity of care, the patient's problematic behavior and the presence of minors in the family;

vi. Secondary losses, including economic and professional difficulties.

Using Braz and Franco [5], risk and protection factors must be aligned and understood from their context, culture, personality, from the function and meaning that the individual narrates to himself about such an event, and that therefore can change according to identified variables, that is, the same factor can be considered risk or protection.

In Order nº 3254/2018, D.R., II, of March 29th, it is explained that the needs of people bereaved by significant losses, of which the loss of children or other close family members is a paradigmatic example, but also of losses in the context of natural disasters, require the National Health Service to pay specific attention to these bereaved people, who constitute risk groups for the development of physical and mental complications, in about 10% to 30% of cases, representing a loss of quality of life for themselves, for their families and for society.

TranSMuteiting reflects the need to promote mental health in the bereaved person, following the guidelines of DGS standard 003/2019. Thus, TranSMuteiting intends to develop strategies to promote adaptive grief, responding to the goals of the Nacional Mental Health Program [7] and the guidelines of the WHO [20], in a community logic (Primary Care context) with a focus on prevention.

Aim of the Study

This article aims to present the design of a mental health intervention program (TransSMutar) anchored in the Disease Prevention Model with a focus on promoting strategies that enhance adaptive grief.

Methodology

The TransSMutar programme is based on the cognitive theory that proposes that thoughts, emotions and behaviors are not influenced by the situation itself, but by the way people perceive and process reality [3], as well as the integrative-relational model developed by Alba Payas Puigarnau [15]. This author considers that grief is a dynamic process over time, which is characterized by a sequence of steps with specific characteristics and functions, where the function of the process is to deal with the impact of the loss and adapt yourself to a new situation. The program consists of psychotherapeutic interventions aimed at a better understanding of the grieving process, thereby enabling the person to develop new human responses to identified life problems or to new problems that emerge throughout the life cycle, increasing the feeling of well-being.

Objective: To enable the bereaved person at risk of PGD to experience adaptive grief through a structured psychotherapeutic intervention that enhances gains in mental health.

Intervention: The TransSMutar Project is a selective intervention, with the objective of preventing the disease from causing problems or disorders, evaluated according to the levels of risk exposure (universal, selective and indicated) [10]. A selective support is provided through resources available in the local community and through different levels of health care - primary health care, hospital care and integrated continuing care. Interventions are standardized using good practice measures to prevent PGD in two moments: end-of-life and after-death process. This project relies on community partners to disseminate it to the target population. In addition to this, it relies on the use of strategies to raise awareness of the issue, dissemination of information, and campaigns to raise awareness of the program in the community, ensuring the greatest possible access to bereaved people at risk of PGD.

Target population: Bereaved people at moderate risk of PGD, with intermediate support needs (with mild or moderate symptoms of grief-related distress or at risk of developing PGD) and who should receive qualified but undifferentiated support provided by MHPSN with qualified training in grief.

Results and Discussion

Expected outcomes

The program consists of 6 psychotherapeutic sessions following the key themes of the Grief process of the Puigarnau model [15]: Dazzle and shock; Avoidance and denial; Connection and integration; Growth and transformation (Table 1). The intervention includes the application of the Grief Risk Assessment scale at the beginning and end of the intervention.

TranSMuteiting Programme				
Session		**Content**	**Objective**	**Resources**
TransMuteiting Initial	Session 0 Introduction	Presentation of the proposed programme to be carried out. Grief experience.	Identify the context of loss Apply the PGD scale	Images PGD Scale
Transfer	Session 1 Grieving Process - Dazzle and shock: Task -facing the trauma	The grieving process and the recognition of awe and shock responses	Revisit the history of loss Narrating the experience of loss and progress since the loss Legitimize the need to express emotional symptoms Explore current needs	Life's history Narrative of loss Expression of loss in an artistic way
Transform	Session 2 Grieving Process - Avoidance and denial: Task -Work the defensive system	Recognition of the impact of loss Identification/recognition of avoidance and denial	Identify the unstable functions of the self, Identify past losses that have not been explored Identify the support network Identify the defense/avoidance system	Building a network where the support network/ community support services can be visualized
Connect	Session 3 Connection/Integration: Task - to elaborate aspects related to the loss	Dialogue with memories associated with the loss (emotions and emotional states), as well as internal representations Promotion of loss connection strategies	Facilitate the full expression of emotions Point out and underline the interpretations and meanings of loss and the relationship with the loss Identify tasks	Building a memory book with photographs and/or significant objects
Trans-mute	Session 4 Growth and Transformation: Task -to experience integration and new paths	Restructuring meanings Integration of loss into life history Reconstruction of the system of values and beliefs	Identify strategies for experiencing loss without suffering Rewriting life history with a view to the future	Narrative of loss with the future as a background
TranSMute Final	Session 5 Evaluation	Recognition of the route taken Application of the PGD scale	Identify developed capabilities Apply the PGD scale	Illustrative path of the journey taken Scale

Table 1: *TraSMuteiting program structure.*

The TransMuteiting Project hopes to generate health gains measured through direct evaluation indicators. One such indicator is a target 50% participation rate by the bereaved; as well as a project completion rate of 60%. The program intends to achieve a 2 point reduction in the Grief Risk Assessment Instrument Score as a target. It is expected that the implementation of the TransMuteiting Project generates health gains, contributing to goals established by the DGS [7] and WHO [20]. The evaluation of the psychotherapeutic program will be carried out through the impact described by the users, after the end of the program.

It is possible that a high index of the PGD scale and associated symptoms may persist due to participation in the program, driven by a high degree of vulnerability in the bereaved. Articulation of the program with specialized services can be a fundamental tool for the resolution of this eventual difficulty.

Conclusions and Implications for Practice

The implications for nursing practice of the project have to do with the realization of the MHPSN's perspective on bereavement intervention and the integration of this perspective in the community. Effectively, the operationalization work of the program opens the way for structured intervention in this setting, an aspect that, now, in particular, dominates the agenda with the progression of the pandemic and the increased number of losses due to death that were not followed or for which customary rituals were carried, thereby increasing the relevance of the application of the TranSMuteiting project. In the project, the relevance of the MHPSN is evidenced in the search for strategies to promote mental health and materialized in the reasoning underlying the elaboration and execution of the project.

Understanding the determinants of health, with the vision that the MHPSN requires before making a decision, implies a deepening of the areas of care to be evaluated. In the metaparadigmatic framework of nursing the person is central, (in this instance the bereaved person as an intentional agent of their health path) and must be considered in three types of processes: intentional (decision mechanisms intentionally taken by the person and associated with factors in the cognitive domain); unintentional (factors not intentionally controllable by people), and interaction with the environment (closely linked to the context that influences intentional processes, but the control goes beyond the person's individual capacity)[(11)] determinants of health for the bereaved person are closely related to the processes described, that is, the intentional processes mirror the health determinant "lifestyles", the unintentional processes the biological health determinants and the processes of interaction with the environment. the social, economic, environmental and accessibility determinants of health [11].

The MHPSN must be attentive to people bereaved by death, with regard to their psychicological, cognitive, social structures, among others, in order to prevent the disorganization of these structures, and not only when it is already present.

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