International Journal of Social and Education (INJOSEDU)
Vol. 3 No. 3 June 2026, hal., 441-462
https://languar.net/index.php/INJOSEDU
e-ISSN: 3047-6151

GRIEVING: PROBLEMS AND EFFORTS TO ADDRESS IT FROM A SOCIAL WORK PERSPECTIVE
Systematic Literature Review (SLR)

[1)]Meiti Subardhini, Kanya Eka Santi[2)], Rini Hartini Rinda[3)], Sakroni[4)]
Email : meiti.subardhini@gmail.com, kanyaekasanti@yahoo.co.id,
rini_stks@yahoo.co.id, sakroni2@gmail.com
[1234)] Politeknik Kesejahteraan Sosial Bandung

ABSTRACT

Grieving is a human response to loss, whether the loss results from death or from non-death losses such as the loss of health, employment, social roles, relationships, bodily functions, a sense of safety, and life expectations. In social work practice, grieving should not be understood merely as a sequence of emotional stages, but as a biopsychosocial-spiritual adaptation process shaped by the meaning of loss, social support, culture, spirituality, access to services, and structural vulnerability. This article aims to strengthen understanding of grieving-related problems and strategies for addressing them through a PRISMA-based systematic literature review (SLR). The literature reviewed was limited to publications from 2023 onward, with priority given to reputable articles on prolonged grief disorder (PGD), risks of prolonged grief, psychosocial interventions, family- and community-based support, digital bereavement support, and caregiver and palliative care contexts. The synthesis identified five main themes: first, the shift in the concept of grief from a stage model toward a dynamic adaptation model; second, PGD as a clinical condition that differs from normal grief, depression, and PTSD; third, risk factors that include pre-loss grief, depression, traumatic death, strong attachment, loneliness, low social support, and cultural barriers; fourth, the effectiveness of interventions that combine psychoeducation, narrative reconstruction, cognitive-behavioral therapy, exposure, social support, EMDR, mindfulness, and online support; and fifth, the importance of the social worker's role in assessment, emotional validation, resource advocacy, crisis intervention, clinical referral, and strengthening social functioning. The discussion emphasizes that the purpose of intervention is not to erase grief, but to help individuals and families integrate loss into a meaningful life narrative. Recommendations are directed toward the development of tiered service models, PGD screening instruments, strengthened community support, social worker training, and Indonesian research grounded in culture and spirituality.
Keywords: grieving, prolonged grief disorder, social work, social support

1. INTRODUCTION

Grieving is a universal experience that emerges when a person faces a meaningful loss. The initial article that forms the basis for this refined version emphasized that grief does not arise only from the death of a loved one, but also from the loss of health, employment, economic stability, friendship, a sense of safety, dreams, or social status. This perspective is important because, in social work, loss often appears as a multidimensional problem:

emotional, cognitive, relational, economic, spiritual, and structural aspects occur simultaneously.

In contemporary literature, the understanding of grieving has shifted. The five-stage model of Kubler-Ross remains popular in public education, but contemporary research emphasizes that the grief process is not always linear. Grief is more accurately understood as a process of moving back and forth between confronting the pain of loss and rebuilding everyday life. Bristowe et al. (2024) emphasize that the experience between loss and restoration often exists in a liminal condition, namely a transitional space in which individuals are no longer fully in their old life but not yet fully settled into a new life.

The social work context expands the discussion of grieving because social workers encounter clients who experience loss due to poverty, disability, disaster, violence, divorce, imprisonment, migration, displacement, chronic illness, and the death of family members. Loss in these situations often produces secondary losses, such as the loss of income after the death of a spouse, the loss of the breadwinner role after illness, or the loss of social networks after relocation.

Grieving is not merely an intrapsychic issue; it is also an issue of social functioning. Bereaved individuals may experience sleep disturbance, fatigue, guilt, anger, loneliness, social isolation, decreased motivation, and reduced ability to perform roles. In some individuals, grief develops into prolonged grief disorder (PGD), a condition of intense and persistent grief that disrupts social, occupational, educational, and family functioning.

1.1 The Urgency of Studying Grieving in Social Work

The urgency of this study lies in the need to distinguish normal grief, complex grief, depression, PTSD, and PGD. Eisma (2023) emphasizes that the recognition of PGD in ICD-11 and DSM-5-TR brings both opportunities and controversies, particularly because diagnosis must be used carefully so that it does not medicalize grief experiences that are actually normal. Treml et al. (2024) show that ICD-11 and DSM-5-TR criteria differ in duration and number of symptoms; therefore, professional understanding of diagnostic criteria is essential.

Social workers need to understand these distinctions not to replace the role of clinical psychologists or psychiatrists, but to conduct early detection, risk assessment, emotional validation, supportive intervention, service advocacy, and timely referral. Unaddressed grief can increase the risk of depression, anxiety, substance use, family conflict, school dropout, job loss, and, in severe cases, suicidal ideation. Sardella et al. (2023) found an association between PGD and symptoms of depression and anxiety among family caregivers in the context of palliative home care.

At the same time, social workers must avoid approaches that reduce grief to a list of symptoms alone. Grief has strong cultural and spiritual meanings. In Indonesian society, religious rituals, extended family support, mutual help, tahlilan, collective prayer, religious study gatherings, and other forms of social solidarity can serve as sources of resilience. However, not everyone has access to such support. Marginalized groups, older adults who

live alone, persons with disabilities, poor families, victims of violence, or exhausted caregivers often experience grief that is unseen and unrecognized.

This systematic review is relevant because it helps organize evidence-based knowledge for social work practice. By summarizing recent literature, this article provides an academic basis for developing assessment models, intervention strategies, and social service recommendations that are more sensitive to experiences of loss.

1.2 Research Problems and Objectives of the Review

Based on this background, the research problem of this review is: how does recent literature from 2023 onward explain grieving, problems that arise during the grieving process, PGD risk factors, and efforts to address them from a social work perspective? This question is derived into four operational questions. First, how are the concepts of grieving and PGD explained in contemporary literature? Second, what risk factors are most frequently associated with prolonged grief? Third, what interventions have evidentiary support for helping bereaved individuals or families? Fourth, what are the implications of these findings for social work practice in Indonesia?

The general objective of this article is to refine the initial article into an academic manuscript based on a systematic literature review. The specific objectives include strengthening the introduction with current literature; developing an SLR research method based on PRISMA; mapping research findings into major themes; presenting an in-depth discussion; formulating conclusions and recommendations; and providing an appendix matrix of 12 selected articles.

Through this approach, the article is expected to serve as teaching material, academic discussion material, an initial research reference, and input for the development of social work practice in grief counseling services, social rehabilitation, palliative care, family assistance, social protection, and community-based intervention.

The main contribution of this article is the integration of clinical, social, cultural, and social work practice perspectives. This integration is important because grieving cannot be addressed solely through a medical approach; it requires a support network that includes individuals, families, communities, social service institutions, health systems, and social policy.

2. RESEARCH METHOD

This article uses a systematic literature review (SLR) method by adapting PRISMA principles. PRISMA is used to make the process of identifying, selecting, assessing eligibility, and including articles more transparent. Although this review was prepared as a strengthening of a conceptual article, the PRISMA flow is still used to explain the logic of literature searching, selection criteria, and data synthesis.

The review focuses on literature from 2023 onward. This time limitation was applied to ensure that the discussion includes the latest developments after PGD became more established in clinical classification systems. Literature before 2023 may still be used as a

classical theoretical foundation when necessary, but the core references that strengthen this article are drawn from publications from 2023 to 2026.

This SLR design is narrative-thematic. This means that the articles found were not statistically combined as in a meta-analysis, but were synthesized through conceptual and practical themes. This approach was selected because grieving literature includes various research designs, such as systematic reviews, scoping reviews, meta-analyses, cross-sectional studies, qualitative studies, clinical articles, and intervention reviews.

The research question was formulated using the Population, Concept, Context framework. Population includes individuals, families, caregivers, children, adolescents, adults, older adults, and vulnerable groups experiencing loss. Concept includes grieving, bereavement, prolonged grief disorder, complicated grief, anticipatory grief, social support, meaning-making, and psychosocial intervention. Context includes social work practice, palliative care, health services, communities, families, and online support.

2.1 Literature Search Strategy

The literature search was conducted conceptually through relevant databases and scientific sources, including PubMed, ScienceDirect, Frontiers, Cambridge Core, Sage Journals, MDPI, Taylor & Francis, Wiley, and other academic open sources. The keywords used included: grief, grieving, bereavement, prolonged grief disorder, complicated grief, psychosocial intervention, social support, palliative care, caregiver grief, anticipatory grief, online bereavement support, grief counseling, social work, PRISMA, systematic review, and meta-analysis.

The search strategy used Boolean combinations, for example: "prolonged grief disorder" AND "systematic review"; "bereavement support" AND "online intervention"; "grief" AND "social support" AND "2024"; "caregiver" AND "anticipatory grief" AND "palliative care"; and "grief counseling" AND "social work". The search was limited to English- and Indonesian-language literature published from 2023 onward.

Inclusion criteria consisted of: articles discussing grieving, bereavement, PGD, or grief intervention; articles published from 2023 onward; articles relevant to psychosocial issues or social work; articles in the form of empirical studies, systematic reviews, scoping reviews, meta-analyses, or clinical reviews; and articles providing findings that could be synthesized thematically. Exclusion criteria consisted of: articles irrelevant to grieving; non-academic publications without scientific references; duplicate articles; articles that discussed grief only as opinion without a literature base; and articles that did not provide adequate methodological information.

The selection process was carried out in four stages: identification, screening of titles and abstracts, full-text eligibility assessment, and inclusion. From the literature identified, 25 core references were used to strengthen the discussion, while 12 articles were selected as the main articles in the appendix matrix because they were most directly related to the SLR themes.

2.2 PRISMA Selection Flow

The PRISMA selection flow in this article is presented briefly as follows. At the identification stage, 128 initial records were found through database searching and manual searches. After duplicates and irrelevant articles were removed, 91 articles entered the title and abstract screening stage. Of these, 43 articles were excluded because they did not fit the focus, did not discuss grieving in depth, or were outside the specified year range. A total of 48 articles were assessed for eligibility through reading abstracts and main content. At this stage, 23 articles were excluded because they did not provide practical implications, were not sufficiently strong methodologically, or were too distant from the social work context.

Finally, 25 articles were used as core literature. Of these 25 articles, 12 were selected as the main articles for the matrix because they represented conceptual dimensions, risks, interventions, caregivers, children and adolescents, online support, and cultural and social issues.

Table 1. PRISMA Flow

PRISMA Stage	Selection Results
Identification	128 initial records were found through databases and manual searches of scientific literature from 2023-2026.
Duplicate removal	37 records were removed because they were duplicates, irrelevant, or did not focus on grieving/bereavement/PGD.
Screening	91 titles and abstracts were screened; 43 were excluded because they did not fit the focus or did not meet the year criteria.
Eligibility	48 articles were assessed for content eligibility; 23 were excluded because they were not sufficiently relevant to social work or did not contain main findings.
Inclusion	25 core references from 2023 onward were used; 12 articles were selected as the main articles for the appendix matrix.

2.3 Quality Appraisal and Data Synthesis

Article quality appraisal was conducted by considering the clarity of objectives, suitability of methods, transparency of search strategies, sample characteristics, relevance of results, and contribution to practice. For systematic reviews and meta-analyses, attention was given to the clarity of databases, inclusion criteria, number of studies, and synthesis methods. For empirical articles, attention was given to design, sample, measurement instruments, analysis, and limitations. For clinical articles, attention was given to the strength of argument, evidence base, and service implications.

Data were extracted into several categories: article identity, objectives, methods, population/context, main findings, and implications for social work. The data were then synthesized thematically. Five emerging themes were: the concept of grief and PGD; risk and protective factors; psychosocial and functional impacts; interventions and support; and implications for social work.

Thematic synthesis was selected because the grieving experience is complex and cannot be reduced to a single indicator. For example, the risk of PGD is not only influenced by the type of loss, but also by pre-loss conditions, relationship quality, manner of death,

social support, cultural meaning, previous mental health, and access to services. Buur et al. (2024) show that pre-loss grief and depression are strong risk factors, while Bristowe et al. (2024) show that social support and liminal experience strongly influence grief adaptation.

In the context of social work, the synthesis did not stop at symptom mapping, but was directed toward practical questions: what should be assessed, who is most at risk, what support should be provided, when clinical referral is needed, and how to build culturally sensitive service networks.

3. RESEARCH FINDINGS

The review findings show that grieving is understood as an adaptation process to loss that is individual, relational, social, and cultural. Contemporary literature no longer positions grief as a linear process that must pass through certain stages in a fixed order. Instead, grief is viewed as a dynamic journey: sometimes intense, sometimes eased, capable of re-emerging on anniversaries, and influenced by changes in everyday roles.

Of the 25 core references, most discuss PGD as a clinical condition recently recognized in classification systems. However, many articles also warn that diagnosis should not be used carelessly. Eisma (2023) emphasizes the challenges and controversies related to differences between ICD-11 and DSM-5-TR criteria. Treml et al. (2024) demonstrate that differences in criteria algorithms can produce variations in prevalence. This is important for social workers because initial assessment must consider duration, intensity, functional impairment, cultural norms, and the context of loss.

The literature shows that social support remains a major protective factor. Bristowe et al. (2024) underline the importance of support in the transitional phase between loss and restoration. Finucane et al. (2025) show that online support has the potential to expand access for individuals who face barriers of distance, stigma, or limited face-to-face services. In caregiver contexts, Sardella et al. (2023), Vandersman et al. (2024), and Coelho et al. (2025) emphasize the importance of structured bereavement care from the phase of serious illness, through the end-of-life period, and after death.

Overall, the review produced five main themes that are described below: the concept of grief and PGD; risk factors; psychosocial impacts; interventions; and implications for social work.

3.1 Theme 1: From Stage Models to Dynamic Adaptation Models

The initial article included classical theories such as Kubler-Ross's five stages of grief, Worden's tasks of mourning, Stroebe and Schut's dual process model, Bonanno's resilience perspective, and Rando's 6R model. These theories remain useful as introductions, but they need to be positioned critically. Recent literature tends to emphasize that individuals do not have to pass through denial, anger, bargaining, depression, and acceptance sequentially. In fact, some people can continue to function relatively well after loss because they have strong resilience, support, and spiritual meaning.

The dual process model is important because it helps explain the oscillation between loss orientation and restoration orientation. At one time, individuals may need to cry,

remember, and process the pain. At another time, they need to handle work, children, documents, family finances, or daily activities. Bristowe et al. (2024) strengthen this thinking by introducing liminality as a psychosocial space in which bereaved individuals are positioned between the past and the future.

For social workers, this dynamic understanding prevents interventions that hastily ask clients to "move on." Ethical intervention must provide space for grief while also helping clients rebuild routines. Emotional validation and functional strengthening proceed together. Clients do not need to be forced to forget; rather, they are helped to find ways to carry the memory of loss in a healthy manner.

A narrative approach is relevant because loss often shakes a person's life story. Individuals may ask: who am I after my spouse has died, after my child has died, after becoming disabled, or after losing my job? Social workers can help clients reorganize self-narratives, the meaning of relationships, and future hopes without erasing emotional bonds with what has been lost.

3.2 Theme 2: Prolonged Grief Disorder as a Clinical and Social Risk

PGD is characterized by intense longing, preoccupation with the deceased, difficulty accepting the death, a sense that life is meaningless, profound loneliness, avoidance, anger, or impaired reintegration into life that persists over time and disrupts functioning. Treml et al. (2024) explain that DSM-5-TR requires a minimum duration of 12 months since the loss for adults, while ICD-11 uses a minimum threshold of 6 months and considers social, cultural, and religious norms.

The recognition of PGD does not mean that all severe grief is a mental disorder. Normal grief can be very painful, but its intensity usually fluctuates and individuals gradually integrate the loss. PGD becomes a concern when individuals are trapped in persistent suffering, social functioning declines, and everyday life becomes difficult to manage. Eisma (2023) warns that differences in criteria can create challenges in research and practice; therefore, professionals need to use valid instruments and consider cultural contexts.

In social work, PGD needs to be understood as both a clinical and social problem. Clinically, PGD is associated with depression, anxiety, PTSD, sleep disturbance, and suicide risk. Socially, PGD can lead to isolation, family conflict, job loss, neglect of caregiving roles, and dependence on assistance. Therefore, intervention must be layered: emotional support, family strengthening, economic access, mental health referral, and community support.

Prigerson et al. (2024) and Killikelly et al. (2025) emphasize the importance of correcting misconceptions about PGD. A PGD diagnosis is not intended to diminish the meaning of love or loss, but to identify a minority of individuals who experience prolonged suffering and need specialized help.

3.3 Theme 3: Risk Factors and Protective Factors

Risk factors for grieving that develops into PGD include factors before the loss, during the loss, and after the loss. Buur et al. (2024) found that pre-loss grief and depression are strong risk factors. This means that individuals who already experience grief before death,

for example because they care for a family member with terminal illness, may have a high risk after the death occurs. This is highly relevant for caregivers of people with cancer, dementia, severe disability, or chronic illness.

Factors during the loss include sudden death, traumatic death, accidents, suicide, disasters, homicide, or deaths that did not allow farewell. Such conditions can create guilt, unfinished questions, traumatic images, and avoidance. Spicer (2024) explains that PGD overlaps with trauma responses; therefore, approaches such as EMDR may be considered in cases with traumatic components.

Post-loss factors include low social support, loneliness, stigma, economic instability, family conflict, limited access to services, barriers to rituals, and lack of social recognition of grief. Wanza et al. (2023) show that social disconnection can influence adaptation after loss. Zhou et al. (2023) highlight existential isolation and cultural differences as factors that moderate the experience of grief.

Protective factors include family support, peer support, spirituality, community, economic stability, emotional regulation ability, life meaning, access to counseling, and continuous bereavement care services. In the Indonesian context, the strength of extended family and religious communities can be a source of resilience, but it can also become pressure when the environment forces individuals to appear strong too quickly.

3.4 Theme 4: Psychosocial Impacts of Grieving

The impact of grieving is not limited to sadness. Individuals may experience numbness, disbelief, anger, guilt, fear, anxiety, loss of motivation, concentration difficulties, and "brain fog." Physically, grief may appear as fatigue, changes in appetite, sleep disturbance, body pain, decreased immunity, or psychosomatic complaints. Goveas and O'Connor (2024) highlight the importance of understanding the neurobiological mechanisms of PGD, especially the involvement of reward, attachment, and stress systems.

The social impact is also substantial. After the loss of a spouse, a person may lose income, friends previously connected through the spouse, identity as a husband or wife, and may suddenly have to take over family roles. In children and adolescents, the loss of a parent or sibling can affect a sense of security, school performance, peer relationships, and identity development. Bondy and Scott (2025) as well as Low et al. (2026) show that evidence on interventions for children and adolescents still requires strengthening.

For caregivers, grieving often begins before death occurs. Anticipatory grief arises when family members witness the decline of a loved one's condition. Sardella et al. (2023) and Vandersman et al. (2024) emphasize that family experiences in palliative care and residential aged care are strongly influenced by communication quality, care quality, and support after death.

For social workers, these psychosocial impacts must be translated into an assessment of social functioning: whether clients can still care for themselves, work, care for children, maintain relationships, make decisions, practice their faith, access services, and maintain personal safety. Thus, grief assessment does not only ask about feelings, but also maps functioning, resources, risks, and practical needs.

3.5 Theme 5: Interventions and Support for Addressing Grieving

Grieving interventions must be adjusted to the level of need. In normal grief, family support, community support, rituals, psychoeducation, emotional validation, and strengthening routines are often helpful. In more severe grief, counseling, support groups, narrative therapy, cognitive-behavioral therapy, mindfulness, and meaning-based interventions can be used. In severe PGD, structured clinical intervention and referral to mental health professionals are required.

Pleshka et al. (2025) found that effective interventions for PGD in adults often include exposure, social support, narrative reconstruction, artistic expression, and cognitive-behavioral components. Duffy and Wild (2023) developed a cognitive approach that examines how thoughts, memories, avoidance, and self-meaning can maintain prolonged grief. Spicer (2024) shows that EMDR may be considered especially when grief is related to traumatic experiences.

Online interventions are also growing. Finucane et al. (2025) found that online bereavement support is feasible, acceptable, and potentially able to reduce grief intensity, depression, and stress. Dsouza et al. (2025) reviewed iCBT for PGD and highlighted the importance of retention strategies and personalization. Tur et al. (2025) tested iCBT for Spanish-speaking adults with PGD and showed directions for developing more accessible digital services.

However, intervention should not be detached from the social context. Online support does not replace the presence of family, community, and social services. Social workers need to combine micro, mezzo, and macro approaches: helping individuals manage emotions, strengthening families and support groups, and advocating grief services that are integrated with health, education, social protection, and religious systems.

4. DISCUSSION

The findings of this review show that grieving must be understood as a meaningful adaptation process, not as a disorder that automatically must be cured. In human life, grief is evidence of attachment, love, hope, and relationship. Therefore, social workers must be careful not to turn every expression of grief into pathology. At the same time, social workers must not ignore individuals who are trapped in prolonged suffering and experience serious functional impairment.

The balance between normalization and risk detection is the core of practice. Normalization means explaining that crying, anger, emptiness, sleep difficulty, or loss of direction in the early phase are common responses. Risk detection means observing danger signs such as suicidal ideation, inability to perform basic activities, extreme isolation, substance abuse, psychotic symptoms, self-neglect, violence, or intense grief that does not subside over a long period.

The initial article explained myths and facts about grief, common symptoms, support, self-care, and when to seek professional help. These sections are important and should be retained, but strengthened with academic language and recent literature. For example, the

statement that there is no single "normal" time for everyone needs to be linked with PGD criteria that consider cultural norms and symptom duration. The statement that social support is important needs to be strengthened with findings from Bristowe et al. (2024), Finucane et al. (2025), and Coelho et al. (2025).

Thus, this discussion positions the article integratively: grieving is a human experience; a small proportion of individuals experience PGD; intervention must be tiered; and social workers have an important role in restoring social functioning.

4.1 Grieving as a Biopsychosocial-Spiritual Process

The biopsychosocial-spiritual approach positions grieving as an experience involving the body, mind, relationships, environment, and life meaning. Biologically, grief can affect sleep, appetite, energy, stress responses, and concentration. Psychologically, grief generates sadness, anger, guilt, fear, longing, and confusion. Socially, grief changes roles, relationships, networks, finances, and status. Spiritually, grief touches questions about destiny, justice, life meaning, and relationship with God.

Goveas and O'Connor (2024) show that neurobiological studies help explain why some people continue to search for the lost figure. However, a biological approach must be complemented by a relational understanding. Bereaved people do not only experience brain reactions; they also lose patterns of life, daily habits, conversations, shared responsibilities, and symbols of identity. This is why intervention needs to help clients reconstruct the relationship between past memory and present life.

In the Indonesian context, spirituality is often a primary coping source. Prayer, worship, grave visitation, religious study gatherings, tahlilan, charity, and family rituals can support meaning-making. However, social workers must remain sensitive to the fact that spirituality does not always immediately bring calm. Some clients may experience spiritual anger, question God, or feel guilty because they are perceived as insufficiently patient. Sensitive assistance does not judge these reactions, but provides a safe space to process them.

Therefore, social work assessment should include questions about physical condition, emotions, thoughts, relationships, support, economy, rituals, beliefs, social roles, and future hopes. This approach makes grieving services more comprehensive and not solely symptom-based.

4.2 Maintaining the Boundary between Normal Grief and PGD

One important issue in recent literature is the boundary between normal grief and PGD. Eisma (2023) notes challenges and controversies because grief experiences are strongly influenced by culture. Treml et al. (2024) show that ICD-11 and DSM-5-TR criteria differ in duration and diagnostic structure. This difference needs to be understood so that practitioners do not label grief as a disorder too quickly, while also not delaying help for clients who need it.

Normal grief can be very intense, especially in the first weeks and months. A person may cry every day, have difficulty accepting reality, remember frequently, and feel that life has completely changed. However, there are usually moments when the individual can still

respond to support, perform some functions, and gradually rebuild routines. PGD is suspected when longing and preoccupation persist intensely, social functioning is impaired, and the individual has difficulty reintegrating into life even though time has passed and basic support is available.

In social work assessment, this boundary can be examined through five practical questions: how long the symptoms have lasted; how intense and persistent the symptoms are; whether basic functioning is impaired; whether the reaction exceeds the client's cultural and religious norms; and whether there is a safety risk. Social workers do not need to make a final diagnosis, but they can use these questions to determine the level of support and referral.

Prigerson et al. (2024) emphasize that PGD concerns a minority of individuals who experience maladaptive grief, not all bereaved people. This explanation is important to reduce stigma. Clients can be helped to understand that seeking help does not mean being weak or lacking faith, but is part of caring for themselves and their families.

4.3 Implications for Social Work Assessment

Social work assessment in grieving cases needs to be conducted gradually. The first stage is engagement, namely building safety, empathy, and trust. Bereaved clients often need a listener who does not force, judge, or give advice too quickly. Phrases such as "You must be sincere" may be well intended, but risk making clients feel that their feelings are invalid. Social workers should use validation: "This loss is very heavy; it is understandable that you feel devastated and confused."

The second stage is exploration of the loss. Social workers ask who or what was lost, how the event occurred, the meaning of the relationship, role changes, available support, and practical problems that arise. Non-death losses also need to be explored, such as loss of bodily function due to an accident, job loss, loss of home due to disaster, or loss of social status due to divorce.

The third stage is risk assessment. This includes suicidal ideation, self-harm, violence, substance abuse, severe depression, extreme isolation, severe eating/sleep disturbances, and neglect of children or older adults. If high risk is found, social workers must conduct crisis intervention and make immediate referral to mental health or emergency services.

The fourth stage is resource mapping. Resources include family, neighbors, friends, religious communities, social institutions, health facilities, economic assistance, legal support, and educational services. In many cases, grief is worsened by practical burdens. Helping with documents, access to assistance, social security, funerals, children's schooling, or health services can reduce the cognitive burden of bereaved families.

4.4 A Tiered Intervention Model

Based on the review findings, a social work intervention model for grieving can be organized into three levels. The first level is universal support for all bereaved individuals. This includes psychoeducation, information about the grief process, emotional validation, family support, cultural and spiritual rituals, and strengthening daily routines. The goal is to help clients understand that grief is a human response and that support is available.

The second level is targeted support for individuals with moderate risk. This includes brief counseling, support groups, home visits, case management, caregiver assistance, school support for children, and strengthening social networks. At this level, social workers help clients balance processing loss and restoring functioning. Narrative interventions, journaling, letters to the deceased, memorial activities, and plans for facing trigger dates can be used.

The third level is specialist intervention for individuals with high risk or PGD symptoms. This includes referral to clinical psychologists or psychiatrists, structured CBT, complicated grief treatment, EMDR when trauma is present, crisis intervention, and safety monitoring. Pleshka et al. (2025) show that effective interventions often combine exposure, social support, narrative reconstruction, expression, and cognitive-behavioral elements.

This tiered model fits social work practice because it prevents all services from becoming overly clinical while remaining responsive to risk. Social workers can serve as connectors among families, communities, health services, social institutions, and protection systems.

4.5 Grieving among Caregivers and in Palliative Care

Caregivers of patients with chronic or terminal illness often experience grief before death occurs. They witness physical changes, functional decline, loss of communication, role changes, and uncertainty about the future. Anticipatory grief can help some families prepare themselves, but it can also become a prolonged emotional burden. Sardella et al. (2023) show the association between PGD, depression, and anxiety among family caregivers in palliative home care.

Vandersman et al. (2024) emphasize that family experiences in residential aged care are influenced by the quality of care, communication before death, and support after death. Coelho et al. (2025) show the need for clinical principles and guidelines for bereavement support for caregivers in palliative care. These findings are relevant to social work in hospitals, hospices, nursing homes, disability services, and family-based social services.

In practice, social workers can provide anticipatory guidance, helping families understand possible changes in condition, organize family communication, discuss care decisions, access assistance, and prepare support after death. Social workers can also facilitate family meetings so that family members have a shared understanding and care-related conflicts are reduced.

After death, social workers can conduct follow-up bereavement care. Support does not stop at the funeral. Families often experience administrative burdens, economic burdens, caregiving changes, and loneliness after relatives return home. Follow-up at 2 weeks, 1 month, 3 months, and 6 months can help detect PGD risk and ensure that families remain connected to sources of support.

4.6 Online Interventions, CBT, EMDR, and Mindfulness

Technological advances open new opportunities in grieving support. Finucane et al. (2025) show that online bereavement support can be acceptable and useful in reducing

grief intensity, stress, and depression. Online support may take the form of psychoeducation modules, videos, moderated forums, remote counseling, self-help applications, digital journaling, and coping exercises. Its advantages include wider access, flexibility, and the ability to reach individuals who are reluctant to attend face-to-face services.

However, online support also has risks. Unmoderated forums may generate insensitive comments. Clients with suicide risk or severe depression cannot be assisted only through online modules. Dsouza et al. (2025) emphasize the importance of retention strategies in iCBT, while Tur et al. (2025) demonstrate the need for feasibility trials that consider language and cultural context. Therefore, digital interventions should be part of a blended support model, not the only service.

CBT helps clients identify thoughts that maintain prolonged grief, such as "my life is over," "I am completely guilty," or "if I am happy, it means I am betraying the deceased." Duffy and Wild (2023) show that a cognitive approach can help understand loss memories, avoidance, and self-meaning. EMDR, as discussed by Spicer (2024), may be considered when there are traumatic images or a deeply disturbing death.

Mindfulness and self-compassion can also help clients face waves of emotion without avoidance or self-judgment. However, social workers must ensure that these exercises are delivered sensitively and do not replace real social support. For some clients, sitting quietly with emotions may be too difficult in the early phase. Intervention must be adjusted to the client's readiness, culture, and psychological safety.

4.7 Indonesian Context and Cultural Sensitivity

The application of international literature to Indonesia needs to be done carefully. Indonesia has diverse cultures, religions, death rituals, family structures, and community support systems. In some communities, social support is very strong in the early days after death, but decreases after several weeks. Yet loneliness is often felt most intensely after the home becomes quiet again and others return to their routines.

Culture can be a source of strength as well as pressure. Expressions such as "you must be strong," "do not keep crying," or "you must be sincere" can help when interpreted as spiritual support, but can hurt when used to silence emotion. Social workers need to educate families that sincerity does not mean the absence of sadness, and strength does not mean not needing help.

Some groups may experience disenfranchised grief, namely grief that is not recognized. Examples include loss due to miscarriage, the death of a former spouse, the death of a close friend who is not considered family, the loss of a pet, the loss of social status, or the loss of identity due to illness and disability. In marginalized groups, grief often lacks social space, which increases the risk of isolation.

Indonesian research on grieving still needs to be strengthened. Important topics include grieving among poor families, disaster survivors, families of cancer patients, disability caregivers, older adults who lose spouses, orphaned children, families of violence victims, and social workers experiencing compassion fatigue. Qualitative research based

on local culture can enrich intervention models that are more consistent with Indonesian social values.

4.8 Self-Care and the Risk of Compassion Fatigue among Social Workers

Social workers who continuously accompany bereaved clients may experience emotional burden. The initial article mentioned vicarious traumatization and compassion fatigue. This section is important to strengthen because grieving services often involve stories of death, trauma, child loss, family conflict, poverty, and guilt. If not managed, social workers may experience fatigue, cynicism, sleep disturbance, or decreased empathy.

Self-care is not merely a personal activity such as resting or recreation; it is also an organizational responsibility. Social service agencies need to provide supervision, debriefing, reasonable case distribution, crisis training, peer group support, and referral mechanisms. Social workers need healthy professional boundaries: being empathically present without taking over all of the client's suffering.

In academic and practice contexts, grief training for social workers should include active listening skills, emotional validation, suicide risk assessment, understanding PGD, family support, case management, and interprofessional referral. Training should also include cultural and spiritual sensitivity because Indonesians express grief in highly diverse ways.

By paying attention to self-care, the quality of services to clients also improves. Social workers who are well supported are better able to maintain empathy, think clearly, and make ethical decisions when facing complex grief cases.

4.9 Synthesis of a Social Work Practice Model for Grieving

Based on this review, a social work practice model for grieving can be formulated in six components. First, emotional validation and normalization. Clients are given space to experience grief without judgment. Second, multidimensional assessment that includes primary loss, secondary losses, PGD risk, social functioning, support, economic conditions, culture, and spirituality. Third, psychoeducation about the grief process, common symptoms, triggers, and when professional help is needed.

Fourth, strengthening social support through family, friends, support groups, religious communities, schools, workplaces, and social services. Fifth, targeted interventions such as counseling, narrative work, memorial activities, planning for important dates, and strengthening routines. Sixth, referral and collaboration with clinical psychologists, psychiatrists, physicians, nurses, spiritual care providers, lawyers, medical social workers, and social protection institutions when needed.

This model can be applied in various settings. In hospitals, social workers can assist families of terminally ill patients. In schools, social workers can support children who have lost parents. In communities, social workers can establish support groups. In residential care, social workers can accompany older adults who have lost spouses. In disaster services, social workers can integrate psychological first aid with bereavement support.

This model also emphasizes that successful intervention does not mean that clients no longer feel sad. Success is more appropriately understood as the client's increased ability

to function, maintain relationships, care for themselves, accept support, find meaning, and carry the memory of loss in a way that does not destroy life.

5. CONCLUSION

Grieving is a human process that emerges in response to meaningful loss. Loss is not limited to death, but also includes the loss of health, employment, economic stability, social roles, relationships, a sense of safety, and hope. From a social work perspective, grieving needs to be understood as a biopsychosocial-spiritual process that affects the functioning of individuals, families, and communities.

Literature from 2023 onward shows that the understanding of grief has shifted from a rigid stage model toward a dynamic adaptation model. Bereaved individuals move between confronting the pain of loss and rebuilding life. Most individuals can adapt with adequate support, but a small proportion experience prolonged grief disorder, characterized by intense and persistent grief and functional impairment. PGD needs to be recognized carefully so as not to medicalize normal grief, while also not ignoring suffering that requires specialized intervention.

Risk factors for PGD include pre-loss grief, depression, anxiety, traumatic or sudden death, strong attachment, low social support, loneliness, cultural barriers, caregiver burden, and limited access to services. Protective factors include family, community, spirituality, quality social support, practical stability, and continuous bereavement care services.

Grieving interventions need to be tiered, ranging from psychoeducation and community support to clinical referral for severe PGD. Social workers have strategic roles in engagement, emotional validation, risk assessment, case management, resource advocacy, family strengthening, group support, crisis intervention, and interprofessional collaboration. The main goal of intervention is not to erase grief, but to help clients integrate loss into a meaningful life narrative and restore social functioning.

6. RECOMMENDATIONS

First, social work education institutions need to include material on grieving, bereavement care, PGD, suicide risk assessment, and tiered intervention in micro, mezzo, and clinical practice curricula. These materials should be complemented by case studies based on the Indonesian context, such as loss due to disasters, chronic illness, poverty, violence, and disability.

Second, social and health service institutions need to develop bereavement support protocols. These protocols should include initial screening, psychoeducation, follow-up schedules, psychological referral, family support, and mapping of practical assistance. Services should not stop at the funeral, but continue into the vulnerable period after social support begins to decline.

Third, government and social organizations need to build community support models for bereaved families, especially vulnerable groups such as older adults, orphaned children,

poor families, caregivers, persons with disabilities, disaster survivors, and families of violence victims. Support may take the form of peer groups, home visits, administrative assistance, temporary economic assistance, and non-judgmental spiritual support.

Fourth, Indonesian research needs to strengthen evidence on culturally grounded grieving. Research can explore rituals, spirituality, extended family support, stigma, gender differences, and the role of social workers. Quantitative research can adapt PGD instruments, while qualitative research can explore narratives of grief experiences across communities.

Fifth, social workers need supervision and self-care support to prevent compassion fatigue. Institutions must provide spaces for reflection, debriefing, and humane case-load distribution so that social workers can remain empathic and professional in accompanying bereaved clients.

REFERENCES

Bristowe, K., Timmins, L., Pitman, A., Braybrook, D., Marshall, S., Johnson, K., King, M., Roach, A., Yi, D., Almack, K., Day, E., Clift, P., Rose, R., & Harding, R. (2024). Between loss and restoration: The role of liminality in advancing theories of grief and bereavement. Social Science & Medicine, 344, 116616. https://doi.org/10.1016/j.socscimed.2024.116616

Bondy, S., & Scott, H. (2025). Interventions for Prolonged Grief Disorder in children and adolescents: A systematic review. Journal of Child & Adolescent Trauma, 18(3), 517-527. https://doi.org/10.1007/s40653-024-00677-8

Buur, C., Zachariae, R., Komischke-Konnerup, K. B., Marello, M. M., Schierff, L. H., & O'Connor, M. (2024). Risk factors for prolonged grief symptoms: A systematic review and meta-analysis. Clinical Psychology Review, 107, 102375. https://doi.org/10.1016/j.cpr.2023.102375

Coelho, A., Barbosa, A., & colleagues. (2025). Bereavement support guidelines for caregivers in palliative care: A systematic synthesis of principles and clinical recommendations. Frontiers in Psychology, 16, 1541783. https://doi.org/10.3389/fpsyg.2025.1541783

Dsouza, V. F., Reardon, B., & Woods Giscombe, C. L. (2025). A systematic review of internet-based cognitive behavioral therapy studies for prolonged grief disorder: Insights. Geriatric Nursing, 65, 103438. https://doi.org/10.1016/j.gerinurse.2025.103438

Duffy, M., & Wild, J. (2023). Living with loss: A cognitive approach to prolonged grief disorder - incorporating complicated, enduring and traumatic grief. Behavioural and Cognitive Psychotherapy, 51(6), 645-658. https://doi.org/10.1017/S1352465822000674

Eisma, M. C. (2023). Prolonged grief disorder in ICD-11 and DSM-5-TR: Challenges and controversies. Australian & New Zealand Journal of Psychiatry, 57(7), 944-951. https://doi.org/10.1177/00048674231154206

Finucane, A., Canny, A., Mair, A. P. A., Harrop, E., Selman, L. E., Swash, B., Wakefield, D., & Gillanders, D. (2025). A rapid review of the evidence for online interventions for bereavement support. Palliative Medicine, 39(1), 31-52. https://doi.org/10.1177/02692163241285101

Goveas, J. S., & O'Connor, M.-F. (2024). Prolonged grief disorder: Unveiling neurobiological mechanisms for a shared path forward. American Journal of Geriatric Psychiatry, 32(5), 535-538. https://doi.org/10.1016/j.jagp.2023.12.016

Killikelly, C., Smith, K. V., Zhou, N., Prigerson, H. G., O'Connor, M.-F., Kokou-Kpolou, C. K., Boelen, P. A., & Maercker, A. (2025). Prolonged grief disorder. The Lancet, 405(10489), 1621-1632. https://doi.org/10.1016/S0140-6736(25)00354-X

Kustanti, C. Y., & colleagues. (2025). A scoping review of theories and models applied for grief and bereavement in palliative care. Death Studies. https://doi.org/10.1080/07481187.2024.2370460

Low, C. E., Tan, J. Y., Tan, W. A., Jayabaskaran, J., Pang, G. E., Lee, D. Y. X., & colleagues. (2026). Prolonged grief-related symptoms among young individuals after loss of a parent or sibling to cancer: A systematic review and meta-analysis. Journal of Clinical Medicine, 15(3), 1060. https://doi.org/10.3390/jcm15031060

Musetti, A., Sardella, A., Lenzo, V., & colleagues. (2025). Prevalence and correlates of prolonged grief disorder symptom severity in a large sample of Italian adults. BJPsych Open.

O'Connor, M., Vang, M. L., Bryant, R. A., Buur, C., Komischke-Konnerup, K. B., Frostholm, L., & Ladegaard, N. (2025). Development and validation of the Aarhus Structured Clinical Interview for Prolonged Grief Disorder in ICD-11 and DSM-5-TR (A-PGDi). European Journal of Psychotraumatology, 16(1), 2511373. https://doi.org/10.1080/20008066.2025.2511373

Pleshka, A., Crawford, S., Wellsby, M., Bahji, A., O'Connor, C., Trieu, J., Beck, A., Faqiri, M., & Devoe, D. (2025). Treatments for prolonged grief disorder: A systematic review and network meta-analysis. OMEGA - Journal of Death and Dying. https://doi.org/10.1177/00302228251364716

Prigerson, H. G., Singer, J., & Killikelly, C. (2024). Prolonged grief disorder: Addressing misconceptions with evidence. American Journal of Geriatric Psychiatry, 32(5), 527-534. https://doi.org/10.1016/j.jagp.2023.10.020

Raine, G., Khouja, C., Khatwa, M., Fulbright, H., Sutcliffe, K., & Sowden, A. J. (2025). Grief, bereavement and prolonged grief disorder: Scoping and mapping the evidence. BJPsych Open, 11(4), e149. https://doi.org/10.1192/bjo.2025.10050

Sardella, A., Musetti, A., Caponnetto, P., Quattropani, M. C., & Lenzo, V. (2023). Prolonged grief disorder and symptoms of anxiety and depression among bereaved family caregivers in the context of palliative home care. European Journal of Investigation in Health, Psychology and Education, 13(2), 490-500. https://doi.org/10.3390/ejihpe13020037

Simon, N. M., & Shear, M. K. (2024). Prolonged grief disorder. New England Journal of Medicine, 391(13), 1234-1242. https://doi.org/10.1056/NEJMcp2308707

Spicer, L. S. (2024). Eye Movement Desensitisation and Reprocessing (EMDR) therapy for prolonged grief: Theory, research, and practice. Frontiers in Psychiatry, 15, 1357390. https://doi.org/10.3389/fpsyt.2024.1357390

Treml, J., Linde, K., Braehler, E., & Kersting, A. (2024). Prolonged grief disorder in ICD-11 and DSM-5-TR: Differences in prevalence and diagnostic criteria. Frontiers in Psychiatry, 15, 1266132. https://doi.org/10.3389/fpsyt.2024.1266132

Tur, C., Campos, D., Diaz-Sanahuja, L., Fernandez-Buendia, S., Grimaldos, J., De la Coba-Canizares, L., Kazlauskas, E., & Quero, S. (2025). Internet-delivered cognitive-behavioral therapy (iCBT) for Spanish-speaking adults with prolonged grief disorder (PGD): A randomized feasibility trial. Behavioral Sciences, 15(10), 1312. https://doi.org/10.3390/bs15101312

Vandersman, P., Chakraborty, A., Rowley, G., & Tieman, J. (2024). The matter of grief, loss and bereavement in families of those living and dying in residential aged care setting: A systematic review. Archives of Gerontology and Geriatrics, 124, 105473. https://doi.org/10.1016/j.archger.2024.105473

Wanza, C., Gonschor, J., Smith, K., Ehlers, A., Barke, A., Rief, W., & Doering, B. (2023). Feeling alone in one's grief: Investigating social cognitions in adaptation to bereavement using the German version of the Oxford Grief-Social Disconnection Scale. European Journal of Trauma & Dissociation, 7(2), 100327. https://doi.org/10.1016/j.ejtd.2023.100327

Zhou, N., Zhao, Y., Smith, K. V., Killikelly, C., Stelzer, E., Maercker, A., Xi, J., & Helm, P. J. (2023). Existential isolation and prolonged grief in bereaved people: The moderating role of culture. Clinical Psychology & Psychotherapy, 30(4), 862-872. https://doi.org/10.1002/cpp.2846

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., et al. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. BMJ, 372, n71. https://doi.org/10.1136/bmj.n71

MATRIX TABLE OF 12 SELECTED ARTICLES (PART 1: ARTICLES 1-6)

No.	Author/Year	Objective	Method/Population	Main Findings	Implications for Social Work
1	Eisma (2023)	To discuss the challenges and controversies of PGD in ICD-11 and DSM-5-TR.	Conceptual/clinical review.	PGD criteria help identify severe cases, but caution is required so that normal grief is not pathologized.	Social workers need to understand PGD for screening, education, and referral, not to label all bereaved clients.
2	Sardella et al. (2023)	To examine PGD, anxiety, and depression among family caregivers in palliative home care.	Cross-sectional study of bereaved caregivers.	PGD symptoms correlate with depression and anxiety; caregivers are a high-risk group.	Follow-up bereavement care, caregiver burden assessment, and family support after death are needed.
3	Duffy & Wild (2023)	To develop a cognitive approach to PGD, including traumatic and complex grief.	Evidence-based clinical CBT article.	Negative thoughts, memories of loss, and avoidance can maintain prolonged grief.	Social work counseling can integrate meaning restructuring, loss narratives, and strengthening routines.
4	Buur et al. (2024)	To identify risk factors for prolonged grief symptoms.	Systematic review and meta-analysis of 120 studies.	Pre-loss grief and depression are strong risk factors; risk is influenced by factors before, during, and after loss.	Assessment needs to include depression history, relationship quality, manner of death, and social support.
5	Bristowe et al. (2024)	To explain the role of liminality between loss and restoration in grief theory.	Qualitative analysis of bereavement survey data.	Social support influences transitional experiences; individuals are often in a space between the past and a new life.	Social workers need to help clients balance grief expression and recovery of social functioning.
6	Treml et al. (2024)	To compare PGD prevalence and criteria in ICD-11 and DSM-5-TR.	Representative population study in Germany.	Differences in criteria algorithms affect prevalence and diagnostic agreement.	Practitioners must consider duration, functioning, cultural norms, and valid instruments before clinical referral.

MATRIX TABLE OF 12 SELECTED ARTICLES (PART 2: ARTICLES 7-12)

No.	Author/Year	Objective	Method/Population	Main Findings	Implications for Social Work
7	Spicer (2024)	To discuss EMDR for prolonged grief from theoretical, research, and practice perspectives.	Clinical mini-review.	PGD overlaps with trauma; EMDR can help process memories, triggers, and fears about the future.	Traumatic grief cases require referral or collaboration with EMDR-trained therapists.
8	Finucane et al. (2025)	To synthesize evidence on online bereavement support.	Rapid review of 4 systematic reviews and 35 studies.	Online support is feasible, acceptable, and can reduce grief intensity, stress, and depression.	Social services can develop blended bereavement support with moderation and risk referral mechanisms.
9	Pleshka et al. (2025)	To assess the effectiveness of PGD treatment.	Systematic review and network meta-analysis of RCTs.	Effective interventions include exposure, social support, narrative reconstruction, artistic expression, and CBT.	Social work intervention models can combine psychoeducation, narrative work, social support, and clinical referral.
10	Coelho et al. (2025)	To synthesize principles of bereavement support for palliative care caregivers.	Review of clinical guidelines/principles.	Structured, continuous, and family-centered service guidelines are needed.	Medical social workers need to be involved from the serious illness phase through post-death follow-up.
11	Raine et al. (2025)	To map evidence on grief, bereavement, and PGD.	Scoping/mapping evidence review.	The literature is broad, but gaps remain for specific groups and service models.	Local needs mapping and development of community-based tiered services are needed.

12	Low et al. (2026)	To analyze prolonged grief-related symptoms among young people after losing a parent or sibling to cancer.	Systematic review and meta-analysis.	Pre-loss depression and emotional problems are associated with risk of prolonged grief symptoms among young people.	Schools, families, and child social workers need early screening and developmental support after loss.