RESEARCH NOTES

Bridging The Void: Social Work Interventions For Prolonged Grief Disorder In Covid-19 Bereavement

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Abstract: *The COVID-19 pandemic has exacerbated risks for Prolonged Grief Disorder (PGD) due to traumatic deaths and disrupted mourning practices. This study examines the role of social work in mitigating PGD through pre- and post-death interventions and proposes scalable solutions for equitable bereavement care. Social workers are critical in addressing pandemic-related grief, yet global disparities in bereavement care persist. Policy reforms must prioritize workforce training, digital mental health infrastructure, and inclusive mourning practices to prevent a "shadow pandemic" of PGD.*

Keywords: Prolonged grief disorder (PGD), COVID-19 bereavement, Social work interventions, Ritual Disruption, Telemental health.

INTRODUCTION

The COVID-19 pandemic has not only claimed millions of lives globally but has also redefined the landscape of grief and bereavement. Sudden deaths, restricted end-of-life rituals, and social isolation have created a fertile ground for Prolonged Grief Disorder (PGD), a debilitating condition marked by persistent yearning and functional impairment. With 40% of COVID-19 bereaved individuals reporting severe grief symptoms, the pandemic has underscored systemic gaps in mental health support (Wallace et al., 2021). Social workers, positioned at the intersection of healthcare and community care, have emerged as pivotal agents in mitigating PGD through pre- and post-death interventions. However, disparities in resource allocation and workforce training persist, particularly in low-income regions. This article examines the role of social work in addressing pandemic-related grief, evaluates evidence-based interventions, and proposes strategies to scale accessible, culturally sensitive bereavement care in a post-pandemic world.

Objectives of the Study

1. To analyze the psychosocial challenges faced by COVID-19 bereaved individuals, including disrupted mourning rituals and PGD risk factors.

2. To evaluate the efficacy of pre-death (e.g., legacy building, advance care planning) and post-death (e.g., ritual adaptation, bereavement follow-up) social work interventions.

3. To identify systemic barriers to equitable grief support and propose policy recommendations for workforce training and digital mental health solutions.

Research Methodology

This study employed a mixed-methods systematic review design to synthesize evidence on social work interventions addressing prolonged grief disorder (PGD) in COVID-19 bereavement. A comprehensive literature search was conducted across three databases (PubMed, PsycINFO, and Scopus) using keywords such as *prolonged grief disorder*, *COVID-19 bereavement*, *social work interventions*, *ritual disruption*, and *telemental health*. Peer-reviewed articles published between January 2020 and December 2023, focusing on adult populations and written in English, were included, while non-empirical studies and those lacking ethical approval were excluded. From an initial pool of 678 articles, 45 studies met the inclusion criteria, comprising qualitative interviews, randomized controlled trials (RCTs), and case reports. Thematic analysis was performed to identify recurring psychosocial challenges (e.g., stigma, isolation) and

effective intervention strategies (e.g.,virtual family conferencing, legacy-building activities). Quantitative data from RCTs were synthesized to assess the efficacy of interventions in reducing PGD symptoms, measured through standardized tools such as the Prolonged Grief Disorder-13 (PG-13) scale. Ethical rigor was maintained by excluding studies with non-consenting participants or non-peer-reviewed sources. This approach enabled a holistic understanding of the role of social work in mitigating pandemic-related grief and informed recommendations for scalable, culturally sensitive care models.

Definition and Conceptualization of Grief

Grief is a multifaceted emotional response to loss, commonly triggered by events such as the death of a loved one, divorce, job loss, or significant life transitions. The *Merriam-Webster Dictionary* (n.d.) defines grief as "deep and poignant distress caused by or as if by bereavement." This distress manifests through a spectrum of psychological and physiological symptoms, including sadness, anger, guilt, anxiety, and somatic complaints such as fatigue or insomnia (Stroebe et al., 2007). C.S. Lewis (1961), in his seminal work *A Grief Observed*, poignantly likened grief to an "invisible blanket" that isolates the bereaved from the world, emphasizing its isolating and all-consuming nature (p. 40). While grief is a universal human experience, its intensity and duration vary significantly across individuals, influenced by factors such as cultural norms, personal resilience, and the nature of the loss (Bonanno & Mancini, 2008). Most individuals gradually adapt to loss through a process termed *integrated grief*, where the pain of loss coexists with a return to daily functioning (Shear, 2015). However, for some, grief becomes debilitating and chronic, evolving into a clinical condition known as prolonged grief disorder (PGD).

Stages of Grief: A Framework and Its Critiques

Elisabeth Kübler-Ross's (1969) five-stage model of grief-denial, anger, bargaining, depression, and acceptance-remains a widely recognized framework for understanding grief. Introduced in *On Death and Dying*, this model was initially designed to describe the emotional journey of terminally ill patients but was later applied to bereavement (Kübler-Ross, 1969). While the stages provide a heuristic for conceptualizing grief, contemporary scholars critique the model for its linearity and lack of empirical validation (Stroebe & Schut, 1999). For instance, not all individuals experience every stage, and grief often involves oscillation between emotions rather than sequential progression (Maciejewski et al., 2016). Alternative models, such as the Dual Process Model (DPM), propose that adaptive grieving involves alternating between *loss-oriented* (e.g., sadness, yearning) and *restoration-oriented* (e.g., adapting to new roles) coping (Stroebe & Schut, 1999). This dynamic approach better captures the non-linear, individualized nature of grief.

Prolonged Grief Disorder: Symptoms and Diagnostic Criteria

Prolonged grief disorder (PGD), also termed persistent complex bereavement disorder in the DSM-5-TR (APA, 2022), is characterized by persistent, intense yearning for the deceased, accompanied by functional impairment lasting at least 12 months for adults (6 months for children). Symptoms include emotional numbness, bitterness, avoidance of reminders of the loss, and a shattered sense of identity (WHO, 2018; Prigerson et al., 2021). Unlike major depressive disorder (MDD), which involves pervasive low mood, PGD centers on longing and preoccupation with the deceased (Boelen&Prigerson, 2013). Neurobiological studies suggest that PGD involves dysregulation in reward-processing brain regions, such as the nucleus accumbens, which may perpetuate attachment-seeking behaviors toward the deceased (O'Connor et al., 2008). Epidemiological studies estimate that **7–10%** of bereaved individuals develop PGD, with higher rates following traumatic or sudden losses (Lundorff et al., 2017; Bryant et al., 2020).

Risk Factors for PGD

Key risk factors include:

1.Circumstances of the death: Sudden, violent, or preventable deaths (e.g., suicide, accidents) increase vulnerability (Keesee et al., 2008).

2.Relational dynamics: Overly dependent or insecure attachment to the deceased (Johnson et al., 2007).

3.Pre-existing mental health conditions: History of depression, anxiety, or prior trauma (Shear et al., 2011).

4.Lack of social support: Isolation or stigma surrounding the loss (Stroebe et al., 2020).

Clinical Implications and Treatment

PGD is associated with severe health consequences, including elevated risks of cardiovascular disease, substance abuse, and suicidal ideation (Szuhany et al., 2021). Effective treatments include Complicated Grief Therapy (CGT**)**, a targeted psychotherapy combining cognitive-behavioral techniques with narrative exposure to facilitate acceptance (Shear et al., 2005). Pharmacological interventions, such as SSRIs, may alleviate comorbid depression but do not directly address grief-specific symptoms (Zisook et al., 2018). Emerging therapies, like mindfulness-based interventions, show promise in reducing grief severity by fostering emotional regulation (Huang et al., 2021).

Cultural Considerations in Grief

Cultural norms profoundly shape grief expression and expectations. For example, collective societies may emphasize communal mourning rituals, whereas individualistic cultures might prioritize personal resilience (Rosenblatt, 2008). The DSM-5-TR and ICD-11 caution against pathologizing culturally normative grief practices, underscoring the need for culturally sensitive diagnostics (APA, 2022; WHO, 2018).

Grief and Depression: Distinct Yet Intertwined Phenomena

Grief following the death of a loved one encompasses multifaceted affective, cognitive, behavioral, and somatic responses (Stroebe et al., 2007). Affective symptoms may include profound sadness, anger, or numbness, while cognitive aspects often involve intrusive thoughts about the deceased or difficulty accepting the loss. Behavioral responses range from social withdrawal to rituals of remembrance, and somatic manifestations such as fatigue or appetite changes are common (Shear, 2012). Individual differences in grieving are shaped by factors like the nature of the relationship (e.g., losing a spouse vs. a distant relative), the cause of death (sudden vs. anticipated), cultural norms, and personal resilience (Dyregrov et al., 2014; Bonanno et al., 2008). For instance, deaths perceived as preventable or traumatic, such as suicide or accidents, often amplify grief intensity (Kristensen et al., 2012).

Depression and grief share overlapping symptoms, such as sadness and sleep disturbances, but differ fundamentally. Grief is typically tied to specific memories of the deceased, whereas depression involves pervasive hopelessness and self-critical thoughts (Zisook et al., 2009). The DSM-5-TR distinguishes major depressive disorder (MDD) from grief by emphasizing that grief-related sadness fluctuates and is linked to reminders of the loss, while MDD symptoms are persistent and generalized (APA, 2022). Longitudinal studies reveal that 15% of bereaved spouses experience clinically significant depression one year post-loss, declining to 12% after two years (Zisook et al., 2009). However, traumatic losses-such as those from disasters or violence-show higher rates. For example, 25% of Norwegian survivors bereaved by the 2004 tsunami met depression criteria two years later (Kristensen et al., 2009). Comorbidity between prolonged grief disorder (PGD) and depression is striking, with 50–70% of PGD cases also exhibiting depression (Zisook& Shear, 2009). This overlap suggests shared mechanisms, such as dysregulated stress responses, but PGD is uniquely characterized by persistent yearning and preoccupation with the deceased (Prigerson et al., 2021).

Prolonged Grief Disorder (PGD): A Distinct Clinical Entity

PGD, now recognized in the ICD-11 and DSM-5-TR, involves persistent, disabling grief lasting beyond cultural norms (WHO, 2018; APA, 2022). Core symptoms include intense longing for the deceased, emotional numbness, identity confusion, and avoidance of reminders of the loss. Unlike depression, PGD centers on attachment disruption rather than low self-worth (Boelen&Prigerson, 2013). Neuroimaging studies highlight heightened activity in brain regions associated with attachment, such as the anterior cingulate cortex, which may sustain prolonged yearning (O'Connor et al., 2008).

Risk Factors for PGD-Depression Comorbidity

- Traumatic Deaths: Sudden, violent, or stigmatized deaths (e.g., COVID-19, suicide) increase PGD risk (Eisma et al., 2020).
- Relational Dynamics: Overdependency or unresolved conflicts with the deceased (Johnson et al., 2007).
- Social Isolation: Lack of communal mourning rituals or support (Stroebe et al., 2020).

COVID-19 and Exacerbation of Prolonged Grief

The COVID-19 pandemic has created a "perfect storm" for PGD due to sudden deaths, restricted end-of-life rituals, and social isolation (Eisma & Tamminga, 2020). Approximately 40% of individuals bereaved by COVID-19 report severe grief symptoms, compared to 10% pre-pandemic (Wallace et al., 2021).

Key Contributing Factors:

1. Sudden and Stigmatized Deaths: COVID-19 deaths often occurred rapidly, leaving families unprepared. The stigma associated with the virus exacerbated shame and avoidance (Goveas & Shear, 2020).

2. Disrupted Mourning Rituals: Lockdowns and infection control measures barred families from bedside goodbyes, funerals, and communal grieving. In Tamil Nadu, India, funeral attendance was restricted to 50 people, and children were prohibited from rites, depriving families of cultural solace (Department of Health, 2020). Similar restrictions in the U.S. and U.K. led to "virtual funerals," which many found insufficient for closure (Selman et al., 2021).

3. Moral Injury and Guilt: Survivors who inadvertently transmitted the virus to loved ones faced profound guilt, a known PGD risk factor (Mayland et al., 2020).

Case Example: The death of Dr. Simon Hercules, a Chennai neurosurgeon, illustrates pandemic-era grief complexities. After contracting COVID-19 from a patient, Dr. Hercules faced violent opposition to his burial from fearful residents, compounding his family's trauma (Sinduja &Omjasvin, 2020). Such incidents highlight how societal stigma and disrupted rituals intensify grief.

Clinical and Societal Implications

PGD's ripple effects include heightened risks of substance abuse, cardiovascular disease, and suicidal ideation (Szuhany et al., 2021). Culturally sensitive interventions are critical. For example, **Complicated Grief Therapy (CGT)** incorporates narrative techniques to help individuals reconcile loss (Shear et al., 2005). During COVID-19, teletherapy and online support groups emerged as vital tools, though accessibility gaps persist in low-resource settings (Breen et al., 2022).

Recommendations for Practitioners:

- Screen for PGD in COVID-19 bereaved families.
- Advocate for policies enabling safe mourning practices (e.g., protected funeral spaces).
- Address systemic inequities, such as unequal access to mental healthcare (Mason et al., 2020).

Need for a Multidisciplinary Skilled Workforce

The COVID-19 pandemic has created a high-risk environment for prolonged grief disorder (PGD) due to sudden deaths, disrupted mourning rituals, and social isolation (Eisma et al., 2020). A skilled interdisciplinary workforce-including social workers, clinicians, and mental health professionals-is essential to address the complex psychosocial needs of bereaved families. Social workers, in particular, serve as critical mediators between healthcare systems and grieving families, providing emotional support, facilitating communication, and connecting families to resources (Johns et al., 2020). Their role is amplified in pandemic contexts where traditional support networks are disrupted, and families face logistical barriers such as visitor restrictions and PPE requirements (Mason et al., 2020).

For example, social workers in hospital settings can conduct early screenings for PGD risk factors, such as traumatic loss experiences or pre-existing mental health conditions (Lobb et al., 2010). In high-income countries, social workers often lead bereavement teams that coordinate with medical staff to deliver holistic care. A study in U.S. hospitals found that integrating social workers into palliative care teams reducedby 30% through proactive communication and emotional validation (Breen et al., 2022). However, in low-resource settings, the lack of trained social workers exacerbates disparities in grief support, leaving many families vulnerable to PGD (Selman et al., 2021).

Pre-Death Interventions: Building Resilience and Connection

Pre-death interventions aim to prepare families for impending loss and mitigate anticipatory grief. Key strategies include:

1. Advance Care Planning: Social workers guide families in discussing end-of-life preferences, reducing decisional

conflict and fostering a sense of control (Curtis et al., 2018).

2. Legacy Building: Activities such as recording video messages or creating memory books help patients and families preserve meaningful connections. These interventions are associated with reduced grief intensity post-loss (Allen et al., 2019).

3. Proactive Communication: Regular, empathetic updates from clinicians-facilitated by social workers—help families process medical realities. A study of ICU families during COVID-19 found that structured virtual family conferences reduced PTSD symptoms by 25% (Hart et al., 2021).

4. Technology-Mediated Connections: Social workers use tablets or smartphones to facilitate virtual goodbyes, addressing the isolation of dying COVID-19 patients. In India, platforms like WhatsApp enabled final interactions for 68% of families barred from hospitals (Sundararajan et al., 2021).

These interventions are most effective when delivered through interdisciplinary teams. For instance, oncology social workers collaborating with nurses and chaplains reported a 40% increase in family satisfaction with end-of-life care (Johannsen et al., 2019).

Post-Death Interventions: Facilitating Adaptive Grieving

Post-death support focuses on validating grief and restoring social connections:

1. Ritual Adaptation: Social workers help families create alternative mourning rituals, such as virtual memorials or candlelight vigils. Research shows that adapted rituals reduce feelings of "unfinished business," a key PGD risk factor (Neimeyer & Burke, 2017).

2. Bereavement Follow-Up: Structured follow-up programs, including psychoeducation on grief trajectories and coping strategies, are critical. A UK program offering six weekly counseling sessions reduced PGD symptoms by 45% in COVID-19 bereaved individuals (Selman et al., 2022).

3. Memento Provision: Providing families with items like handprints or lockets of hair fosters continued bonds with the deceased, which can buffer against severe grief (Steffen et al., 2020).

4. Child-Centered Support: Social workers use play therapy or art-based interventions to help children express grief. A meta-analysis found such methods reduced emotional distress in 73% of bereaved children (Cohen et al., 2017).

CONCLUSION

The pandemic has underscored systemic gaps in grief support, particularly in low-resource regions. To address this, three priorities emerge:

1. Workforce Training: Scaling evidence-based PGD interventions, such as Complicated Grief Therapy (CGT), requires training programs for social workers and community health workers. Teletraining platforms like the WHO's iSupport for grief show promise in resource-limited settings (WHO, 2021).

2. Digital Innovations: Internet-based CBT programs, such as *GriefHelp*, have demonstrated efficacy in reducing PGD symptoms by 50% in randomized trials (Eisma et al., 2022). Expanding access to these tools is critical as pandemic-related grief persists.

3. Policy Advocacy: Governments must fund bereavement care as part of universal health coverage. For example, New Zealand's integration of grief support into primary care reduced PGD prevalence by 20% in Mâori communities (Breen et al., 2021).

Future research should explore cultural adaptations of PGD interventions and longitudinal outcomes of pandemic-related grief. Without urgent action, the "shadow pandemic" of PGD will strain global mental health systems for decades.

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