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Complicated grief knowledge, attitudes, skills, and training among mental health professionals: A qualitative exploration

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ABSTRACT

The knowledge, attitudes, skills, and training of professionals regarding complicated grief influence their practice. We conducted 30 semi-structured interviews with psychiatrists, psychologists, and counselor/psychotherapists; the preliminary findings were contextualized via interviews with three experts in complicated grief research/practice. Findings suggest that professionals did not substantially rely on research evidence, favoring instead personal and professional knowledge. They expressed concern regarding the possible pathologization of normal grief that might arise from having a diagnosis of complicated grief. Deficits in professional training were evident. A need for an improved culture of collaboration between researchers and practitioners was identified.

Grief that has failed to become integrated into a bereaved person's life is variously named as Complicated Grief (Shear, Frank, Houck, & Reynolds, 2005), Prolonged Grief (World Health Organization, 2016), Prolonged Grief Disorder (Prigerson et al., 2009), and Persistent Complex Bereavement Disorder (American Psychiatric Association, 2013). Complicated grief is a severe grief reaction, including symptoms of persistent yearning for the deceased, intense sorrow and emotional pain, rumination, and preoccupation with the deceased and with the circumstances of the death (Shear et al., 2005). People experiencing complicated grief have elevated levels of suicidal ideation (Zisook et al., 2018), impaired health (Lannen, Wolfe, Prigerson, Onelov, & Kreicbergs, 2008), poorer quality of life (Prigerson et al., 2009), and are at greater risk of cognitive decline (Pérez, Ikram, Direk, & Tiemeier, 2018), compared to other bereaved people.

The prevalence of complicated grief in the general population is estimated at 3.7% (Kersting, Brähler, Glaesmer, & Wagner, 2011) and 6–7% in the bereaved population (Aoun et al., 2015; Kersting et al., 2011), although this figure may be greater depending on the circumstances of the death (Kristensen, Weisaeth, & Heir, 2012). Given that complicated grief has the potential to adversely affect the lives of many, it is important to understand mental health professionals' knowledge, attitudes, skills, and training regarding complicated grief. A systematic review by Dodd, Guerin, Delaney, and Dodd (2017) highlighted a paucity of primary research examining the response of mental health professionals to a person experiencing complicated grief. A Europe-wide survey found an overall lack of both national and local guidance on the provision of bereavement support and concluded that there may be "a reliance on intuition over evidence" (Guldin et al., 2015, p. 188) when caring for the bereaved.

A study of 29 bereavement counselors in the UK reported little awareness of newer models of grief and grief was viewed as complicated if too much time had elapsed (Payne, Jarrett, Wiles, & Field, 2002). The results of a study examining the referral practices of General Practitioners (GPs) in the UK indicate that their understandings of what constitutes normal or problematic grief were central to their referral decisions (Wiles, Jarrett, Payne, & Field, 2002). They relied on linear conceptualizations of grief as opposed to newer models which recognize oscillation between psychological orientations. A study exploring the knowledge and attitudes to traumatic grief found that healthcare professionals in the United States regarded referral to pastoral care as the most appropriate intervention (Latin & Fort, 2011). In a study of counselors and psychologists in Australia, 55.5% felt that

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recognizing complicated grief risked pathologizing a normal life event (Ogden & Simmonds, 2014). A study of health professionals in Germany found that, although 42.4% believed that the inclusion of complicated grief in diagnostic manuals outweighed the disadvantages, almost one-third (32.9%) believed the opposite to be the case (Dietl, Wagner, & Fydrich, 2018). Finally, in a study by Davis, Deane, Barclay, Bourne, and Connolly (2018), Australian professionals, predominantly nurses (90%), were largely accepting of Prolonged Grief Disorder as a diagnosis and were confident in their knowledge and skills to respond appropriately to caregivers.

Studies have identified a need for both undergraduate and postgraduate bereavement education for health professionals (Breen, 2011; O'Connor & Breen, 2014; Wiles et al., 2002). Similarly, a Canadian study of grief professionals from a variety of backgrounds found that they relied on outdated training and only reviewed the grief literature as time permitted (Thompson, Whiteman, Loucks, & Daudt, 2017). Accordingly, the aim of this study was to add an Irish perspective to the wider debate by exploring the knowledge, attitudes, skills, and training of mental health professionals in relation to complicated grief.

Method

Research design

We set out to gain insight into the experiences of professionals working with clients presenting with complicated grief, and also to inform the survey in a later phase of the overall project. A broadly phenomenological design was appropriate given the exploratory nature of this investigation and the desire to capture professionals' understanding. The study was designed in line with the guidelines proposed by O'Brien, Harris, Beckman, Reed, and Cook (2014), including sampling of participants, collection and analysis of data, and grounding in empirical data. In terms of reflexivity and positionality, the first author is an experienced psychotherapist and undertook this research as part of her PhD. However, the potential for this role to influence the research was moderated by the inclusion of other professions (including psychology and psychiatry) on the research team.

Participants and sampling

Thirty mental health professionals were interviewed (13 men; 17 women), 10 each from psychiatry, psychology, and counseling/psychotherapy. Counselor/psychotherapists and psychologists were sampled purposively and selected randomly from within the purposively-selected potential sample. Psychologists and counselor/psychotherapists were selected from the online directory of their professional bodies, while psychiatrists were selected from the Irish Medical Directory. It was possible to sample counselors/psychotherapists based on the inclusion of loss/bereavement as an area of interest in the directory and psychologists on the basis of their membership of the Psychological Society of Ireland Special Interest Group in Death, Dying and Bereavement, increasing the likelihood that the sample would have experience of engaging with the research literature and exposure to clients. However, psychiatrists were sampled randomly as no specific information regarding their interest in grief matters was available. Psychologists were predominantly women, while the gender balance of counselor/psychotherapists and psychiatrists was more even. The psychiatrists were the most experienced, all having more than 10 years in practice, while 6 out of 10 psychologists and 8 out of 10 counselor/psychotherapists had less than 10 years in practice. No additional demographic information was collected to minimize the potential identifiability of participants.

Three international experts in complicated grief were also interviewed to contextualize the professionals' responses, by giving an account of current international practice against the backdrop of research in the field (Padgett, 2017). Experts were defined as individuals who had made a significant contribution to the area of grief and bereavement, either in research or practice. It was important that the experts chosen had a demonstrated interest in training in relation to complicated grief and not solely in research. The choice of experts was agreed upon, following discussion with the research team. To protect their identities, no further detail is provided about their geographic location or professional backgrounds.

Materials and procedure

Interviews took place between September 2015 and January 2016 and used a semi-structured interview guide, which was informed by the findings of the systematic review of professionals' knowledge of complicated grief (Dodd et al., 2017), with the intention of examining the knowledge, attitudes, skills, and training. The interview probed knowledge of complicated grief and how professionals delineated between uncomplicated and complicated grief; their attitudes to the concept of complicated grief, particularly its

inclusion in diagnostic manuals; their mode of engagement with someone presenting with complicated grief (i.e., their skills); and their level of, and interest in, training in complicated grief. The interview guide was piloted with one psychotherapist to identify any need for adjustments. However, no changes were needed. A separate interview guide was used with experts, who were interviewed concurrent to the main samples. Topics included the relationship between research and practice in the area and the medicalization debate. Experts were not explicitly asked about skills given that all three were not active in practice, though all three were asked about the training needs of professionals. All interviews were audio-recorded and took place face-to-face or by telephone, depending on participant preference. Professional interviews varied in duration from 11 to 39 minutes (Mean = 16.7) while the expert interviews lasted between 30 and 45 minutes.

The researchers were aware that the research interview could generate unanticipated distress. However, the risk was no greater than what they might reasonably experience in their clinical practice, particularly as personal grief experience was not being explored (Widdowson, 2012). Ethics exemption was confirmed by the Office of Research Ethics of University College Dublin.

Data analysis

The data were analyzed using thematic analysis (Braun & Clarke, 2006). Verbatim transcripts were prepared, anonymized, read, and re-read to immerse the researchers in the data. Line-by-line coding was carried out across the entire data set, codes were collated and candidate themes were generated. To inform reflection on the interpretation of the first author and add to trustworthiness, the second author independently coded 20% of the transcripts and generated candidate themes. Themes were reviewed across the entire dataset for convergence and divergence and discussed by the researchers. Having reflected on patterns, the final themes were defined and named by the first author. Although consensus coding was not the objective, the research perspective of the second researcher acted as a useful counterpoint to the strong practice experience of the lead researcher. Having identified themes in the main sample, the expert interviews were reviewed for patterns evident on these issues. In distilling the results and reflecting the structure of the interview, the themes from across the groups were sorted into the topics of knowledge, attitudes, skills, and training.

Results

A visual summary of the results relating to knowledge, attitudes, skills, and training is depicted in Figure 1. The satellite squares represent the number of professional interviews in which each theme was identified, while the satellite circles represent the findings from the expert interviews. In the sections below, extracts are presented with a code indicating each participant's profession–Psychiatry (PY), Psychology (PS), and Counseling/Psychotherapy (CP).

Knowledge

The first knowledge theme from the professionals was that complicated grief is slow in gaining acceptance across professions. The level of awareness of complicated grief was variable: "People don't know enough about it. I don't think that people distinguish between the two [normal grief and complicated grief]" [CP4]. Although practitioners may be familiar with the idea of complicated grief, doubt was expressed as to whether there was widespread understanding of its clinical underpinnings. The notion that there may be a shift in thinking about complicated grief was also expressed: "it's only relatively recently that psychiatrists began to take this seriously" [PY10]. Overall though, polarized views were expressed; for instance, one counselor/psychotherapist described himself as being "a little bit dismissive of the notion of complicated grief" [CP10] because "every grief is complicated in some way" while a psychiatrist described complicated grief as being "a very significant cause of psychopathology and I think it is often overlooked" [PY3]. The experts proffered explanations as to why complicated grief might sometimes not be acknowledged. Expert 1 felt that the "ambiguity of terms like complicated grief" was problematic and he regarded it as having "created chaos" among both experts and practitioners. Both he and Expert 2 voiced concern that the lack of agreed-upon diagnostic criteria affected recognition. However, Expert 3 maintained that, "regardless of the diagnostic nomenclature or the textbooks or the manuals, in practice people de facto recognize this issue".

The second theme concerned knowledge transfer from research into practice. Three professionals cited reading journal articles as important for staying abreast of research. The inclusion of articles on

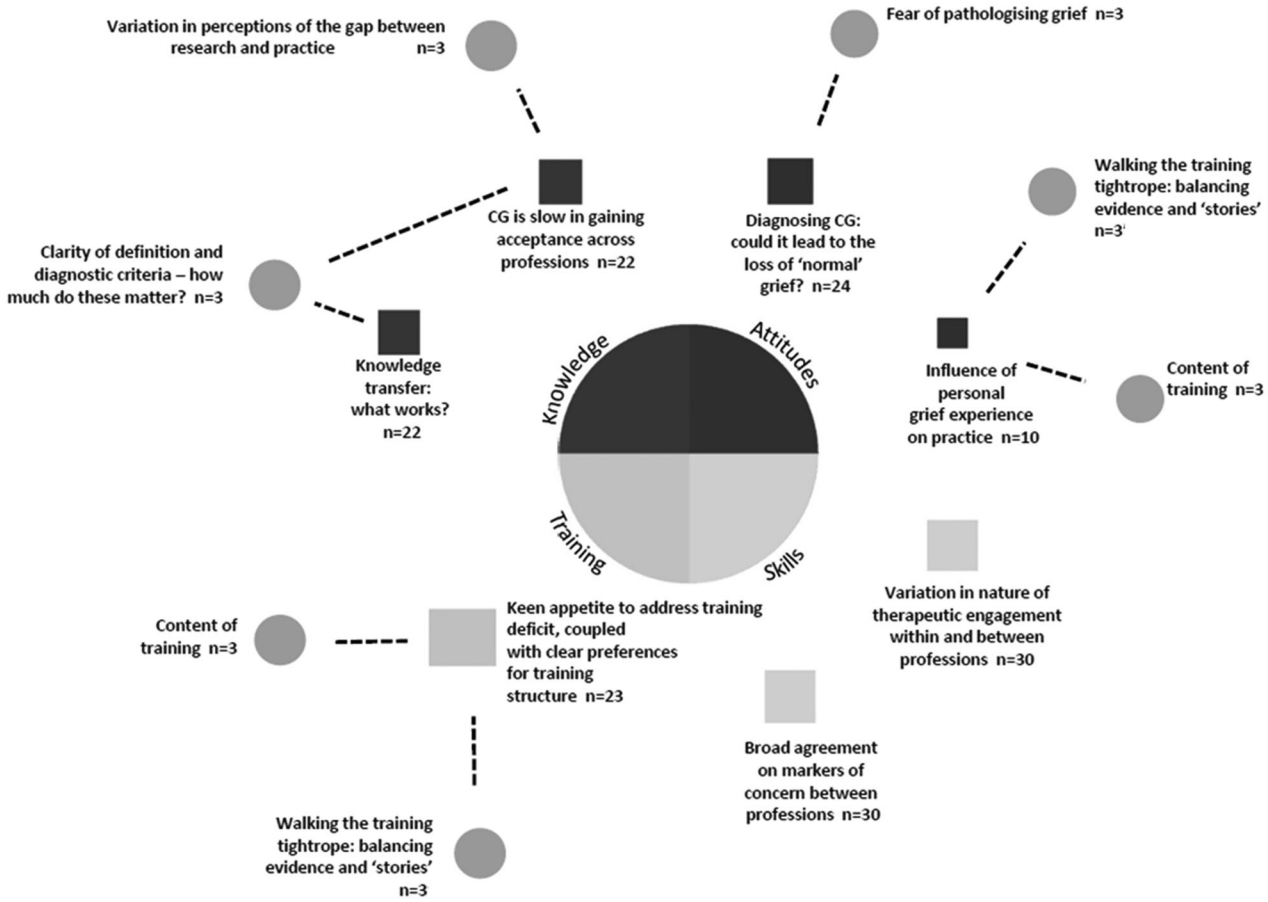

Figure 1. Summary of results relating to knowledge, attitudes, skills and training.

complicated grief in practitioner-focused journals was mentioned as worthwhile in this regard by professionals and experts. Expert 1 emphasized the responsibility of researchers to publish findings that are accessible to both practitioner and public audiences, stating that "a lot of psychiatric journals are totally unintelligible to the average layman".

The professionals on the Irish Hospice Foundation database described weekly bereavement literature updates as useful for staying current with research. Psychologists referred to having students conduct literature reviews as a useful mechanism for staying up-to-date. Social media was also mentioned in this context. These methods were regarded as being "very doable, if you only have a few minutes to spare" (PS8), which was important given perceived time and cost barriers to further training. Professional bodies were mentioned as having a responsibility in providing continuing professional development (CPD). While acknowledging that researchers and practitioners work from differing perspectives, the experts regarded the recognition/confrontation of this research-practice tension as central to overcoming barriers to knowledge transfer:

> I'm a researcher and when I present to clinicians … they don't want numbers, they want stories. And I have a kneejerk response to hearing "I want stories" because to me that says "I don't want to hear any evidence" [Expert 3].

Attitudes

The first attitudes theme concerned whether diagnosing complicated grief could lead to the loss of "normal" grief. Professionals were in general agreement that, at least in acute phases, normal grief has a range of presentations. They also agreed that normalizing the person's experience is important. The level of impairment of functioning was a key factor in distinguishing between normal grief and grief that required intervention. As one professional commented, "there's no help in normalizing something that is maladaptive" [PS10].

The idea that normal grief might be pathologized by diagnosis was a concern for many counselor/psychotherapists and psychologists. Typical statements were "I don't actually believe that it's pathological. I believe that it's a natural process of living" [CP3] and

Table 1. Markers of concern across professionals[a].

Psychiatrists	Psychologists	Counselor/Psychotherapists
Consensus features		
Time since death	Time since death	Time since death
Nature of death	Nature of death	Nature of death
Depression	Depression	Depression
Suicidal ideation	Suicidal ideation	Suicidal ideation
Being stuck	Being stuck	Being stuck
Level of impairment of functioning	General functioning	Impairment of functioning
Psychiatric morbidity	Co-morbidity	Co-morbidity
Shared features[b]		
Duration of symptoms	Severity of symptoms	
	Nature of relationship	Nature of relationship
Ambivalence regarding the deceased		Pre-occupied with deceased
Severely distorted thinking	Distorted thinking	
Persistent yearning	Yearning and longing	
Support structures		Support structures
Impaired sleep	Impaired sleep	
	Loss of meaning	Loss of meaning
Features particular to each profession		
Proportionality for intensity of symptoms	Lack of joy	Idealizing the deceased
Anxiety	Guilt	Blame
Client's personality	Anger	Comparison with prior functioning
	Avoidant behavior	Death anxiety
	Disbelief	Helplessness
	Ability to reengage with daily life	

[a]Coding/analysis was done separately for each group, so there is some variation in theme names. However, similarities in *meaning* are noted.
[b]Shared means mentioned by two of the three groups.

"I find it very hard to buy into the notion that bereavement can ever be classified as an illness" [PS2]. By contrast, psychiatrists displayed more ease with diagnosis and typical statements were "we only try to medicalize what is abnormal" [PY6] and "let's diagnose it properly. You only pathologize grief if you mislabel it" [PY4]. Only three psychiatrists mentioned over-diagnosis as a concern.

All three experts maintained that, in certain circumstances, specialist intervention is warranted. However, they displayed varying degrees of sensitivity to the idea that intervention might pathologize a normal condition. Expert 3 said "diagnostically, the concern, and I think it's a real concern, is overdiagnosis" and sometime later referred to ignoring intervention in cases of "abnormal" grief as being "irresponsible". Expert 2 maintained that "there is no such thing as grief that is pathological", but rather that the process of grief may become problematic. She was keen note that no deficiency was attached to the person simply because their grief went off-track. Expert 1 seemed more comfortable with defending a diagnosis of abnormal grief, with his view reflecting the idea that "there is no point in making a diagnosis if nobody benefits from it". He was also totally accepting of the idea of false positives as pertinent to any diagnosis, not just complicated grief, and that diagnoses must be made without apology when benefits outweigh the risks.

The possible benefit associated with diagnosis was alluded to but immediately juxtaposed with the potential drawbacks, in one case, referring to naming grief as complicated as "a kind of double-edged sword" [PS8]. Others acknowledged that labels may be helpful for some but for others it "puts them into a place where they are blinded by the label and actually see themselves as 'less than'" [CP10]. Overall, for counselor/psychotherapists and psychologists, there was a concern that "normal" grief might be eroded by a diagnosis of complicated grief.

The second theme considered the influence of personal grief on professional practice. Members of all three professions acknowledged that personal experiences had a bearing on engagement with a person presenting with grief issues. One view was that intervention in complicated grief "is mixed up maybe in clinicians' own experience of grief and in their compassion level around grief and bereavement" [PS9]. The universality of grief set it apart from other presenting issues and required acknowledgement to ensure that clients' issues did not trigger the professional's own grief. Personal experience was also seen as giving a greater understanding: "my main experience of bereavement is because my wife died back in 2000 […] it gives me a better understanding" [CP4].

Skills

In exploring how the professionals identified complicated grief, there was good agreement on markers of dysfunctional grief (Table 1). Although the professionals agreed that the length of time since the death

was relevant in separating normal and complicated grief, there was little consensus regarding this time span. The time span varied from "no specific time frame", to "it would certainly be within six months", to "eight months", to "at least a year", to "two years or more" and, in the case of a griever with intellectual disability, "4 years". While there was good agreement regarding what was considered important to look for in a presenting client/patient, there is no suggestion that these markers were weighted the same by all, noting that many of these markers are subjective in nature.

The second theme relating to skills was variation in therapeutic intervention within and between professions. Psychiatrists, in the first instance, tended to check for co-morbidity, such as depression, anxiety, or underlying personality disorder rather than engaging with complicated grief itself. One participant noted, "I would assess to see if they have a mental health disorder that would need treatment, so I would look for depression, anxiety, I suppose things from the medical point of view that I would be able to manage" [PY1]. There was some variation in the use of medication for these co-morbidities. On response was "occasionally it can be appropriate to use medication, you know if somebody is very distressed" [PY4], while another said "I'd pop pills into them if there was depression but I'd probably wait until they got some relief from the pills and then encourage bereavement therapy" [PY8]. One psychiatrist exhorted actively looking for grief, likening consultation to "detective work" [PY3], where grief may not always be the presenting issue. None of the psychiatrists mentioned using a screening instrument for complicated grief.

For the counselor/psychotherapists, if co-morbidity or any self-harm or suicidal ideation was present, medical assistance was enlisted from GPs. No consistent approach to intervening in complicated grief was taken by this group, relying instead on supportive, person-centered counseling, holding the client and listening out for any evidence of the client being stuck in their grief. They reported being "comfortable to see anyone" [CP1], and "able to hold anyone as long as medication wasn't required" [CP5]. Only one of this group mentioned having familiarity with a complicated grief screening instrument, although he had never actually used it.

Five of the psychologists had varying levels of exposure to Complicated Grief Therapy (Shear et al., 2005) and used this approach to inform their practice. Three engaged in grief psychoeducation whereby clients learned about the reactions one might expect in a normal grieving process and were exposed to new strategies to deal with loss. These psychologists saw psychoeducation as central to work with complicated grief whereas psychoeducation was mentioned only by one counselor/psychotherapist and two psychiatrists as being used in practice.

One area where there was overall agreement on therapeutic approach was the referral of the client to another professional. Seven psychiatrists engaged in this practice and, in all cases, expressed a preference for referring to a psychologist if one was available. Six psychologists also said they would refer, including to psychiatry through the GP, to someone else on the mental health team, or to another psychologist with specialist grief experience. Seven counselor/psychotherapists said they would refer if the presentation was outside their sphere of competence, and four of these would refer to a GP. The remaining three would refer to another counselor with specific grief experience, although to date they had not found it necessary.

There was scant evidence in interviews that professionals relied on knowledge of current grief literature to inform their practice. One counselor/psychotherapist and one psychologist described the Dual Process Model (DPM; Stroebe & Schut, 1999) very useful. Two psychiatrists and one counselor/psychotherapists said their approach was influenced by Complicated Grief Therapy (Shear et al., 2005), tailoring it to the client's needs. General reference was made by two people to attachment theory and another mentioned Yalom's (1980) existential approach. Two counselor/psychotherapists made reference to the stages of grief and another explicitly mentioned the work of Kübler-Ross (1969), as did two psychiatrists. However, a further two psychiatrists, who had been exposed to Kübler-Ross in training, no longer regarded this approach as relevant, commenting that "we all learn [the] Kübler-Ross stages and all that sort of stuff which we put to the side" [PY4] and "we were taught those stages … but it's more complex than that" [PY6]. However, they did not mention an alternative theory. Two psychologists expressed annoyance that, despite not having an evidence base, the stages of Kübler-Ross were still employed by their colleagues.

Training

Participants displayed a keen appetite to address a perceived training deficit, coupled with clear preferences for training structure. They expressed being

unsure of how to manage complicated grief, due largely to inadequacies in training: "I think that there probably could be more attention given to it in training. I think that there probably would be a lot of people who would not be comfortable working in the area" [PS5]. This was reinforced by a counselor/psychotherapist who said "It's a little bit like working with suicide. Colleagues are very anxious about it. I get a sense that people are not very well trained and are not possibly skilled enough" [CP2]. This deficiency in training was seen in both initial training and CPD opportunities, though there were two notable exceptions in this regard. Two psychologists, who had undertaken training in Complicated Grief Therapy (Shear et al., 2005), expressed confidence that they were fully equipped to deal with any grief issue. Others who had more introductory complicated grief training saw it as "a good first step" [PS9], while the majority had generic bereavement training and had none in complicated grief.

Although interest in further training was expressed by many, there were some, especially psychiatrists, who had no interest in training, largely because they did not see it as relevant "from the point of view of delivering my day job" [PY4]. Another psychiatrist, while interested in grief, regarded complicated grief as not being "a huge bread and butter thing" for her [PY2]. Another, *not* interested in training, thought it important "to have somebody in her team trained up" [PY1]. One of the key barriers to embarking on training in complicated grief was the professionals' time deficit. To be attractive, training would have to be coupled with CPD accreditation. Assessment of complicated grief and treatment options based on the latest research, were identified as being most desired, if time were limited. The cost of training was also identified as being a barrier.

There was a preference for training with "a mixture of academic and experiential … using stories to illustrate points" [PS2]. Some professionals voiced that they would like training to provide "an opportunity to actually integrate the theory, to consider it, to be reflective" and that perhaps training "one day a month over a year" would be appropriate to provide the necessary mix of information and time [CP7]. However, while many professionals expressed the view that grief training required an experiential component, one counselor/psychotherapist also stated that "workshops are useful for some things [but] sometimes the whole counseling scene is 'over-workshopped'" and expressed a preference for "hard facts … giving the latest information and the latest academic research particularly on the differentiation between complicated grief and [normal] grief" [CP9]. One psychiatrist was explicit about the inclusion of grief as a topic in psychiatric training, saying "Maybe two or three lectures. The palliative care people should push forward a package of what they think psychiatrists would need to know" [PY8].

The experts agreed that training that emphasized the dissemination of knowledge alone is not sufficient to bring about changes in practice. Echoing the views of professionals, experts recognized that personal experiences and attitudes also need to be addressed, if training is to be successful. Their recommended approach is best illustrated by Expert 1: "what is needed is a certain amount of didactic teaching around the research so that people do understand the issues, and … experiential types of teaching involving people, bringing people in close touch with the feeling side of things". Expert 3 found the use of vignettes particularly successful in teaching about a diagnosis of complicated grief and in distinguishing this from normal grief and other conditions in DSM-5 (American Psychiatric Association, 2013). Two experts recommended role play as useful in providing an experiential learning environment, facilitating the engagement of practitioners with their own grief. In addition to the use of role play, the "examination in small groups of people's personal experiences of loss" [Expert 1] was regarded as being helpful in terms of engaging affectively with grief. This affective engagement was a necessary component of training, since witnessing another's pain is difficult and may activate practitioners' own grief. It was also suggested that practitioners' noninvolvement in training might be related to the painful nature of confronting grief–"emotionally they may not want to [engage]. It's just too hard" [Expert 2], echoing the personal dimension to grief that the professionals mentioned earlier. Both the experts and professionals recognized that good training is multi-facetted: evidence must be presented; opportunity must be afforded for the practice of skills, and practitioners' personal experience of grief must be given due consideration.

Discussion

This study is the first to explore the knowledge, attitudes, skills, and training of a group of Irish professionals regarding complicated grief. Recognizing that complicated grief is associated with poor clinical outcomes and is an important public health issue (Shear et al., 2014), the research aimed to add to the global

debate about complicated grief by giving an account of current practice and attitudes against the backdrop of expert opinion.

The experts identified a gap between research and practice in complicated grief, although perceptions of the size of this gap differed. To some extent, this gap was evidenced in the professionals' description of their practice. There was scant mention of contemporary grief theories such as meaning making (Neimeyer, Burke, Mackay, & van Dyke Stringer, 2010) or continuing bonds (Klass, Silverman, & Nickman, 2014), though professionals were not explicitly asked about grief theories which shaped their practice. However, the interviews revealed that stage theories are still somewhat pervasive. This is consistent with research elsewhere, which reports that stage-based theories, while lacking in empirical foundation (Stroebe, Schut, & Boerner, 2017), are still emphasized in some university training courses (Breen, Fernandez, O'Connor, & Pember, 2013), text books (Corr, 2018), and amongst the public at large (Breen, Penman, Prigerson, & Hewitt, 2015). Given that stage theories are so firmly embedded in our societal consciousness, it is important that any education or training in complicated grief, and in grief generally, takes account of the fact that such training does not start from a neutral base.

Both review/opinion papers and empirical studies suggest the importance of the six-month mark in a grief trajectory (Prigerson et al., 2009). Moreover, follow-up studies indicate that symptoms of complicated grief present at the six-month mark are predictive of poor outcome at both 13 and 23 months (Prigerson et al., 1996, 1997). There was little evidence of this among professionals, with many appearing wedded to the notion that at least a year is needed, and much longer in many cases. This echoes the findings of a recent study of German mental health professionals (Dietl et al., 2018), which found that only 11.3% of the professionals supported the 6-month timeframe. It must also be noted that some research suggests that the timeframe may be considerably lengthened depending on the circumstances of the death (Neria et al., 2007; Shear, Jackson, Essock, Donahue, & Felton, 2006), though this is not part of current diagnostic criteria. Training initiatives, if they are to be successful, need to address the competing views on this issue.

A concern for most psychologists and counselor/psychotherapists was that accepting complicated grief risks pathologizing a normal life experience. There was a real sense from these professionals, while acknowledging the possible benefits for a person receiving the diagnosis, that a diagnosis was always pejorative and not merely informative. The psychiatrists and the experts were less concerned about this and saw accuracy of diagnosis as a cornerstone of good practice. However, all were mindful that overdiagnosis of complicated grief was something about which to be vigilant. Summerfield (2001) describes the "trauma industry" (p. 96), which he maintains grew out of the designation of Post-traumatic Stress Disorder (PTSD) as a diagnosis. It is possible that participants in this study were fearful of diagnostic inflation around complicated grief and the creation of a similar industry. However, intervention to improve well-being is not necessarily predicated on the presence of disease and it may be the case that the notions of pathologization and medicalization are somewhat conflated. While common sense dictates that we guard against turning the distress of grief into a disease, this does not preclude us from using intervention, where someone is experiencing complicated grief, for "genuine empowerment" (Morgan, 1998, p. 115). Parens (2013) usefully distinguishes between "good and bad forms of medicalization" (p. 28) and the question exists whether, like pregnancy, childbirth, sexual dysfunction, and a host of other life experiences, treating complicated grief might come under the umbrella of "good medicalization".

In terms of professionals' skills, there was limited evidence that approaches adopted were explicitly grounded in the bereavement literature. There was almost no mention of formal screening for complicated grief and it seemed that depression or another co-morbidity was first explored. Research evidence shows that symptoms of complicated grief are largely distinct from depression, anxiety, or PTSD (Prigerson et al., 2009) but this distinction was not widely recognized in the professional interviews. It seems likely, as was suggested by the experts, that this lack of clarity regarding diagnostic criteria for complicated grief is due to limited knowledge transfer, which has hampered the adoption of complicated grief as a diagnostic entity. Contemporary models of grieving recognize oscillation between loss and restoration orientations as being an important feature of grief integration (Stroebe & Schut, 1999). Though they were not explicitly asked about theories, utilization of the concept of oscillation was only evident in the professional practice described by two participants. It is also noteworthy that three professionals mentioned tailoring Complicated Grief Therapy to specific patient/client need, suggesting that fidelity to the protocol was not considered necessary to achieving a good outcome.

While there are well-developed policies in many countries relating to bereavement care (e.g., the national standards for bereavement care in Ireland), the lack of a "gold standard" definition and criteria for complicated grief inhibits the development of policy and standards to address this particular aspect of bereavement. Researchers must strive for this and recognize that it is difficult to garner acceptance for complicated grief amongst practitioners, and wider society, in the absence of such clarity.

Even in the presence of such clarity, however, there is no guarantee that research findings will be used in practice. The gap between research and practice may not represent any unwillingness to use the research but rather that the research is not addressing the issues that are important to practitioners. A top-down model in which researchers see themselves as producers of knowledge and practitioners as mere consumers is unlikely to succeed. A more collaborative approach between researchers and practitioners is clearly necessary so that practitioners are agents, and not simply objects, of enquiry. A recent Delphi study identified 10 research priorities in grief and bereavement care and these provide an excellent basis for a practice-based research agenda (Hay, Hall, Sealey, Lobb, & Breen, 2019). Greater funding for working partnerships between grief researchers and practitioners would be a first step toward such collaboration. In addition, sustained attention could be given to the communication of grief research findings in undergraduate curricula to increase awareness and knowledge of this issue. Early exposure to relevant research might support the development of research-literate reflective practitioners, enabling a better flow of knowledge between practice and academia.

From the professional and expert interviews alike, it was clear that attention needs to be given to both training content and process. A recent randomized controlled trial found training to be effective in equipping practitioners to accurately diagnose Prolonged Grief Disorder (Lichtenthal et al., 2018). However, despite the gaps in knowledge and the deficit in training identified, most participants stated that they would be comfortable treating this population. This discordance between professionals' level of training and their confidence to treat people raises questions. At one level, it reinforces the need for enhancing the provision of, and access to, initial training and CPD since training has been shown to improve professional practice in the provision of bereavement care (Zhang & Lane, 2013). Perhaps, future research needs to examine the basis for confidence in these populations in the absence of training.

Greater access to research for practitioners would be beneficial, but only if both undergraduate training and CPD courses embed a culture of research receptiveness and equip practitioners to critically evaluate research findings. It was noted by one of the experts that the findings of many journals are unintelligible to the average layperson and regarded it as a duty of researchers to make such findings accessible to a wider audience. In the professional interviews, Twitter was mentioned as an efficient means of accessing knowledge regarding grief and complicated grief. Social media is a useful tool to address barriers inherent in traditional academic approaches to knowledge transfer and exchange of health research, but professionals may be ambivalent and lack familiarity regarding its use in this way (Grande et al., 2014). In terms of increasing the accessibility of grief research, education in the employment of social media tools regarding knowledge exchange might be an avenue worthy of exploration.

Although professionals would welcome improved initial training and CPD in complicated grief, they described barriers of time-deficits and financial constraints. All three groups expressed the view that the provision of such CPD lies, to some extent, within the remit of individual professional organizations or accrediting bodies. However, while the issue of professional governance needs to be acknowledged, it must be stressed that there is also a personal, ethical responsibility on every practitioner to engage in continuous professional development to stay abreast of current research (Vasquez, 2011).

Traditional training methods usually increase knowledge and enhance skills. However, such methods may not always readily engage with professionals' attitudes and this may present a barrier to the uptake of research, and its implementation into routine practice (Lilienfeld et al., 2013). Attitudinal factors that have been identified in this research include the time at which intervention is deemed appropriate, the possible pathologization of normal grief and the influence of personal grief on professional practice. In adult education, the use of role play or other simulation, or case vignettes, are recommended as aiding attitude-learning (Knowles, 1990). Simulation has also been shown to be a particularly useful method in teaching professionals about bereavement care. Given the experiential nature of simulation, participants are enabled to develop their attitudes and not only their knowledge and skills (Lateef, 2010). The use of vignettes has been

effective in presenting attitudinal content regarding bereavement (DiMarco, Renker, Medas, Bertosa, & Goranitis, 2002). The experts endorsed the use of such methods. However, it is possible that real-world responses may be different to those voiced in response to vignettes (Munday, 2013). Notwithstanding this reservation, vignettes must be regarded as useful tools that might be successfully employed in exploring and engaging with the attitudinal issues identified in the professional interviews.

This study gave voice to practitioners and therefore makes a valuable contribution to our overall understanding of complicated grief. The interviews varied in duration and those at the shorter end of the range were more a transmission of information rather than a nuanced conversation as was the case in the longer interviews, which provided richer data. This variation in length is a limitation of the study and may reflect the professionals' level of experience in working with complicated grief, since their willingness to participate indicates an interest in the area. The experts were not active in practice therefore were not asked explicitly about skills. The interview guide was informed by the findings of a systematic review (Dodd et al., 2017) and while this enhances its face validity and its transferability to the practice context, it may have limited the inductive nature of the process or given rise to the emergent themes. The research team, representing psychology, psychiatry, and research methodology, were well-positioned to comment on the suitability of the questions, thus adding to the robustness of the interview guide. As some interviews were carried out via telephone, and others face-to-face, the results obtained may not be directly comparable as the nature of the interaction is different. Inevitably, the data relied on self-report with the inherent risk of social desirability bias, which may have led professionals to over-state their competence. Finally, we acknowledge that bereaved people may seek help from spiritual directors, social workers, or other professions whose views may differ from those of this study.

Conclusion

The findings of this study make a valuable contribution to our overall understanding of how complicated grief is viewed and engaged with by practitioners in their work. The study suggests that deficits in professional knowledge regarding complicated grief may exist, and that practice is not substantially informed by the grief literature. It further suggests that there is some ambivalence among professionals regarding the inclusion of complicated grief as a disorder in diagnostic manuals. The lack of definitional clarity around complicated grief is impacting the lack of alignment between research and practice and is an urgent research concern. In anticipation of this clarity, however, the inclusion in curricula of contemporary grief theory would be welcome. Alternative methods of knowledge exchange between researchers and practitioners such as the use of social media are areas worthy of further investigation. The findings suggest deficits in bereavement training but a willingness on the part of professionals to undertake such training is indicated. A need for an improved culture of collaboration and inclusivity between researchers and practitioners is in evidence and much of the responsibility for developing this must rest with researchers. Those involved in grief education and training could play a significant bridging role in this regard, so that complicated grief research does not become irrelevant to practitioners.

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