



Journal of Loss and Trauma

International Perspectives on Stress & Coping

ISSN: 1532-5024 (Print) 1532-5032 (Online) Journal homepage: <http://www.tandfonline.com/loi/upil20>

Complicated Grief in Canada: Exploring the Client and Professional Landscape

Marney R. Thompson, Allyson D. Whiteman, Karen D. Loucks & Helena M. L. Daut

To cite this article: Marney R. Thompson, Allyson D. Whiteman, Karen D. Loucks & Helena M. L. Daut (2017): Complicated Grief in Canada: Exploring the Client and Professional Landscape, Journal of Loss and Trauma, DOI: [10.1080/15325024.2017.1358574](https://doi.org/10.1080/15325024.2017.1358574)

To link to this article: <http://dx.doi.org/10.1080/15325024.2017.1358574>



© 2017 Taylor & Francis Group, LLC



Accepted author version posted online: 10 Aug 2017.
Published online: 10 Aug 2017.



Submit your article to this journal [↗](#)



Article views: 7



View related articles [↗](#)



View Crossmark data [↗](#)

Full Terms & Conditions of access and use can be found at
<http://www.tandfonline.com/action/journalInformation?journalCode=upil20>

Complicated Grief in Canada: Exploring the Client and Professional Landscape

Marney R. Thompson^a, Allyson D. Whiteman^a, Karen D. Loucks^a, and Helena M. L. Daudt^b

^aBereavement Services, Victoria Hospice, British Columbia, Canada; ^bEducation and Research, Victoria Hospice

ABSTRACT

Complicated grief (CG) is one of the central themes in bereavement research and advanced clinical practice today. Using a mixed-methods approach, we wanted to learn (a) what tools Canadian practitioners used to identify or diagnose CG and (b) what interventions or strategies they used to address CG. Sixty-three professionals responded to our survey. There were no straightforward answers to these questions: the state-of-the-art of CG in Canada is, in fact, complicated. Practitioners used a wide assortment of tools and strategies with no consensus on any one approach or tool. Building a Canadian CG community of practice was recommended.

ARTICLE HISTORY

Received 13 May 2017
Accepted 22 June 2017

KEYWORDS

Community of practice;
complicated grief; diagnosis;
treatment

Complicated Grief (CG) is one of the central themes in bereavement research and advanced clinical practice today. Among practitioners and researchers there has been ongoing debate about its name, definition, and diagnostic criteria, and confusion about what constitutes best treatment (Breen, Penman, Prigerson, & Hewitt, 2015). There has also been concern about the dangers versus the benefits of categorizing CG as a mental health disorder—an entity distinct from the continuum of normal grief (Wakefield, 2012). Recent studies focused on CG indicated that between 3% and 10% of bereaved people will experience CG (He, Tang, Yu, Wu, Xie, & Wang, 2014; Kersting, Brähler, Glaesmer, & Wagner, 2011; Shear et al., 2011). People suffering with CG may experience intrusive thoughts, intense emotions, distressing yearning, excessive avoidance of reminders of the deceased or the death, and loss of interest in personal activities (Horowitz et al., 2003). They may be at increased risk for suicide, depression, anxiety, physical illness, and disease (Lichtenthal, Cruess, & Prigerson, 2004). However, helping people experiencing CG is a challenge for many practitioners as there has been little to no real consensus

CONTACT Marney R. Thompson  marney.thompson@viha.ca  1952 Bay Street, 4th Floor, Richmond Pavilion, Bereavement Services, Victoria, BC, V8R 1J8 Canada.

Published with license by Taylor & Francis Group, LLC © 2017 Marney R. Thompson, Allyson D. Whiteman, Karen D. Loucks, and Helena M. L. Daudt

This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives License (<http://creativecommons.org/licenses/by-nc-nd/4.0/>), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited, and is not altered, transformed, or built upon in any way.

in the research literature or in the field of grief counseling about diagnostic criteria and best practice (Wetherell, 2012).

The phenomenon of CG was first examined and contrasted with depression by Prigerson et al. (1995). By 1999, the language had shifted from complicated grief to traumatic grief, and the first set of diagnostic criteria was proposed (Prigerson et al., 1999). To this day, various names for CG are used, including prolonged grief, complex grief, pathologic grief, and the term currently recommended in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5; American Psychiatric Association, 2013): Persistent Complex Bereavement Disorder (Maciejewski, Maercker, Boelen, & Prigerson, 2016). However, despite decades of research, reflection, and debate, the misperceptions and uncertainty remain.

Since CG has been identified as an area of grief worthy of further investigation, numerous assessment and screening tools have been developed. The most recognized of these include several iterations of the Inventory of Complicated Grief (ICG; Prigerson et al., 1995; Jacobs, Mazure, & Prigerson, 2000), the Brief Grief Questionnaire (BGQ; Ito et al., 2012), the Inventory of Complicated Spiritual Grief (Burke & Neimeyer, 2015), and the Structured Clinical Interview for Complicated Grief (SCI_CG; Simon et al., 2007). There have also been a number of treatments and interventions identified for CG including Complicated Grief Treatment (CGT; Shear, Frank, Houck, & Reynolds, 2005; Shear, Wang, Skritskaya, Duan, Mauro, & Ghesquire, 2014; Shear et al., 2016; Shear & Bloom, 2016), cognitive behavioral treatment (CBT; Boelen, de Keijser, van den Hout, & van den Bout, 2007, 2011), and Internet-based interventions (Wagner, Knaevelsrud, & Maercker, 2006).

The majority of research on CG in Canada originated within a small group of professionals who were particularly interested in how to approach group therapy for people with CG (see Piper, Ogrodniczuk, Azim, & Weideman, 2001; Piper, McCallum, Joyce, Rosie, & Ogrodniczuk, 2001; Ogrodniczuk, Piper, McCallum, Joyce, & Rosie, 2002; McCallum, Piper, Ogrodniczuk & Joyce, 2002. Piper, Ogrodniczuk, McCallum, Joyce, & Rosie, 2003; Piper, Ogrodniczuk, Joyce, Weideman, & Rosie, 2007). More recently, Spiwak et al. (2012) from the University of Manitoba, identified Aboriginal people as being at significant risk for CG and suggested there needs to be more CG research focused specifically on this population. However, to our knowledge, no one has attempted to broadly explore the issues of CG within the Canadian context. Further research focused on the cultural relevance of CG is needed and there are clinicians and researchers exploring CG in other countries such as Japan, the Netherlands, Denmark, and Ireland (Mizuno, Kishimoto, & Asukai, 2012; Newson, Boelen, Hek, Hofman, & Tiemeier, 2011; Dodd, Guerin, Delaney, & Dodd, 2017; Guldin, 2014) and within particular cultural groups including African Americans, Nepalese widows, married and unmarried bereaved American and Chinese people, and Bosnian refugees

(Granek & Peleg-Sagy, 2017; Kim et al., 2017; Burton et al., 2012; Momartin, Silove, Manicavasagar, & Steel, 2004).

The overall goal of this exploratory mixed-methods study was to engage in dialogue with Canadian grief counselors about CG, to contribute to the international discussion about the topic, and to explore the possibility of creating a community of practice focused on this area. We were guided by the question: What is the state of the art of CG diagnosis and treatment in Canada? Our specific goals were (a) to identify the tools most used by Canadian practitioners to diagnose CG, (b) to identify the interventions most used for CG treatment in Canada, (c) to determine possible challenges to diagnosing and treating CG in Canada, and (d) to determine if there is an interest in developing a community of practice focused on CG in Canada. As we analyzed the data, we realized that the information we collected was not consistent enough to fully address our first two goals. Therefore, these goals were modified and we focused our inquiry on only two goals: (a) how Canadian practitioners diagnose CG, and (b) how Canadian practitioners respond clinically to CG.

This study was approved by the Island Health Ethics Board and participants provided informed consent before taking part in the study.

Method

Study design

We used a convergent parallel QUAN+QUAL mixed-method design (Creswell & Clark, 2007; Creswell, 2014) focused on professionals working with grief. This triangulation model allowed us to expand and validate quantitative data (from surveys) with qualitative data (from interviews). We compared and integrated main findings to better understand the state of the art of CG in Canada.

Study population

To identify Canadian clinicians diagnosing or treating CG, we consulted The Canadian Counseling and Psychotherapy Association website and the website of the Psychological Association of each Canadian province (see [Table 1](#)). Yukon does not have an association, and the associations from Northwest Territories and Nunavut do not have a website. With the intention of being as inclusive as possible, we selected all professionals who specialized in grief and those for whom we were able to obtain an e-mail or phone number.

Professionals from each province or territory whose e-mail addresses we had obtained were invited to respond to an online survey through an introductory e-mail. We also telephoned additional professionals when phone numbers rather than e-mail addresses were provided and invited them to

Table 1. List of consulted professional organizations and their websites' addresses.

Association	Website address
Association of Psychology in Newfoundland and Labrador	http://www.apnl.ca/
Association of Psychologists of Nova Scotia	http://apns.ca/
British Columbia Psychological Association	https://www.psychologists.bc.ca/
Canadian Counselling and Psychotherapy Association	https://www.ccpa-accp.ca
College of Psychologists of New Brunswick	http://cpnb.ca/
Manitoba Psychosocial Society	http://mps.ca/
Ontario Psychological Association	http://www.psych.on.ca/
Ordre des psychologues du Quebec	https://www.ordrepsy.qc.ca/
Psychological Association of Prince Edward Island	http://www.peipsychology.org/papei/
Psychology Association of Saskatchewan	http://psychsask.ca/
Psychologists' Association of Alberta	http://www.psychologistsassociation.ab.ca/

respond to the survey. A Google search also identified hospice programs that provide bereavement services from all provincial capitals.¹ These hospices were contacted by phone, and surveys were sent to institutions that agreed to forward them to their bereavement staff.

The online survey collected demographics plus information regarding tools used for CG diagnosis and interventions. Participants were also asked to provide their contact information if they were interested in being interviewed or if they were interested in participating in a CG community of practice. Participants that provided their contact information to be interviewed were contacted by phone.

Participants reported a number of different titles when asked about their profession: psychologist ($n = 21$, 33.3%), psychotherapist ($n = 17$, 26.9%), counselor ($n = 10$, 15.9%), counseling or clinical therapist ($n = 6$, 9.5%), social worker ($n = 3$, 4.8%), director ($n = 2$, 3.2%), therapist ($n = 1$, 1.6%), child and youth mental health therapist ($n = 1$, 1.6%), volunteer coordinator ($n = 1$, 1.6%), and clergy ($n = 1$, 1.6%),

Surveys

We developed a survey (see [Figure 1](#)) to collect demographics and data on CG diagnosis and treatment and to collect contact information when participants were willing to be interviewed or participate in the CG community of practice (name, mailing address, email address, and phone number). The survey was developed after a literature review using PUBMED. We used the terms “complicated grief” or “prolonged grief” or “complex grief” or “persistent complex bereavement disorder” and searched articles published between January 2010 and January 2015. Our search yielded 439 articles overall: 6 tools to diagnose CG and 18 interventions to treat CG were identified and included in our survey. We also conducted a grey literature search (Google search) using the name of each identified intervention looking for supplementary information on their use. Aiming to provide respondents with additional

COMPLICATED GRIEF RESEARCH PROJECT

1. Please specify your location:
2. What is your profession?
3. Please specify your experience with Complicated Grief (CG) (please check off all the answers that apply).
 - a. I have counselled or treated people with CG.
 - b. I have conducted or participated in research about CG.
 - c. Other (specify)
4. Which tools have you used for assessment or diagnosis of CG? (Check off all that apply)
 - a. 19-item self-rated Inventory of Complicated Grief (Prigerson et al., 1995)
 - b. Inventory of Complicated Grief - Revised (Prigerson et al., 1995)
 - c. Brief Grief Questionnaire (Shear et al., 2006)
 - d. Prolonged Grief 13 (Prigerson et al., 2009)
 - e. Adult Attitude Grief Scale (Machin et al., 2007)
 - f. Prolonged Grief Disorder Criteria (Prigerson et al., 2009)
 - g. Other (specify)
5. What interventions or treatments have you used in your work with people who have CG? (Check off all that apply)
 - a. Behavioural Activation (Papa et al., 2013)
 - b. Bereavement Support Group (Wagner, 2010)
 - c. Cognitive Behavioural Therapy (Ghesquiere et al., 2011)
 - d. Cognitive Narrative Therapy (Barbosa et al., 2015)
 - e. Complicated Grief Therapy (Shear et al., 2013)
 - f. Complicated Grief Therapy in Group Format (Supiano et al., 2013)
 - g. Family Focused Grief Therapy (Strada, 2011)
 - h. Group Psychotherapy (Jordan & Litz, 2014)
 - i. Group Treatment (Piper et al., 2011)
 - j. Guided Mourning for CG (Hefren & Fryer, 2012)
 - k. Internet Based Support Group (Wagner, 2010)
 - l. Internet Based Peer Support Forum (Kramer et al., 2014)
 - m. Interpersonal Therapy (Bryant, 2012)
 - n. Mindfulness-Based Cognitive Therapy for CG (O'Connor & Hougaard, 2014)
 - o. Music Therapy (Iliya, 2015)
 - p. Pharmacotherapy (Strada, 2011)
 - q. Restorative Retelling (Rheingold et al., 2014)
 - r. Short Term Group Therapy (Joyce et al., 2010)
 - s. Other (specify)
6. Would you be interested in joining a community of practice for CG?
 - a. Yes
 - b. No
7. For the 2nd phase of our research project, we wish to invite approximately 30 people for a 30 minute interview in the near future. The interview seeks to determine what challenges practitioners/researchers face in diagnosing and treating CG and what challenges exist in creating a community of practice in Canada. Would you be interested in participating in this interview?
 - a. Yes
 - b. No

Thank you for completing this survey. If you answered yes to Question 6 or 7, please, follow the link below and provide us with your contact information.

Figure 1. Survey.

information regarding the selected tools and interventions, we added the author(s) and date of recent references that either reviewed tools and interventions used to diagnose and treat CG or described the tool or intervention in detail. To our knowledge, the only interventions designed specifically for CG were Complicated Grief Therapy (CGT) and Complicated Grief Group Therapy (CGGT). The other 16 interventions represent approaches that have been applied to CG with varying degrees of success.

Interviews

All participants interested in being interviewed were contacted. Interviews were performed by a master's-level clinical counselor (AW) with extensive grief counseling experience. During the interviews, we sought to obtain

in-depth information regarding challenges for diagnosing and treating CG and also participants' potential interest in the development of a community of practice for professionals who are working with CG (see Appendix 1). Interviews were audio-recorded and subsequently transcribed verbatim. The sources of all quotations presented within this manuscript have been assigned numbers to ensure participants' anonymity.

Data analysis

Quantitative data were analyzed using descriptive statistics (percentage of responses). The small number of participants and the heterogeneity of the data did not allow for any inferential analysis.

Qualitative data were analyzed using thematic analysis (Braun & Clarke, 2006). We chose a data-driven approach to thematic analysis due to the descriptive and exploratory nature of this study. In addition, we chose to provide a thematic description of our entire data set rather than a detailed account of one particular aspect.

We conducted two levels of thematic analysis: looking for both the semantic or explicit meaning and the latent or underlying meaning of the data. The first three authors independently generated initial codes after reading 12 transcripts. Codes were determined according to the number of times and ways in which they were raised, and their importance or "keyness" to the practitioners in the context of the interviews. The four authors then met to share and discuss the codes they had identified independently. As there were differences, a second reading of the transcripts and coding of data was done. The authors reconciled remaining differences through further discussion, sorted the codes into broader themes, and coded one additional interview (13 in total) to ensure the semantic analysis was complete.

Quantitative and coded qualitative data were subsequently compared and integrated in a second level of interpretive analysis by the four authors. The focus of this second level of analysis was to uncover and explore relevant assumptions or impressions that may have informed the semantic analysis. Next, themes and subthemes were further defined and checked for consistency as a group until latent analysis was completed.

Results

Quantitative findings

Using the contact information obtained through our website searches, we sent 1,058 emails (83 of them were returned as undeliverable). Therefore, the number of people identified through our website searches that received e-mails from us was 975. We also phoned 108 individuals and contacted 39 Canadian

hospices. A total of 63 Canadian grief professionals (approximately 6% of those contacted) responded to our survey. The main reason voiced by the majority of professionals that declined to participate was that they were not involved with diagnosing or treating CG. Table 2 summarizes the response rates by province or territory.

Twenty-one (37%) of the 63 professionals surveyed agreed to be interviewed, but only 13 (21%) were actually interviewed due to scheduling difficulties (e.g., unable to connect for booking). Twenty-seven (approximately 43%) of the 63 respondents were interested in a CG Community of Practice. Table 2 summarizes the response rates by province or territory.

A large number of participants ($n = 36$, 47%) indicated they used tools other than the ones listed in our survey or did not use a tool at all to diagnose CG but rather based assessments on their clinical experience and judgment. Other tools the participants used were the Beck Depression Inventory II, Grief and Mourning Status Interview and Inventory, Bereavement Risk Assessment Tool, Childhood Grief Inventory, Geriatric Depression Scale, and DSM-IV.

None of the respondents used only CG specific interventions (CGT or CGGT) to treat CG; however, 13% of them ($n = 8$) reported using CGT and at least one of the other listed interventions on our survey. Cognitive behavioral therapy ($n = 6$) was the more frequent intervention used alongside CGT to treat CG. A large number of respondents ($n = 28$, 44%) reported using one to five of the listed interventions to treat CG (but did not use CGT). Bereavement Support Group ($n = 11$), cognitive behavioral therapy ($n = 19$), and Mindfulness-Based Cognitive Therapy ($n = 8$) were the most-used listed interventions by this group of clinicians.

Table 2. Summary of response rates by province and territory.

Place	Received e-mail	Declined to answer ^a	Survey		Interview		Community of Practice
			Completed	% ^b	Agreed	Completed	Agreed
BC	207	15	16	8.3	6	3	7
AB	168	1	5	3	2	1	3
MB	89	5	5	5.9	2	1	2
ON	223	5	23	10.5	3	2	6
NS	129	0	5	3.9	3	1	2
NB	86	0	2	2.3	1	1	1
QB	58	1	0 ^c	0	1	1	2
NF	0	0	0 ^c	0	1	1	2
PEI	9	2	1	14.3	1	1	1
YK	4	0	0 ^c	0	1	1	1
NT	2	0	0	0	0	0	0
NU	0	0	0	0	0	0	0
Total	975	29	63	7	21	13	27

Notes: ^aAlthough we have asked on our e-mail for people to let us know if they decide to decline answering our survey (and why), only a small number formally declined (by e-mail or over the phone). The main reason was not diagnosing and or treating complicated grief. ^bPercentage of people that received e-mail in each province. ^cAlthough people did not identify themselves on the survey as working in these provinces or territory, they all provided contact numbers and, when interviewed, confirmed their address.

Table 3. Summary of diagnostic tools and interventions used by respondents to treat Complicated Grief (CG).

Diagnostic Tool	<i>n</i>	Percentage of respondents	Intervention	<i>n</i>	Percentage of respondents
CG Specific	18	29	CGT/CGGT only	0	0%
No tool/own assessment	21	33	CGT/CGGT + Other Listed Therapy(s)	8	13%
Other—not CG specific	15	24	Other Listed Therapy (s) only (not CGT/CGGT)	28	44%
Did not respond or did not diagnose CG	9	14	Other listed therapy (s) + Nonlisted therapy(s)	22	35%
		0	Nonlisted therapy(s) only	5	8%
Total	63			63	

Notes: CGT = Complicated Grief Therapy. CGGT = Complicated Grief Group Therapy.

Interventions that were cited by respondents but were not part of the list we provided included Eye Movement Desensitization and Reprocessing ($n = 3$, 5%), Internal Family Systems ($n = 2$, 3%), emotion-focused therapy ($n = 2$, 3%), and art therapy ($n = 2$, 3%). Table 3 summarizes the answers related to the tools used to diagnose and treat CG.

Qualitative findings

Thematic analysis (semantic and latent) of participants' responses ($n = 13$) to our individual interviews highlighted three main themes related to the diagnosis and treatment of CG in Canada: complex clients, diverse professionals, and CG challenges.

Complex clients

We identified significant client-specific factors that appeared to contribute to the complex issues that were identified in most clients who were believed to have CG. Within this overarching theme of "Complex Clients," four subthemes were identified: concurrent mental health or addiction issues, multiple layers and losses, trauma, and barriers to diagnosis and treatment.

Concurrent mental health or addiction issues. The presence of concurrent mental health and addiction issues was identified as a common and complicating factor for many clients who experienced CG. This co-occurrence may or may not have included a DSM diagnosis such as clinical depression, generalized anxiety, or mood disorders. Whether or not a DSM diagnosis existed for a client, practitioners identified the presence of these concurrent issues as a major consideration in treatment. One practitioner said,

Often, I find when people are having difficulty ... sometimes it can be more complicated than that but often there's kind of a major thing that's in the way of helping them to heal. Sometimes it can be something like ... experience of depression in their lives that has come up more because of the grieving. So ... there's multiple things going on. [Interview 7]

Although concurrent mental health diagnoses were noted as occurring for many clients who may have CG, another interviewee expressed additional complex considerations specific to the past and present challenges faced by clients: “There is a good part of the population that really displays that generational complex family dynamic of alcoholism and the sexual abuse, physical abuse, verbal abuse, et cetera.... It is rare that I receive healthy, simple grief.” [Interview 8]

Multiple layers/losses. A second subtheme identified was the presence of “multiple layers” of loss and death in the lives of clients who present with CG.

I’m a Child and Youth Therapist on reserve where ... there are ... many sudden deaths ... and where, either through car accident or liver failure ... it affects ... the whole community whether ... you were actually related or not. And then ... the layers, like the multiple layers of that, I suppose. [Interview 1]

Within the interviewee’s responses there seemed to be little delineation between what represented CG and what was a complicating factor in the larger context of the client’s life.

Trauma. Practitioners noted that very often clients who have CG have also experienced trauma. Practitioners addressed trauma and grief concurrently in the context of grief counseling. “And just how [grief is] linked ... to trauma ... the multiple traumas that many ... [people] are facing on a daily basis” [Interview 1]. In addition to the experience of trauma, additional consideration was given to treatment and intervention when the person who died was an abuser: “When an abuser ... gets sick and dies or commits suicide there is a whole host of feelings that you could put under the rubric of Complicated Grief” [Interview 6].

Barriers to diagnosis and treatment. A number of the practitioners interviewed work either in entirely First Nations communities or communities in which many aboriginal people live. One interviewee reflected on this particular theme in the following way: “Probably a third of my clients are First Nations ... many of them are residential school survivors so there’s ... grief” [Interview 7]. A barrier to treatment was related to a client’s lifestyle, and pertained to life in rural communities. One interviewee said, “Always with [rural] clients, whether it’s transportation or timing or work schedules ... there’s just a time factor” [Interview 5]. If a client was a recent immigrant, or was a family member of recent immigrants, this also was seen to be significant. Among the other considerations were cultural views of mental health, variations in how stigma is attached to mental health issues, religious and cultural beliefs, knowing how to access services, and the recognition (or lack of recognition of) mental health problems. For example, “Deep down, in their culture.... they know there is a problem but they don’t really consider that it’s a problem

either ... people think they are crazy if they access this kind of service.... They don't want to be labeled" [Interview 2]. Additional barriers might include language barriers and stigma related to the kind of loss. "There are very few people [who] are professionally trained *and* can speak the language too ... there are some, but not enough" [Interview 2], and also, "One of the first hurdles is feeling stigma or shame at the intensity and complexity of feelings ... oftentimes people are getting messages from friends and family or workplace about 'get over it'" [Interview 6]. Social responses to a person and their experience of grief can be positive or negative, and can be received from anyone connected to a client such as friends and family members or health professionals.

Diverse professionals

We identified significant factors related to the diversity of professionals dealing with CG that appeared to contribute to the way CG is diagnosed and treated in Canada. Within this overarching theme of "Diverse Professionals," four subthemes were identified: settings, diverse definitions, wide-ranging assessment tools, and diversity in interventions.

Settings. Professionals working with CG in Canada came from a variety of settings ranging from private practice to community and hospital settings. Many worked in specialty areas such as perinatal loss or sexual abuse. Some worked with accident victims or cancer patients. Other professionals worked in community agencies, or hospital and hospice settings. When asked what their involvement with CG had been, professionals often described their work settings. For example, "Well, I am the volunteer coordinator.... This is a small town, around sixty-five thousand people ... and it is ... historically a miner region here" [Interview 8].

Diverse definitions. There was no common definition of CG among the professionals interviewed, nor were there any CG characteristics that were universally identified. What professionals did agree on regarding the definition of CG was that it is unclear and continually evolving.

I guess what I find challenging is finding consistency in terms of a model when working with complicated bereavement. I feel as though ... for myself and my colleague ... all of us are doing it a little differently.... So that always concerns me, right, there doesn't seem to be a consistent, evidence-based approach. [Interview 11]

Wide-ranging assessment tools. There also was no consistent diagnostic tool or framework that was used among the Canadian professionals interviewed.

The only thing consistently reported was the idea that if there were multiple areas of risk or concern, then that would point toward the person having CG. Examples of client characteristics that were seen as predictive factors for CG were multiple losses, addictions, or preexisting mental health issues such as depression or anxiety. For example:

During our screening process, I try to just get the overall history of the client and the red flags. And if I find multiple loss in [the] case of history of abuse, et cetera, or if the person is dealing with mental health issues and is under medication, et cetera, this goes to my workload of complex grief. [Interview 8]

Diversity in interventions. Interventions identified to treat CG were as diverse as the definitions, diagnostic tools, and care settings. Theoretical orientation, the value of mind–body work, and the importance of creating a safe environment shaped the interventions used by Canadian practitioners. Many professionals identified their theoretical orientation and training as the foundation for their CG interventions. Examples of theoretical perspectives used by professionals in this study include narrative, psychodynamic, behavioral, cognitive behavioral, meaning reconstruction, humanistic, and holistic perspectives. As one participant stated, “I have some background in psychodynamic approaches to treatment as well as a long behavioral and cognitive behavioral training. And so I... draw on several areas of my background in treating people” [Interview 9].

Mind–body-focused interventions were frequently mentioned and used in two different ways: first, as a way to improve physical health. For example, “The most successful thing for me, is having people eat properly ... get some fresh air and exercise regularly” [Interview 1]. Second, mind–body work was used to help clients process trauma. These interventions employed techniques from Cranial Sacral therapy, Somatic Emotional Release, Emotional Freedom Technique, Neuro-Emotion Technique, Mindfulness, Equine-Assisted Therapy, and Journaling.

Professionals also spoke of the importance of creating an environment of safety and hope. As one participant said, “My main way of working ... [is] really creating a sacred space for people to feel that ... anything is allowed and then just really deep listening and allowing for whatever needs to come up, ... so that people feel heard and they feel safe” [Interview 7]. Another stated, “Hope instillation is a critical component ... when you’re treating complicated grief because people sometimes have lost that hope” [Interview 10].

Complicated grief challenges

This final latent theme represents the story behind the data and embodies our understanding of CG research and clinical practice in Canada today. These

challenges are divided into three subthemes: conceptual ambiguity, eclectic approaches, and resources and opportunities for a community of practice.

Conceptual ambiguity. A wide range of names, characteristics, preexisting conditions, and circumstances were identified by practitioners as a representation of, or diagnostic criteria for, CG. Also, there seemed to be an idea that there are different kinds or classifications of CG; such as complex or prolonged grief, and yet these different names are used interchangeably. For example, “The two forms ... I’ve run into have been primarily ... chronic or masked or inhibited grieving not exaggerated ... I used prolonged and chronic grief interchangeably” [Interview 9]. Another expressed concern that even though she sees people with CG, the clinical language put forth by the current study was “not the language I speak in ... it’s not my training ... that could be challenging” [Interview 7].

Other interviewees seemed to have difficulty with restricting themselves to a singular definition of CG. One stated: “I strayed from the traditional definition of CG.... I see this as unresolved multiple traumas” [Interview 1]; and from another: “My definition ... is not just over someone’s death ... it’s more overall ... something ... [that] creates a lot of complicated feelings” [Interview 2].

Professionals were unsure about the construct of complicated grief for a number of reasons. Paramount among those reasons was a concern that normal grief responses would be falsely pathologized. For example:

It’s difficult to tease out exactly how much of this is related to what is normal grief and what we certainly couldn’t be pathologizing ... as opposed to grief that is ... -entrenched ... in such a way that the person is having trouble moving on in ... life. [Interview 13]

This pervasive mixture of caution and confusion about CG was aptly captured by another participant who said, “I’m not sure that grief isn’t always complicated” [Interview 5].

Eclectic approaches. There is no single widely accepted approach to the care of people with CG in Canada (see Table 2). Practitioners described their work with CG as being uniquely tailored to fit each client’s particular set of challenges. The work done depended not only on the client’s needs but also the practitioner’s individual set of skills. As one interviewee explained, “Everyone has a different approach ... everybody could have their different skills ... which [is] all good because this is how you believe the change will work and ... should totally [be] respected ... even though you have different approaches” [Interview 2].

Although practitioners valued drawing from multiple perspectives, they also highlighted the effort this requires. For example, “Everything seems

compartmentalized ... you have to draw it all together yourself ... because one piece just doesn't seem to address ... all of it" [Interview 3]. "We need to bring [them] together ... the mental, emotional, physical, spiritual" [Interview 5] because "complicated grief necessitates complicated therapy" [Interview 10], "you're not going to get it in two sessions" [Interview 5]. They also adapted their approach based on their view of each client's needs. For example, "[What I use] really depends on the unique profile of the client ... most probably [for] a very complex client I will use all the tools possible" [Interview 8]. Another said, "I tend not to have anything I especially use but I try to look at what might be helpful for this person based on his or her history and what they might bring to the counseling session itself ... as opposed to my imposing a particular intervention on someone" [Interview 13].

Resources and opportunities for a community of practice. Although Canadian professionals saw several benefits to creating a community of CG practice for CG, obstacles were also identified. Benefits included improved knowledge and skill due to opportunities to consult over CG cases. Obstacles were connected to the vast geography of Canada and also to limited funds and resources available for professional education and skill development. One practitioner stressed the need to "create common ground [about CG]" [Interview 8], while another questioned "how many people would want to do this" [Interview 12]. Also, difficulties relating to the scope and focus of a community of practice surfaced, such as, "What is the mandate, objective, or goal?" [Interview 8].

For some, a community of practice was seen as an opportunity to develop new skills and refresh old approaches to CG. One participant said, "When we practice for years ... sometimes we get into a ... routine and we forget there are other ways to learn.... It cannot be just one person's work" [Interview 2]. Others explained, "We do not have research time in this field" [Interview 6], so, "A community network sharing case studies along with strategies and supporting one another in practice would be great" [Interview 12].

For one professional, what appealed was: "Not only learning or stuffing more information in our heads but actually just being with all of the experiences we're holding from helping people with complicated grief" [Interview 6]. Another said, "There's an argument for having a community so that one can consult and talk with other people who are dealing with complicated grieving because it's a rarity.... I rely on a lot of my old sources" [Interview 9]. Another stated, "I haven't seen a complicated grief conference or complicated grief association ... there's definitely a use to ... getting a sense of what other people are doing" [Interview 10].

However, Canada's expansive geography was seen to be a significant barrier for the development of a CG community of practice. The question was raised: "How do you bring people together who are in different parts of the

country? ... Maybe aligning with some other professional organization? ... the Canadian Association of Psycho-oncology or the CHPCA?" [Interview 13]. One interviewee explained, "It takes 10–12 hours to drive from one side of Newfoundland to the other" [Interview 3]. Another suggested a Canadian community of CG practice would "[have to] have regional or provincial representatives" [Interview 8].

Discussion

Our overarching goal was to engage with professionals in Canada about CG; to understand how they are working with CG and to contribute a Canadian perspective to the ongoing international discussion about CG. We were also curious to know whether other professionals were interested in the possibility of creating a community of practice for complicated grief in Canada. After analyzing our data, we adjusted our original four goals to better fit the information we'd collected and instead focused on two goals: (a) what tools were used to identify or diagnose CG, and (b) what interventions were used to respond to CG. Our results suggest that there is no straightforward answer to these questions: the state-of-the-art of CG in Canada is, in fact, complicated. Practitioners use a wide assortment of tools and strategies to diagnose and treat CG with no consensus on or collective preference for any one approach or tool. It was noteworthy that more people expressed interest in a community of practice than those who agreed to an interview, which may suggest both a low confidence about what CG is and how to deal with it, alongside a desire to understand and to learn more. A Canadian CG community of practice could provide a reliable network to support the work of these professionals and to achieve higher agreement on best practice.

Our study is, to our knowledge, the first attempt to describe the CG landscape in Canada. However, the low number of respondents may not seem to adequately represent Canadian grief professionals. Yet it is our impression that we likely reached the majority of professionals dealing with CG in Canada, as recent studies have found that as few as 3% to 10% of bereaved people experience CG (He et al., 2014; Kersting et al., 2011; Shear et al., 2011). Therefore, it seems possible that since a relatively small percentage of all grief counselors may encounter CG, relatively few would respond to our survey.

It is also possible that general confusion about CG diagnosis and treatment has contributed to their low response. As stated by Wagner and Maercker (2010), "There is still some scepticism and critical discussion concerning the validity of diagnostic criteria of CG" (p. 28) and this debate continues in the literature to this day (see Mauro et al., 2016; Prigerson & Maciejewski, 2017; Reynolds, Cozza, & Shear 2017). It was noteworthy that more people expressed interest in a community of practice than those who agreed to an

interview. This discrepancy may suggest both a low level of confidence about what CG is and how to deal with it, alongside a desire to understand and to learn more. A Canadian CG community of practice could provide a reliable network to support the work of these professionals and to achieve higher agreement on best practices. Grief counselors in British Columbia and Ontario were the largest groups to complete the survey and agree to be interviewed. The higher degree of participation from these provinces is similar to that of a study on counseling psychology practice in Canada (Bedi, Sinacore, & Christiani, 2016).

Several of the practitioners we interviewed reported working either in entirely First Nations communities or communities in which many Aboriginal people live, supporting the argument that this population may need special attention. Spiwak et al. (2012) identified Aboriginal people as being at significant risk for CG and suggested there needs to be research focused specifically on this population. Canada's longstanding colonial and forced assimilation practices as they pertain to Aboriginal populations, and the intergenerational trauma experienced by these individuals, families, and communities (Bombay, Matheson, & Anisman 2014; Nutton & Fast, 2015), have unquestionably contributed to the grief experienced by this population. However, whether a CG diagnosis is fitting for this and other cultural groups has yet to be fully established.

The majority of the grief counselors surveyed by this study did not use CG-specific tools to identify CG. Similar findings were reported by Breen (2011) in her study of the gaps between research and practice in grief counseling. The use of other non-CG measures, such as the Beck Depression Inventory (BDI), Bereavement Risk Assessment Tool (BRAT), or the Grief and Mourning Interview and Inventory (GAMS) were also noted (Beck, Steer, & Brown, 1996; Rose, Wainwright, Downing, & Lesperance, 2011; Rando, 1993). Most of the clinicians we contacted relied almost exclusively on their preexisting, sometimes decades-old training and clinical judgement, and reviewed the literature as their time permitted. We recognize that keeping abreast of current understandings and advancements in a clinical area as small and highly specialized as CG may fall beyond the scope and resources of many Canadian grief counselors and public programs.

Nevertheless, the disparate range of interventions being used to diagnose and treat people with CG was concerning. Since the interview data did not affirm that CG-specific interventions were being widely used, we speculate that the survey question pertaining to tools may have been misinterpreted. Although the list provided on the survey listed CG-targeted interventions, it is possible that when participants saw general terms that they recognized, for example "group therapy," they ticked yes, even though the group therapy they provide was not a CG-specific form of group therapy. In other words, we presume that if they were doing any kind of bereavement support group with

people they recognized as having CG, they felt they were doing a CG bereavement group. This lack of evidence-informed interventions in CG treatment and the need for clinicians to use more proven effective treatments has been confirmed in previous reports (Bryant et al., 2014; Currier, Neimeyer, & Berman, 2008).

Our data highlights some of the systemic challenges grief counselors face as they work to understand and respond to CG. Lack of agreement about what CG is and how best to treat it, paired with somewhat siloed and underfunded mental health services in Canada, have made it difficult for counselors to understand, develop, and introduce best practice for CG. As Beckett and Dykeman (2017) stated, “The further we get from a clear picture of what is normal, the more difficult it is to determine what should cause concern” (p. 9). “Researchers and practitioners alike, all struggle to balance making room for differences with agreement about what should cause concern” (p. 11). Guldin (2014) recently concluded that there is a need for mapping universally valid norms of grief reactions which include the prevalence of complications, validated assessment tools, and identification of effective CG treatment.

Ranmuthgala et al. (2011) argued that communities of practice may have a role in improving practice and sustaining best practice in health care by providing a framework for sharing knowledge and overcoming professional, geographical, and organizational barriers. Approximately 50% of respondents were interested in developing a CG community of practice for the same reasons highlighted by Ranmuthgala et al. Although CG is considered one of the central issues facing the field of bereavement, grief, and loss today, it is still a comparatively rare issue, being treated by a relatively small number of professionals who may feel isolated and dispersed within the expansive geography of Canada. Li et al. (2009) highlighted some characteristics of communities of practice that seem particularly relevant to CG: the emphasis on learning and sharing knowledge, and the investment to foster the sense of belonging among members.

Final considerations

Our study is, to our knowledge, the first attempt to paint a picture of the CG landscape in Canada. Presently, there is no consensus on clinical tools to diagnose, or interventions to treat, CG in Canada. Given that the current international literature highlights considerable debate about CG’s name, definition, diagnosis, and treatment, the finding that a large number of professionals do not use any tool to support CG diagnosis, and that only eight professionals used CG-specific interventions along with other approaches, while perhaps not surprising, is (at a minimum) puzzling. Why do Canadian grief professionals rely so heavily on their own assessments or use tools that

are not CG-specific? Why do they use interventions that are not designed to treat CG specifically? Perhaps the lack of professional standards for bereavement professionals in Canada is impacting these practices. The first author of this study is currently involved in establishing such standards; addressing CG will be part of this work.

Developing a community of practice focused on CG could enable Canadian practitioners and researchers interested in CG to share experiences, increase their skills and knowledge, and contribute to the broader international discussion about this important topic. Cambridge, Kaplan & Suter (2005), when describing the process of developing a community of practice, indicate that the first step is inquiry, and that developing relationships is the starting point of this phase (p. 19). We argue that this study constitutes the first step of this long journey.

Note

1. We could not identify any institution matching our criteria in Quebec City; we did, however, identify hospices in Montreal and include them instead.

Acknowledgments

We would like to thank all respondents for volunteering their time and sharing their thoughts. We also thank Amanda Ng for research support during the early phases of this study. Additional thanks to Dr. Servaty-Seib for her invaluable suggestions to improve our manuscript.

Notes on contributors

Marney Thompson is the Bereavement Coordinator at Victoria Hospice, British Columbia, Canada. Her main clinical and research interests are bereavement standards and assessment and complicated grief. She currently is involved with national bereavement education and support initiatives and is an international partner with the Center for Complicated Grief at Columbia University.

Allyson Whiteman has been a palliative care counselor for over 20 years and for the last 10 has specialized in the care and support of children, youth, and their families at Victoria Hospice. She has also been involved in research and writing regarding palliative care over her career.

Karen D. Loucks currently has a private practice and works as a counselor at Victoria Hospice. Her main areas of clinical interest include grief and loss, infertility, trauma, and interventions that incorporate both mindfulness and response-based approaches.

Helena Daudt is the Director of Education and Research at Victoria Hospice and adjunct assistant professor at University of Victoria, School of Nursing. She has been involved in supportive care research for the last 10 years. Her main interest is working with interdisciplinary teams, patients and families to undertake research projects that support and advance frontline care.

References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). Beck Depression Inventory–II. *San Antonio*, 78(2), 490–498.
- Beckett, C., & Dykeman, C. (2017). *A metatheory of grief: Implications for counselors*. VISTAS Online. Retrieved from https://www.counseling.org/docs/default-source/vistas/Metatheory_of_Grief.pdf?sfvrsn=6
- Bedi, R. P., Sinacore, A., & Christiani, K. D. (2016). Counselling psychology in Canada. *Counselling Psychology Quarterly*, 29(2), 150–162. doi:10.1080/09515070.2015.1128398
- Boelen, P. A., de Keijser, J., van den Hout, M. A., & van den Bout, J. (2007). Treatment of complicated grief: A comparison between cognitive-behavioral therapy and supportive counseling. *Journal of Consulting and Clinical Psychology*, 75(2), 277–284. doi:10.1037/0022-006X.75.2.277
- Boelen, P. A., de Keijser, J., van den Hout, M. A., & van den Bout, J. (2011). Factors associated with outcome of cognitive-behavioural therapy for complicated grief: A preliminary study. *Clinical Psychology & Psychotherapy*, 18(4), 284–291. doi:10.1002/cpp.720
- Bombay, A., Matheson, K., & Anisman, H. (2014). The intergenerational effects of Indian Residential Schools: Implications for the concept of historical trauma. *Transcultural Psychiatry*, 51(3), 320–338. doi:10.1177/1363461513503380
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. doi:10.1191/1478088706qp063oa
- Breen, L. J. (2011). Professionals' experiences of grief counseling: Implications for bridging the gap between research and practice. *OMEGA-Journal of Death and Dying*, 62(3), 285–303. doi:10.2190/OM.62.3.e
- Breen, L. J., Penman, E. L., Prigerson, H. G., & Hewitt, L. Y. (2015). Can grief be a mental disorder? An exploration of public opinion. *The Journal of Nervous and Mental Disease*, 203(8), 569–573. doi:10.1097/NMD.0000000000000331
- Bryant, R., Kenny, L., Joscelyne, A., Rawson, N., Maccallum, F., Cahill, C., ... Nickerson, A. (2014). Treating prolonged grief disorder: A randomized clinical trial. *JAMA Psychiatry*, 21(12), 1332–1339. doi:10.1001/jamapsychiatry.2014.1600
- Burke, L. A., & Neimeyer, R. A. (2015). Inventory of complicated spiritual grief (ICSG). In R. A. Neimeyer (Ed.), *Techniques of grief therapy: Assessment and intervention* (pp. 76–80). New York, NY: Routledge.
- Burton, C. L., Yan, O. H., Pat-Horenczyk, R., Chan, I. S., Ho, S., & Bonanno, G. A. (2012). Coping flexibility and complicated grief: A comparison of American and Chinese samples. *Depression and Anxiety*, 29(1), 16–22. doi:10.1002/da.20888
- Cambridge, D., Kaplan, S., & Suter, V. (2005). *Community of practice design guide: A step-by-step guide for designing & cultivating communities of practice in higher education*. Retrieved from <https://library.educause.edu/~media/files/library/2005/1/nli0531-pdf.pdf>.
- Creswell, J. W. (2014). Chapter 10: Mixed methods procedures. In *Research design: Qualitative, quantitative and mixed methods approaches* (pp. 263–290). Thousand Oaks, CA: Sage.
- Creswell, J. W., & Clark, V. L. P. (2007). *Designing and conducting mixed methods research*. Thousand Oaks, CA: Sage.
- Currier, J., Neimeyer, R., & Berman, J. (2008). The effectiveness of psychotherapeutic interventions for bereaved persons: A comprehensive quantitative review. *Psychological Bulletin*, 134(5), 648–661. doi:10.1037/0033-2909.134.5.648
- Dodd, A., Guerin, S., Delaney, S., & Dodd, P. (2017). Complicated grief: Knowledge, attitudes, skills and training of mental health professionals: A systematic review. *Patient Education and Counseling*, 100, 1447–1458. doi:10.1016/j.pec.2017.03.010

- Guldin, M. (2014). Complicated grief—a challenge in bereavement support in palliative care: An update of the field. *Progress in Palliative Care*, 22(3), 136–142. doi:10.1179/1743291x13Y.0000000078
- Granek, L., & Peleg-Sagy, T. (2017). The use of pathological grief outcomes in bereavement studies on African Americans. *Transcultural Psychiatry*, 54(3), 384–399. doi:10.1177/1363461517708121
- He, L., Tang, S., Yu, W., Xu, W., Xie, Q., & Wang, J. (2014). The prevalence, comorbidity and risks of prolonged grief disorder among bereaved Chinese adults. *Psychiatry Research*, 219(2), 347–352. doi:10.1016/j.psychres.2014.05.022
- Horowitz, M. J., Siegel, B., Holen, A., Bonanno, G. A., Milbrath, C., & Stinson, C. H. (2003). Diagnostic criteria for complicated grief disorder. *Focus*, 1(3), 290–298. doi:10.1176/foc.1.3.290
- Ito, M., Nakajima, S., Fujisawa, D., Miyashita, M., Kim, Y., Shear, M. K., ... Wall, M. M. (2012). Brief measure for screening complicated grief: Reliability and discriminant validity. *PLoS ONE*, 7(2), 1–6. doi:10.1371/journal.pone.0031209
- Jacobs, S., Mazure, C., & Prigerson, H. (2000). Diagnostic criteria for traumatic grief. *Death Studies*, 24(3), 185–199. doi:10.1080/074811800200531
- Kersting, A., Brähler, E., Glaesmer, H., & Wagner, B. (2011). Prevalence of complicated grief in a representative population-based sample. *Journal of Affective Disorders*, 131(1), 339–343. doi:10.1016/j.jad.2010.11.032
- Kim, J., Tol, W. A., Shrestha, A., Kafle, H. M., Rayamajhi, R., Luitel, N. P., ... Surkan, P. J. (2017). Persistent complex bereavement disorder and culture: Early and prolonged grief in Nepali widows. *Psychiatry*, 80(1), 1–16. doi:10.1080/00332747.2016.1213560
- Li, L. C., Grimshaw, J. M., Nielsen, C., Judd, M., Coyte, P. C., & Graham, I. D. (2009). Evolution of Wenger's concept of community of practice. *Implementation Science*, 4(1), 11. doi:10.1186/1748-5908-4-11
- Lichtenthal, W. G., Cruess, D. G., & Prigerson, H. G. (2004). A case for establishing complicated grief as a distinct mental disorder in DSM-V. *Clinical Psychology Review*, 24(6), 637–662. doi:10.1016/j.cpr.2004.07.002
- Maciejewski, P. K., Maercker, A., Boelen, P. A., & Prigerson, H. G. (2016). “Prolonged grief disorder” and “persistent complex bereavement disorder,” but not “complicated grief,” are one and the same diagnostic entity: An analysis of data from the Yale Bereavement Study. *World Psychiatry*, 15(3), 266–275. doi:10.1002/wps.20348
- Mauro, C., Shear, M. K., Reynolds, C. F., Simon, N. M., Zisook, S., Skritskaya, N., ... Ghesquiere, A. (2016). Performance characteristics and clinical utility of diagnostic criteria proposals in bereaved treatment-seeking patients. *Psychological Medicine*, 47(4), 608–615. doi:10.1017/S0033291716002749
- McCallum, M., Piper, W. E., Ogrodniczuk, J. S., & Joyce, A. S. (2002). Early process and dropping out from short-term group therapy for complicated grief. *Group Dynamics: Theory, Research, and Practice*, 6(3), 243. doi:10.1037/1089-2699.6.3.243
- Mizuno, Y., Kishimoto, J., & Asukai, N. (2012). A nationwide random sampling survey of potential complicated grief in Japan. *Death Studies*, 36(5), 447–461. doi:10.1080/07481187.2011.553323
- Momartin, S., Silove, D., Manicavasagar, V., & Steel, Z. (2004). Complicated grief in Bosnian refugees: Associations with posttraumatic stress disorder and depression. *Comprehensive Psychiatry*, 45(6), 475–482. doi:10.1016/j.comppsy.2004.07.013
- Newson, R. S., Boelen, P. A., Hek, K., Hofman, A., & Tiemeier, H. (2011). The prevalence and characteristics of complicated grief in older adults. *Journal of Affective Disorders*, 132(1), 231–238. doi:10.1016/j.jad.2011.02.021

- Nutton, J., & Fast, E. (2015). Historical trauma, substance use, and indigenous peoples: Seven generations of harm from “big event.” *Substance Use & Misuse*, *50*(7), 839–847. doi:10.3109/10826084.2015.1018755
- Ogrodniczuk, J. S., Piper, W. E., McCallum, M., Joyce, A. S., & Rosie, J. S. (2002). Interpersonal predictors of group therapy outcome for complicated grief. *International Journal of Group Psychotherapy*, *52*(4), 511–535. doi:10.1521/ijgp.52.4.511.45520
- Piper, W. E., McCallum, M., Joyce, A. S., Rosie, J. S., & Ogrodniczuk, J. S. (2001). Patient personality and time-limited group psychotherapy for complicated grief. *International Journal of Group Psychotherapy*, *51*(4), 525–552. doi:10.1521/ijgp.51.4.525.51307
- Piper, W. E., Ogrodniczuk, J. S., Azim, H. F., & Weideman, R. (2001). Prevalence of loss and complicated grief among psychiatric outpatients. *Psychiatric Services*, *52*(8), 1069–1074. doi:10.1176/appi.ps.52.8.1069
- Piper, W. E., Ogrodniczuk, J. S., McCallum, M., Joyce, A. S., & Rosie, J. S. (2003). Expression of affect as a mediator of the relationship between quality of object relations and group therapy outcome for patients with complicated grief. *Journal of Consulting and Clinical Psychology*, *71*(4), 664–671. doi:10.1037/0022-006X.71.4.664
- Piper, W. E., Ogrodniczuk, J. S., Joyce, A. S., Weideman, R., & Rosie, J. S. (2007). Group composition and group therapy for complicated grief. *Journal of Consulting and Clinical Psychology*, *75*(1), 116–125. doi:10.1037/0022-006X.75.1.116
- Prigerson, H. G., Maciejewski, P. K., Reynolds, C. F., Bierhals, A. J., Newsom, J. T., Fasiczka, A., ... Miller, M. (1995). Inventory of complicated grief: A scale to measure maladaptive symptoms of loss. *Psychiatry Research*, *59*(1), 65–79. doi:10.1016/0165-1781(95)02757-2
- Prigerson, H. G., Frank, E., Kasl, S. V., Reynolds, C. F., Anderson, B., Zubenko, G. S., ... Kupfer, D. J. (1995). Complicated grief and bereavement-related depression as distinct disorders: Preliminary empirical validation in elderly bereaved spouses. *American Journal of Psychiatry*, *152*(1), 22–30. doi:10.1176/ajp.152.1.22
- Prigerson, H. G., & Maciejewski, P. K. (2017). Rebuilding consensus on valid criteria for disordered grief. *JAMA Psychiatry*, *74*(5), 435–436. doi:10.1001/jamapsychiatry.2017.0293
- Prigerson, H. G., Shear, M. K., Jacobs, S. C., Reynolds, C., Maciejewski, P. K., Davidson, J. R., ... Widiger, T. A. (1999). Consensus criteria for traumatic grief. A preliminary empirical test. *The British Journal of Psychiatry*, *174*(1), 67–73. doi:10.1192/bjp.174.1.67
- Rando, T. A. (1993). *Treatment of complicated mourning*. Champaign, IL: Research Press.
- Ranmuthugala, G., Plumb, J. J., Cunningham, F. C., Georgiou, A., Westbrook, J. I., & Braithwaite, J. (2011). How and why are communities of practice established in the health-care sector? A systematic review of the literature. *BMC health services research*, *11*(1), 273. doi:10.1186/1472-6963-11-273
- Reynolds, C. F., Cozza, S. J., & Shear, M. K. (2017). Clinically relevant diagnostic criteria for a persistent impairing grief disorder: Putting patients first. *JAMA Psychiatry*, *74*(5), 433–434. doi:10.1001/jamapsychiatry.2017.0290
- Rose, C., Wainwright, W., Downing, M., & Lesperance, M. (2011). Inter-rater reliability of the bereavement risk assessment tool. *Palliative and Supportive Care*, *9*(2), 153–164. doi:10.1017/S1478951511000022
- Shear, K., Frank, E., Houck, P. R., & Reynolds, C. F. (2005). Treatment of complicated grief: A randomized controlled trial. *Journal of the American Medical Association*, *293*(21), 2601–2608. doi:10.1001/jama.293.21.2601
- Shear, M. K., & Bloom, C. G. (2016). Complicated grief treatment: An evidence-based approach to grief therapy. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, *35*(6), 6–25. doi:10.1007/s10942-016-0242-2

- Shear, M. K., Reynolds, C. F., Simon, N. M., Zisook, S., Wang, Y., Mauro, C., ... Skritskaya, N. (2016). Optimizing treatment of complicated grief: A randomized clinical trial. *JAMA Psychiatry*, 73(7), 685–694. doi:10.1001/jamapsychiatry.2016.0892
- Shear, M. K., Simon, N., Wall, M., Zisook, S., Neimeyer, R., Duan, N., ... Keshaviah, A. (2011). Complicated grief and related bereavement issues for DSM-5. *Depression and Anxiety*, 28(2), 103–117. doi:10.1002/da.20780
- Shear, M. K., Wang, Y., Skritskaya, N., Duan, N., Mauro, C., & Ghesquiere, A. (2014). Treatment of complicated grief in elderly persons: A randomized clinical trial. *JAMA Psychiatry*, 71(11), 1287–1295. doi:10.1001/jamapsychiatry.2014.1242
- Simon, N. M., Shear, M. K., Thompson, E. H., Zalta, A. K., Perlman, C., Reynolds, C. F., ... Silowash, R. (2007). The prevalence and correlates of psychiatric comorbidity in individuals with complicated grief. *Comprehensive Psychiatry*, 48(5), 395–399. doi:10.1016/j.comppsy.2007.05.002
- Spiwak, R., Sareen, J., Elias, B., Martens, P., Munro, G., & Bolton, J. (2012). Complicated grief in Aboriginal populations. *Dialogues in Clinical Neuroscience*, 14(2), 204–209.
- Stroebe, M., Stroebe, W., Schut, H., & Boerner, K. (2017). Grief is not a disease but bereavement merits medical awareness. *The Lancet*, 38(10067), 347–349. doi:10.1016/S0140-6736(17)30189-7
- Wagner, B., Knaevelsrud, C., & Maercker, A. (2006). Internet-based cognitive-behavioral therapy for complicated grief: A randomized controlled trial. *Death Studies*, 30(5), 429–453. doi:10.1080/07481180600614385
- Wagner, B., & Maercker, A. (2010). The diagnosis of complicated grief as a mental disorder: A critical appraisal. *Psychologica Belgica*, 50(1–2), 27. doi:10.5334/pb-50-1-2-27
- Wakefield, J. C. (2012). Should prolonged grief be reclassified as a mental disorder in DSM-5? Reconsidering the empirical and conceptual arguments for complicated grief disorder. *The Journal of Nervous and Mental Disease*, 200(6), 499–511. doi:10.1097/NMD.0b013e3182482155
- Wakefield, J. C., & Horwitz, A. V. (2016). Psychiatry's continuing expansion of depressive disorder. In S. Demazeux & J. C. Wakefield (Eds.), *Sadness or depression? International perspectives on the depression epidemic and its meaning* (pp. 173–203). Dordrecht, Netherlands: Springer.
- Wetherell, J. L. (2012). Complicated grief therapy as a new treatment approach. *Dialogues in Clinical Neuroscience*, 14(2), 159–166.

Appendix 1: Interview protocol

Step 1: Introduction, establish rapport, general interview procedures.

Step 2: Questions.

- (1) What has been your involvement with CG?
- (2) What are some of the challenges you have faced when diagnosing or treating CG?
- (3) What are some of the most used and successful interventions when diagnosing or treating CG?
- (4) Is there an interest to develop a community of practice focused on CG? If so, what are some challenges you think may arise in the development of this community?

(5) Is there any research that we should be aware of in terms of successes and challenges in diagnosing or treating CG?

If there are any individuals who have conducted research or treated CG that would be interested in taking part in this research project, please provide them with our contact information.

Step 3: Conclusion, expression of appreciation.