Appendix

CPE – 12 Week Unit Syllabi

CPE Unit 1 Syllabus

Unit: ICPT CPE Unit 1
Prerequisites: None
Clock Hours: 400 (100 clock hours didactic study and class time and 300 clock hours clinical/applied learning)
Unit Length: 12 weeks (full-time)

Instructional Methods:

- Didactic Study and Class Time (Instructor-led Onsite and/or Interactive Distance Learning*)
- Clinical (applied learning)
- Customized Coaching
- Peer-to-Peer Projects and Assessments

***Interactive Distance Learning** course content is accessed in the ICPT Learning Center where students work through weekly modules that include readings, research and other articles, case studies, and activities in which they reflect upon and apply the information learned.

Unit Requirements:

- **100 hours of Didactic Learning:** Students are required to participate in 100 hours of didactic study and class time offered live and/or via interactive distance learning (IDL).

- **1 Orientation Paper:** Students must submit an orientation paper the first week of the unit that is no more than 2 pages that discusses their position on one of the following subjects:

    - a theology of person;
    - how do you picture and talk about illness;
    - how you picture human suffering especially among the innocent;
    - how do you picture pain and destruction; or
    - a subject of your own choosing in discussion with your supervisor.

  The orientation paper must be submitted by file upload, in the ICPT Learning Center for the CPE Supervisor(s) review and academic feedback.

- **10 Reflection Reports:** Students must submit 10 reflection reports that detail what they experienced, learned, and thought about regarding ministry during their training. Reflection reports are due each week starting the 2nd week of the unit and completing the final report in the 11th week of CPE training. Reflections should be no more than two pages in length. Topics may include but are not limited to:

    - Significant events that occurred with patients, peers or the CPE Supervisor;
    - Steps taken to meet learning contract and CPE objectives; and
    - Significant learning events in the student's personal and professional life.

  All reflection reports must be submitted by file upload, in the ICPT Learning Center for the CPE Supervisor(s) review and academic feedback.

- **6 Case Studies:** Students must submit a minimum of 6 case studies that reflect interactions with patients or clients. Case studies help students understand their strengths and weaknesses during visits with patients or clients. Case studies are written in a specific format outlined in the appendix of this handbook. Students must present at least 1 case study to their classmates in their cohort. Smaller cohorts may require students to present additional case studies.
    - All case studies must be submitted by file upload, in the ICPT Learning Center for the CPE Supervisor(s) review and academic feedback.
    - Students must also review and evaluate other classmates case studies and provide peer-to-peer feedback.
    - Students must upload case studies 2 days in advance of the scheduled due date for peer review in the ICPT Learning Center.
        - Onsite students may provide in person peer-to-peer feedback.
        - Interactive Distance Education (IDL) students must engage in live case study discussion forums and post peer-to-peer feedback in the interactive chat-board. All IDL students must evaluate peer case studies during each unit.
- **Customized Coaching/Supervision:** Students are responsible for scheduling a weekly coaching/supervision meeting with their CPE supervisor. The weekly supervision meetings allow students to discuss, one-on-one, with their supervisor, any concerns they have, reflection reports, and how they are progressing with their learning contract. All supervisory meetings are held in the strictest confidence. Please note, sessions may be recorded or transcribed to ensure compliance with ICPT academic standards.
- **Group Discussion:** Students must participate in group discussions. Group discussions may be live or via computer mediated live conferencing such as Zoom. Note, these sessions may be recorded or transcribed to ensure compliance with ICPT academic standards.
- **Mid-Unit and Final Unit Self-Evaluations:** Students must complete mid-unit and final unit self-evaluations. The peer review portion of the evaluations may be shared with classmates. These evaluations are codified in a specific format detailed in the appendix of this manual. Students must submit evaluations by file upload, in the ICPT Learning Center for the CPE Supervisor(s) review and academic feedback.
- **Didactic Modules:** Students must complete the didactic modules denoted on the unit syllabus. There will be one test at the end of each module within each unit. Each unit includes at least two or more required modules. Participants will receive a Pass/Fail notification after completing the test in each module. Participants have a total of three attempts to pass the test at the end of each unit with a score of 80 or better. The three attempts must be made within seven days of the unit completion date denoted on the syllabus.
- **300 hours of Clinical/Applied Learning CPE Units:** Each student is responsible for completing a minimum of 300 hours of clinical ministry during the unit. Clinical hours may be completed at your current place of ministry (if you are currently employed as a Chaplain or Pastor of a church), or any number of institutions including but not limited to; hospitals, hospice houses, corporate settings, prison systems, skilled nursing facilities, nursing homes, assisted living facilities, and community services. Your hours may be paid or volunteer. Each student is responsible for keeping track of these hours on the *CPE Weekly Clinical Hours Log* provided in the appendix of the student handbook, and having this form signed by the proctor at the clinical site. The form must be submitted by file upload, in the ICPT Learning Center for the CPE Supervisor(s) weekly verification.

Unit 1 Learning Center Courses:
Unit 1 is comprised of the following required courses:
1. F8CIV - Cultural Competence, Inclusion, and Vulnerable Populations
2. ST2GRF - Living with Heartbreak: Grief, Loss, and Bereavement

Unit 1, Course 1 - Overview:
F8CIV - Cultural Competence, Inclusion, and Vulnerable Populations
This course educates on the topic of Cultural Competence, Inclusion, and Vulnerable Populations. It focuses on the importance of understanding the scope and importance of culture and inclusion is addressed including its influences upon patients and families, the interdisciplinary health care team, and the health care or spiritual care provider him or herself. Emphasis will be on not only identifying the cultural and social issues that may arise, but the skills needed to demonstrate the ability to assist in incorporating those beliefs and values into the patient's plan of care. In addition, the modules within the course define and address marginalized populations - those without the same level of access to health care and other services that others depend on – including those who are illiterate or with low health literacy, people who are intellectually disabled, the homeless, and those who are incarcerated.

Course Competencies:
F8CIV - Cultural Competence, Inclusion, and Vulnerable Populations aligns with the following Quality Indicators in What is Quality Spiritual Care in Health Care and How Do You Measure It? (HCCN. 2016).

- **Structural Indicator 1.C.** Information is provided about the availability of spiritual care services.
- **Structural Indicator 1.B.** Dedicated sacred space is available for meditation, reflection and ritual.
- **Process Indicator 2.B.** All clients are offered the opportunity to have a discussion of religious/spiritual concerns.
- **Process Indicator 2.E.** Families are offered the opportunity to discuss spiritual issues during goals of care conferences.
- **Process Indicator 2.G.** End of life and Bereavement Care is provided as appropriate to the population served.

Module Descriptions and Learning Objectives:
F8CIV - Cultural Competence, Inclusion, and Vulnerable Populations:

1. **Cultural Competence in Health Care**
   According to a report released in 2013 by the U.S. Census Bureau of 2011 data, 60.6 million people, or nearly one in five people in the United States aged 5 or older, spoke a language other than English at home and 9% of the population limited English proficiency. The changes reflect a continuing shift in America's make-up amid the latest wave of immigration from Asia and other regions following influxes from Mexico and other Central and Latin American countries and, before that, Europe. It is estimated that by 2050, the United States will be a "majority minority" nation, with more than half the population coming from racial or ethnic minority backgrounds. (Pew Research Center. 2012.) However, diversity encompasses much more than language. Dimensions such as geography, socioeconomic status, religious, spiritual, or life philosophy beliefs and values, disability status, sexual orientation, and gender identity must also be considered. Attention to these aspects is critical to provide quality health care, and it is imperative that other members of the interdisciplinary care team but seek to identify them, understand their importance, and incorporate them into the plan of care.

   Module Learning Objectives:

- Articulate and explain the impact of demographics, immigration, and population growth on health care.
- Summarize the varying characteristics of culture.
- Define cultural competency as it is applied in health care.
- Describe the federal laws and national standards regarding the responsibilities of health care providers regarding culture and inclusion.

2. Cultural Humility

Cultural humility is grounded in demonstrating respect to the ways in which persons, families, and groups understand and interact with the world around them, including their beliefs and values. Respect provides the foundation for whether a sense of trust will be developed within the relationship between the patient and the health care team, the plan of care that is mutually developed, and the patient/family's willingness to participate in that plan.

Module Learning Objectives:

- Define cultural humility as it is applied in health care.
- Engage in self-awareness of and the ability to articulate one's own cultural values, beliefs, assumptions, and biases and can set those aside to assess for, document, and provide interventions to patients and families.
- Describe and apply the major concepts of healthcare communication with diverse cultures.

3. Religious and Cultural Traditions: Common Beliefs and Practices

An important activity for any chaplain, spiritual care provider, or other health care provider or spiritual care provider is to identify and become familiar with the cultural, religious, and spiritual communities relevant to their workplace setting's patient population. The next step is to outline a plan for building a coalition with community leaders that could identify beliefs, values and practices unique to each that will support/guide the health care and decisions of their members.

Module Learning Objectives:

- Gain basic knowledge of different religious traditions and common beliefs and practices.
- Identify and apply a plan to develop collaborative relationships with community cultural, spiritual, and religious leaders.
- Gain basic knowledge of different cultural groups and common beliefs and practices.
- Identify methods to obtain and employ knowledge on unfamiliar cultures, religious/spiritual beliefs, or existential norms.

4. Inclusion in Health Care and Vulnerable Populations

While cultural competence focuses on knowledge and practice, the concept of inclusion goes to a step further, requiring a paradigm shift in how one thinks and acts. Inclusion means treating all persons with dignity, respect, and equality rather than discrimination. It fosters a commitment to enhance the mental, physical, social, and spiritual care well-being of persons while reaffirming and respecting differences. It also focuses on making the patient and/or family, "family of choice," or caregiver the center of care, ensuring that he or she is actively involved with their care and support. Every community has marginalized populations, those without the same level of access to healthcare and other services. Providing compassionate, high-quality health care to persons who are often treated with exclusion, a lack of respect, dignity and equality, discrimination, or the absence of services is essential.

Module Learning Objectives:

- Define inclusion in health care.

- Identify which vulnerable populations are part of the health care setting's patient/client population cache to evaluate gaps in the provision of spiritual care.
- Describe the importance of identifying the unique spiritual/cultural/religious beliefs within vulnerable patient populations (including non-resident aliens, LGBTQ, homeless, incarcerated, low health literacy/illiterate, mentally-challenged severely disabled).

5. Cultural and Inclusion Issues in Practice

Assessment is a routine part of health care for every discipline. Chaplains and spiritual care providers routinely complete a spiritual assessment of patients and/or families to determine areas of strength and distress as well as identifying resources available to persons as well as those that can be provided. Cultural beliefs, values, and practices are an integral part of a chaplain's spiritual assessment. Chaplains are often called upon to negotiate treatments for patients with the health provider, particularly when they involve cultural issues, including spiritual and religious beliefs and values.

Module Learning Objectives:

- Understand ways to assess, document, and include appropriate spiritual/religious interventions for cross-cultural situations in a care plan or other required documentation.
- Explain the elements of cultural negotiation in chaplaincy practice.
- Identify the issues of spiritual distress often experienced by those of different cultural backgrounds and/or vulnerable populations and appropriate chaplaincy interventions.
- Summarize varying cultural practices relating to end of life and summarize the chaplain's role on the interdisciplinary team to support patients, families, and the health care team.

Unit 1, Course 2 Overview:
ST2GRF - Living with Heartbreak: Grief, Loss, and Bereavement
This course educates about the process of grief and offers current theories that have relevance to assisting grieving individuals. The modules in the course emphasize sensitivities, skills, and interventive strategies to assist chaplains and spiritual care providers in counseling individuals coping with grief and loss. The course also sensitizes learners to factors in certain kinds of losses such as the loss of a spouse/partner, child, parent, and sibling. It also explores disenfranchised grief—a concept that reminds chaplains that the experience of grief encompasses far more than the death of family member.

Course Competencies:
ST2GRF - Living with Heartbreak: Grief, Loss, and Bereavement aligns with the following Quality Indicators in What is Quality Spiritual Care in Health Care and How Do You Measure It? (HCCN. 2016):

- **Process Indicator 2.B.** All clients are offered the opportunity to have a discussion of religious/spiritual concerns
- **Process Indicator 2.G.** End of life and Bereavement Care is provided as appropriate to the population served.

Module Descriptions and Learning Objectives:
ST2GRF - Living with Heartbreak: Grief, Loss, and Bereavement Descriptions and Learning Objectives:

1. Basic Definitions

The term grief can be defined as a type of stress reaction, a highly personal and subjective

response that an individual makes to a real, perceived, or anticipated loss. Grief reactions may occur in any loss situation, whether the loss is physical or tangible, such as a death, significant injury, or loss of property; alternatively, symbolic and intangible such as the loss of a dream. Acute grief distinguishes it from other terms such as bereavement or mourning. Grief can also be anticipatory, disenfranchised, or complicated.

Module Learning Objectives:

- Define and differentiate the following concepts: grief, mourning, bereavement, anticipatory grief, complicated grief, disenfranchised grief.
- Identify the impact of each type of grief on spiritual, emotional, and/or existential issues and chaplaincy care.

2. Developmental Perspectives

Throughout life, a person's orientation towards death changes. While each person grieves uniquely, there are identifiable ways in which developmental stages, from childhood through older adulthood, that are typical responses to grief. Each can be impacted by one's experience of family, society, physical situation, ability to understand, and personal circumstances. Understanding developmental frameworks, patterns, and appropriate intervention and support strategies is essential to providing appropriate and effective chaplaincy and spiritual care.

Module Learning Objectives:

- Understand the ways that grieving is experienced and expressed at varied points within the life cycle

3. The Process of Grief

Individuals can experience typical grief in varied ways. Physical reactions are common as well as affective, cognitive, and spiritual manifestations of grief. The reactions of persons to loss are highly individual and influenced by a number of factors. There have been several approaches to describe the process or course of grief. This module will examine those approaches including myths surrounding grief.

Module Learning Objectives:

- Describe the process of grief noting manifestations of grief, the typical courses or pathways of grief, and signs that grief may be more complicated.

4. Current Perspectives of Grief

Though individuals have written about loss and grief throughout history, there is evidence that many grief responders and counselors, including spiritual care providers, may operate from antiquated models. In the past two decades, understandings of the grief process have changed in a number of significant ways and offer much to those assisting bereaved persons who are experiencing emotional and spiritual distress. This module will address those changes and application.

Module Learning Objectives:

- Discuss current theories of grief including Worden's Task Model, The Dual Process Model, and Meaning Reconstruction.

5. Counseling the Bereaved Individual: Strategies and Tools

Chaplains or spiritual care providers have a unique contribution to make in the care of those who are grieving. Because of their expertise in understanding religious, spiritual, existential, and cultural beliefs, values, and practices, their expertise can be essential in identifying potential areas of spiritual distress as well as spiritual resources to draw upon. Persons experiencing acute grief can help themselves in a number of ways. Because grief is a form of stress, lifestyle

management, including adequate sleep and diet, as well as other techniques for stress reduction, can be helpful. Others may benefit from counselors, par-ticularly if their health suffers or their grief becomes highly disabling, impairing functioning at work, school, or home, or if they harbor destructive thoughts toward self or others.

Module Learning Objectives:

- Describe appropriate and effective spiritual care approaches to grief support and counseling including support groups, rituals, bibliotherapy, and expressive approaches.

6. Sensitivities in Counseling Particular Types of Losses

The most common loss experienced is the deaths of parents, which may create changes in family structure. In a marriage, one spouse will likely outlive the other, and it is critical to recognize that the experiences of widows and widowers are not uniform. Few deaths are as emotionally complicating as the death of a child, whatever the child's age. Siblings are persons that are often known longer and more intimately in one's life, thus is unique. Disenfranchised grief occurs when a death is experienced that cannot be openly mourned. This module will examine these particular types of losses as well as appropriate ways to respond and support grievers.

Module Learning Objectives:

- Demonstrate sensitivities to the varied losses persons may experience such as the loss of a parent, spouse/partner, child, or sibling, as well as losses that may be disenfranchised by the larger community.

7. Complications of Grief

For some, loss leads to other issues and problems – depression, anxiety, alcoholism, or substance abuse. In other cases, it may make us physically ill or self-destructive. Significant loss cannot only increase our chance of illness; it may actually kill. This module will explain the concept of complicated grief, describe its manifestations, and provide appropriate interventions.

Module Learning Objectives:

- Discuss current approaches to complicated grief, noting changes in the DSM-5 as well as sources of referral.

CPE Unit 1 Schedule – Full-time Student:

Week	Topic	Assignments
1	**Group Introduction to Course 1: F8CIV - Cultural Competence, Inclusion, and Vulnerable Populations:**	1. Introduction to course and requirements; Q&A • Getting Started • Welcome to the Course • Pre-test 2. Student Introductions 3. Review material, required articles, and videos and submit assignments. 4. Case study and/or group discussion
2	**Cultural Competence in Health Care** • Competent vs. Incompetent Care • Cultural Diversity in the United States • Defining Culture • Cultural Competence • National CLAS Standards • Health Regulatory Agencies	1. Review material, required articles and videos, and submit assignments. 2. Case study and/or group discussion Videos: • Cultural Competence for Healthcare Providers. Jefferson Center for Interprofessional Education. 2009. • Diversity Nursing. Incompetent vs. Competent Cultural Care. 2011. Articles: • How Demographics Impact Healthcare Delivery. EnsoCare. 2017. Web.

		• The Cultural Demographic Shift Is Changing the Business of Healthcare. Llopis G. 2015. Forbes. Web. • Cultural and Spiritual Sensitivity - A Learning Module for Health Care Professionals. HealthCare Chaplaincy Network. 2009. Web. • Handbook of Patient's Spiritual and Cultural Values for Health Care Professionals. HealthCare Chaplaincy Network. 2014. Web. • National Standards on Culturally and Linguistically Appropriate Services (CLAS) A Blueprint for Advancing and Sustaining CLAS Policy and Practice. Office of Minority Health. U.S. Department of Human Services. Web. 2000.
3	**Cultural Humility** • Self-Awareness • Learning from Others • Communication as Culture • Communication Strategies	1. Review material, required articles and videos, and submit assignments. 2. Case study and/or group discussion Videos: • Legrand T. A Failure to Communicate. 2011. Articles: • Rocque R, Leanza Y. A Systematic Review of Patients' Experiences in Communicating with Primary Care Physicians: Intercultural Encounters and a Balance between Vulnerability and Integrity. PLoS One 10(10). • Industry Collaboration Effort. Talking About End of Life Care and Advance Directives across Cultures. 2007.
4	**Religious and Cultural Traditions: Common Beliefs and Practices** • Liaising with Community Cultural, Spiritual, and Religious Leaders • Resources on Cultural Competency and Customs	1. Review material, required articles and videos, and submit assignments. 2. Case study and/or group discussion Articles: • Health Resources and Service Administration. Culture, Language, and Health Literacy. 2017. Web. • Agency for Healthcare Research and Quality. The Providers Guide to Quality & Culture. 2008. Web. • Champlain Valley Health Education Center. Cultural Competency for Health Care Providers. 2013. • Religion Facts. The Big Religion Chart. 2016. Web.
5	**Inclusion in Health Care and Vulnerable Populations** • Defining Inclusion • Lesbian, Gay, Bisexual, Transgender, Questioning or Queer (LGBTQ) • Illiterate/Low Health Literacy • Intellectually Disabled • Homeless • Incarcerated Persons	1. Review material, required articles and videos, and submit assignments. 2. Case study and/or group discussion Videos: • NYC Health and Hospitals. To Treat Me, You Have to Know Who I Am. 2011. • American Medical Association. Health Literacy Video. 2010. • The Leicestershire Partnership NHS Trust in the United Kingdom. If You Listen You Will Hear Us. 2013. • Growing Films. Without a Roof. 2014. Articles: • Gaudette H. Alphabet Soup: Learning the Language. 2012. • Halfeez, et al. Health Care Disparities among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review. 2017. • Wood AW, Conley AH. Loss of Religious or Spiritual Identities among the LGBT Population. 2014. • Almack, et al. Exploring the Impact of Sexual Orientation on Experiences and Concerns about End of Life Care and on Bereavement for Lesbian, Gay, and Bisexual Older People. 2010 • Safeer and Keenan. Health Literacy: The Gap between Physicians and Patients. 2005.

		• U.S. Department of Health and Human Services. Quick Guide to Health Literacy. 2017. • Surrey Place Center. Adaptive Functioning and Communication Associated with Different Levels of Intellectual and Developmental Disabilities. 2011. • Swinton. No Box to Tick. 2004. • Carter. A Place of Belonging: Research at the Intersection of Faith and Disability. 2016. • Wen, et al. Homeless People's Perceptions of Welcomeness and Unwelcomeness in Healthcare Encounters. 2007. • American College of Emergency Physicians Public Health Committee. Recognizing the Needs of Incarcerated Patients in the Emergency Department. 2006. Web. • Williams, et al. Balancing Punishment and Compassion for Seriously Ill Prisoners. 2011.
6	**Cultural and Inclusion Issues in Practice** • Culture as a Part of Spiritual Assessment • Cultural Negotiation • End of Life Within Differing Cultures • Cross-Cultural/Inclusion Spiritual Care Issues and Interventions • Other Social Considerations **Post-Test**	1. Review material, required articles and videos, and submit assignments. 2. Case study and/or group discussion 3. Course post-test 4. Mid-unit self-evaluation Articles: • Giger and Davidhizar. The Giger and Davidhizar Transcultural Assessment Model. 2002. • Kagawa-Singer and Blackhall. Negotiating Cross-Cultural Issues at the End of Life: "You Got to Go Where He Lives." 2001. • Campinha-Bacote. Delivering Patient-Centered Care in the Midst of a Cultural Conflict: The Role of Cultural Competence. 2011. • Austerlic. Cultural Humility and Compassionate Presence at the End of Life. 2009. • Maly, et al. Racial/Ethnic Group Difference in Treatment Decision-Making and Treatment Received Among Older Breast Carcinoma Patients. 2006. • Fang, et al. A Knowledge Synthesis of Culturally- and Spiritually-Sensitive End of Life Care: Findings from a Scoping Review. 2016.
7	**Group Introduction to Course 2: ST2GRF, Living with Heartbreak: Grief, Loss, and Bereavement** **Basic Definitions** • What Loss Means to You • Grief, Anticipatory Grief, Disenfranchised Grief, and Complicated Grief • Types of Grief and Application to Practice **Developmental Perspectives** • First Encounter with Death • Grief through the Life Span • Case Considerations	1. Review material, required articles and videos, and submit assignments. 2. Case study and/or group discussion Articles: • The Bereavement Exclusion and DSM-5: An Update and Commentary. Pies R. 2014. • Treating Complicated Grief. Simon M. 2013. • Complicated Grief and Related Bereavement issues for DSM-V. Shear MK et al. 2011. • The Impact of Losing a Child on the Clinical Presentation of Complicated Grief. Zetumer S, et al. 2015. • Complicated Grief and Depression in Young Adults: Personality and Relationship Quality. Holly B, et al. 2014. • "I was just trying to stick it out until I realized I couldn't." A Phenomenological Investigation of Support Seeking Among Older Adults with Complicated Grief. Ghesquiere A. 2013. • Grief and its Complications in Individuals with Intellectual Disability. Brickel C, et al. 2008. • Children and Grief. Wintz S. 2014 • Age-Related Differences in Responses to Thoughts of One's Own Death: Mortality Salience and Judgments of Moral Transgressions. Maxfield M, et.al. 2007.

		• Fear of Death in Older Adults: Predictions from Terror Management Theory. Cicireli VJ. 2002.
8	**The Process of Grief** • Grief Experience • What Grief Is • Grief Processes	1. Review material, required articles and videos, and submit assignments. 2. Case study and/or group discussion Articles: • Death Education: An Internationally Relevant Approach to Grief. Doughty and Hoskins. 2011. • Grief and Mourning Gone Awry: Pathway and Course of Complicated Grief. Shear. 2012 • An Evolutionary Account of Vigilance in Grief. White and Fessler. 2018.
9	**Current Perspectives of Grief** • How Grief Theories Have Changed • Applying Current Perspectives of Grief to Practice	1. Review material, required articles and videos, and submit assignments. 2. Case study and/or group discussion Articles: • The Myths of Coping with Loss. Wortman and Silver. 1989. • Loss and Restoration in Later Life: An Examination of Dual Process Model of Coping with Bereavement. Bennett K, et al. 2010. • Grief Therapy and the Reconstruction of Meaning: From Principles to Practice. Neimeyer R, et al. 2010. • Bereavement Challenges and Their Relationship to Physical and Psychological Adjustment to Loss. Trevino K, et al. 2017.
10	**Counseling the Bereaved Individual: Strategies and Tools** • Choosing Interventions • Support to Grievers Helping Themselves • Grief and Differences in Beliefs and Values • Therapeutic Ritual	1. Review material, required articles and videos, and submit assignments. 2. Case study and/or group discussion Articles: • Grief and Mourning in Cross-Cultural Perspective Links to an external site. Encyclopedia of Death and Dying. 2017. Web. • Foxhole Atheism Revisited: The Effects of Mortality Salience on Explicit and Implicit Religious Belief. Jong, J, Halberstadt J, and Bluemke M. 2012. • A Model of Religion and Death. Pyne D. 2010. • Bereavement Counseling: Does it work? Parkes C. 1980. • An Internet Tool to Normalize Grief. Dominick S et al. 2009. • Creating Rituals to Move through Grief. Helbert K. Good Therapy. Web. • Transition Rituals: A Faith-by-Faith Guide to Rites for the Deceased. Belief Net. Web.
11	**Sensitivities in Counseling Particular Types of Losses** • Death of a Parent • Death of a Spouse • Death of a Child • Death of a Sibling • Disenfranchised Grief	1. Review material, required articles and videos, and submit assignments. 2. Case study and/or group discussion Video: • Disenfranchised Grief. Springer Publishing Company. 2013 Articles: • The Impact of Late-Life Parental Death on Adult Sibling Relationships. Khodyakov D and Carr D. 2009. • Grief, Depressive Symptoms, and Physical Health among Recently Bereaved Spouses. Utz R et al. 2012. • Do Afterlife Beliefs Affect Psychological Adjustment to Late-Life Spousal Loss? Carr D and Sharp S. 2014. • Cause of Death and the Quest for Meaning after the Loss of a Child. Lichtenthal W, et al. 2013. • Sibling Death and Death Fear in Relation to Depressive Symptomatology in Older Adults. Cicirelli V, et al. 2009.

		• Adult Loss of a Sibling. Rando, T. 1991. Web. • Ambiguous Loss and Grief: A Resource for Health Care Providers. Alzheimer's Society of Canada. 2013. • Grief after Patient Death: Direct Care Staff in Nursing Homes and Homecare. Boener K et al. 2015. • A Theoretical Study of the Hidden Wounds of War: Disenfranchised Grief and the Impact on Nursing Practice. Aloi J. 2011. • Disenfranchised Grief & LGBT Survivors: Exploring Clinical Considerations. McNutt B. 2012. • Living with and Creating a Spirituality of Loss in a Forensic Context. Lane R. 2012.
12	**Complications of Grief** • When Grief Becomes Difficult • Persistent Complex Bereavement Disorder **Post-Test**	1. Review material, required articles and videos, and submit assignments. 2. Case study and/or group discussion 3. Course post-test 4. Final Unit Self-Evaluation Video: • Persistent Complex Bereavement Disorder. Mason C. 2014. Articles: • Grief, Depression, and the DSM-5 PDF File. Perper, R. 2013.

This unit schedule is subject to change at the discretion of the CPE Supervisor.