Cliinical Elective: Psychology in Palliative Care

PSY8500

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1. Course information

Description

Care for those with life-limiting illness is an integral and important part of health care. When working with people at the end of life and their families, it is essential to assess the overall quality of care they are receiving, to identify sources and ways of alleviating suffering as appropriate, and to determine what decisions need to be made and who needs to be involved in making and implementing those decisions. With this variety of activities, psychologists can play vital roles in clinical care, research, teaching, public policy, organizational leadership, and advocacy. This course provides students with a foundation upon which to build this unique and increasingly necessary set of skills and knowledge as well as how to develop relationships through which these activities can be successfully engaged.

Overview

Achieving standards of care for psychological services at the end of life (EOL) depends on psychologists with strong interpersonal skills, clinical knowledge, technical proficiency, and respect for the culture of individuals, their families, and the health care system; additionally, they should be informed by scientific evidence, values, and personal and professional experience. Psychologists also provide unique skills in policy development, research, and leadership. Often, when it comes to providing psychological support to patients and families, there can be conflicts or overlaps between the roles of clergy, nurses, physicians, psychologists, social workers, volunteers, and other palliative care team members. A central challenge is therefore to delineate unique core competences, and agree on an unambiguous definition of the role of the psychologist that differs from that of other professionals and is acknowledged in health care systems and within the palliative care team, yet can still contribute to the interprofessional nature of these teams.

Psychologists working in palliative care face specific challenges that are due, for example, to the limited time available for intervention when faced with complex patient situations near the end of life, or to the fact that the whole field of psychology in palliative care is still under development. Additionally, the ability to design research, analyze qualitative and quantitative data, publish results, and do meta-analyses as results accumulate are powerful skills for advancing understanding of this complex and often difficult stage of life, and are major strengths that psychologists can bring to the study of the EOL period.

> When defining their own professional role, tasks and responsibilities, psychologists should reflect critically upon the real benefits of their contribution.
>
> Jünger and Payne (2011)

There are numerous opportunities at federal, state, and local levels for psychologists who are interested in assuming advocacy or policy roles to advance the quality of care at the end of life. Psychologists can promote a wider societal commitment to caring well for people who are approaching death by working with other health care professionals and managers, researchers, policymakers, funders of health care, and the public at large to improve policy and practice. The goal of widespread quality care at the end of life is attainable, but realization of that goal will require many system-wide changes in attitudes, policies, and actions.

"To give them a chance to be prepared for working in palliative care, it is necessary to determine the knowledge, skills, and abilities that are needed for psychologists to be effective contributors in the hospice and palliative care environment. Psychologists need to take advantage of what they already know, acquire the additional knowledge and skills that they need, and start finding opportunities to become more involved. To gain additional knowledge, psychologists who wish to get involved in palliative care will want to seek appropriate training to develop the competence to be effective and accepted into the palliative care environment."[1] This course provides an initial step in that training.

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[1] Jünger, S., & Payne, S. (2011). Guidance on postgraduate education for psychologists involved in palliative care. European Journal of Palliative Care, 18(5), pp. 238-252.

Programmatic rationale

The PsyD and Ph.D. clinical psychology programs are organized to enable you to build sequentially on knowledge and skills. This course is part of the PsyD/PhD shared curriculum. Each course in the program is designed to accomplish program specific learning outcomes (or training goals and objectives). The following goals are taken from each program's learning outcomes, goals, and objectives statements.

In the PsyD. program, this course contributes toward the fulfillment of the following PsyD. program learning outcomes:

B. To develop student/graduates who demonstrate competence in (1) relationship, (2) assessment, (3) intervention, (4) research and evaluation, (5) consultation/education and management/supervision.

C. To develop student/graduates who have the knowledge, skills and attitudes necessary to function professionally in a multicultural society

F. To develop student/graduates who are able to intervene, using multiple methods, with diverse populations across many settings and in changing and evolving contexts.

In the Ph.D. program, this course contributes toward the fulfillment of the following Ph.D. program learning outcomes:

Goal 1: To prepare students to be effective professional psychologists who are skilled at evaluating psychological functioning and providing effective interventions with diverse clients across a range of settings.

Objective 1. To develop broad theoretical and scientific knowledge in foundational areas that provides the basis for the effective practice of clinical psychology.

Objective 3. To develop an understanding of psychopathology and psychological assessment, and to apply such knowledge in the evaluation of psychological functioning in a variety of settings with diverse populations

Objective 4. To develop an understanding of the efficacy, and modes of application of, psychological interventions in a variety of settings with diverse populations

Course outcomes

Goals

Overarching goals of the course are for you to:

- Articulate the historical, cultural, and contextual issues that affect EOL care in the United States.
- Recognize your own feelings and attitudes about the many aspects of providing palliative care.
- Develop strategies to prevent burnout and compassion fatigue.
- Understand that cultural considerations are especially important with regard to issues such as medical decision-making, experience, meaning and expression of pain and suffering, and symptom management.
- Identify the major ways in which psychologists can assist patients and their families near the EOL.
- Communicate effectively with staff members at all levels of a palliative care organization regarding patient and family aspects that are within your scope of practice.
- Provide consultation to individuals, teams, and organizations with regard to developing a coherent psychological framework for understanding the needs of patients and families, and of staff members and volunteers.
- Critically evaluate qualitative and quantitative research and reviews, and to formulate research questions and develop study protocols.
- Demonstrate knowledge about palliative care services and the institutional/political/structural context of organizations that provide palliative care.

- Critique and promote a wider societal commitment to caring well for people who are approaching death by working with other health care professionals and managers, researchers, policymakers, funders of health care, and the public at large to improve policy and practice.

Objectives

By the end of the course, you should be able to:

- Define key concepts related to EOL care (Assignment 4, readings for sessions 1 and 2).
- Utilize assessment tools and diagnostic interviews for assessing psychological symptoms and establishing a differential diagnosis (Readings for sessions 3, 6, 7, and 9).
- Distinguish and respect cultural difference, execute culturally appropriate assessments and interventions, and utilize culturally-based strengths (Readings for sessions 3, 4, 6, 8, and 12; activities in sessions 5 and 16).
- Recognize the importance of appropriate assessment for psychological therapy, and the importance of detecting and supporting resilience in individuals, families and groups near the end of life and during bereavement (Readings for sessions 6, 7, and 10).
- Identify palliative care agencies in the San Francisco Bay area with particular competence and outreach to target populations. (Assignment 2)
- Evaluate and respond to ethically complex situations, in particular when the patient expresses a wish for hastened death (Readings for sessions 11 and 13).
- Work within an interprofessional team, including educating others, differentiating between various roles, and dealing with inappropriate expectations of psychologists (Readiings for session 12).
- Reflect on and respond to your own physical and existential issues that arise when working in palliative care (Assignment 3, readings for session 15, and collaborative conversations).
- Identify the roles psychologists can fill in conducting research, developing public policy, and serving as an advocate in this field (Readings for session 14).
- Articulate your understanding of the role of psychology in palliative care in both oral and written formats (Assignments 1, 4, and spontaneous learning opportunities)
- Outline further areas for growth as a competent practitioner (Assignments 1, 2, 4, and collaborative conversations).

2. Teaching philosophy: The flipped classroom and collaborative learning

I am particularly interested in the pedagogy of health care education and the continued search for the most effective use of students' time and the maximum amount of material to be comprehended and made useable in professional settings. Much of my professional life is spent at the University of California, San Francisco working in the areas of faculty development, medical student education, and interprofessional team development. I have found that the flipped classroom helps students "receive and master new knowledge outside the classroom, and teachers use classroom time to reinforce learning and address students' questions."[2]

In this course, you are responsible for reading the chapters and articles that are assigned, then bringing in questions, disagreements, revelations, and confusions that arise during your reading. As you can see, reading is an active act of learning rather than a passive information scan. I will regularly bring palliative care situations to class and, in a problem-based learning modality, ask you to work on those quandaries, generate areas for further knowledge (hence the spontaneous learning opportunities), and come up with approaches based on what you've learned in your readings; this also helps support an underlying intention to develop lifelong learners.

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[2] Prober, C. G. & Khan, S. (2013). Medical education reimagined: A call to action. *Academic Medicine, 88*(10), 1407-1410. doi: 10.1097/ACM.0b013e3182a368bd

Traditional lectures often foster passivity and dependency. They typically provide answers rather than questions and create the impression that knowledge can be successfully dumped into learners' heads, like water in a bucket. In a variation of this analogy, many doctoral students feel that during coursework they are trying to take a drink from a fire hose! During uninterrupted lectures, learners are discouraged or prevented from reflecting on or challenging ideas, even internally. Learning takes place within a context that evokes and encourages the learners' questions. While most instructional groups are a blend, groups that are more often collaborative[3] can create a fertile ground in which learning can grow; this collaborative spirit is a hallmark of interprofessional medical home teams as well as palliative care teams, so the mechanics of this class will stand you in good stead should you enter the profession as a clinician and be involved with the health care system.

The table[4] below highlights some of the traits of collaborative and authoritarian groups.

	Collaborative	***Authoritarian***
Description of class	Learning community	Isolated individuals
Way learners are viewed	Vital contributors to their own and each other's learning	Recipients of teaching
Teachers' main roles	Facilitator of learning, diagnostician, model, coach	Purveyor of information
Teachers' main communication	Questioning, active listening	Telling
Type of leadership	Situational: varies with the learners and the context	Directive
Learners' main roles	*Active:* Questioners, intent listeners, discoverers, teachers of each other	*Passive:* Listeners, receivers of information, note-takers
Nature of discussions	Dialogues; reflective	Monologues
Nature of relationships	Trusting, respectful, collaborative	Formal, guarded, distant, competitive, perhaps adversarial
Responsibility for meetings	Increasingly, the learners'	The teachers'

The goal in this course is for us to work on a collaborative level, not an authoritarian level. Warning: I will not deliver lectures! As you can see, the lecture mode doesn't work well in a flipped classroom setting. Those of you who are used to being "lectured at" may find this challenging, and I encourage you to try what may be new to you. For the time to be interesting, stimulating, beneficial, and worth your time and money, before each class you must have thought about the material from the previous class meetings, completed the readings assigned for the week, and formulated questions, disagreements, and other ideas. Be prepared to discuss your personal and professional reactions with me and with your colleagues in class. Both you as student and I as professor share the responsibility for making the seminar relevant and useful to you. All of us in the class teach each other; learning is a community effort.

Using this approach, there is a great reliance on collaborative learning, as you may imagine from the description above. Plan to spend part of most classes working in duos, trios, or quartets; many of you

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[3] Westberg, J. & Jason, H. (1996). *Fostering learning in small groups.* New York, NY: Springer.

[4] Davis, B. G. (2001). *Tips for teaching* (p. 147). San Francisco, CA: Jossey-Bass.

are used to working on an individual level, and this is different for you. A large body of research demonstrates that adult learners learn best when they are actively involved in the process. Regardless of subject matter, students "…working in small groups tend to learn more of what is taught and retain it longer than when the same content is presented in other instructional formats" (Davis, 2001).

We will frequently organize learning around class discussions. Here are some guidelines[5] that may be helpful as you work in this way:

- Seek the best answer rather than try to convince other people.
- Try not to let your previous ideas or prejudices interfere with your freedom of thinking.
- Speak whenever you wish (if you are not interrupting someone else, of course), even though your idea may seem incomplete.
- Practice listening by trying to formulate in your own words the point that the previous speaker made before adding your own contribution.
- Avoid disrupting the flow of thought by introducing new issues; wait until the present topic reaches its natural end.
- Stick to the subject and talk briefly.
- Avoid long stories, anecdotes, or examples.
- Give encouragement and approval to others.
- Seek out differences – they enrich the discussion.
- Be sympathetic and understanding of other people's views.

The role of discussions as part of the structure of this course is such that the skill of reflection is actively cultivated. "Reflective learning can improve professionalism and clinical reasoning, and reflective practice can contribute to continuous practice improvement and better management of complex health systems and patients."[6] In contrast to the common usage of the term *reflect*, meaning to simply look back upon, *critical reflection* has been described by Mezirow as:

> ...the process of becoming critically aware of how and why our presuppositions have come to constrain the way we perceive, understand, and feel about our world; of reformulating these assumptions to permit a more inclusive, discriminating, permeable and integrative perspective; and of making decisions or otherwise acting on these new understandings. More inclusive, discriminating, permeable and integrative perspectives are superior perspectives that adults choose if they can because they are motivated to better understand the meaning of their experience.[7]

You are expected to develop your critically reflective ability not only to contribute to this class, but to enhance your own lifelong learning skills.

3. Assignments

Reading List

Qualls, S. H. and Kasl-Godley, J. E. (2011). *End-of-life issues, grief, and bereavement: What clinicians need to know*. Hoboken, NJ: John Wiley & Sons. ISBN-13: 978-0470406939

Journal articles, conference proceedings, book chapters, and policy statements that are assigned for each week.

Please bring a copy of the readings for the week to class with you. You'll find electronic copies of the assigned articles on the Moodle course support page or on line.

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[5] Tiberius, R. G. (1990). *Small group teaching: a trouble-shooting guide* (pp. 67-68). Toronto: Ontario Institute for Studies in Education Press.

[6] Aronson, L. (2011). Twelve tips for teaching reflection at all levels of medical education. *Medical Teacher, 33*(3), 200-205. doi: 10.3109/0142159X.2010.507714

[7] Mezirow J. (1990). *Fostering critical reflection in adulthood*. San Francisco: Jossey-Bass.

Discussions, papers, and presentations

For every hour in class, plan to reserve 2-3 hours outside of class for reading and writing (this is the definition of the Carnegie unit, the basis for granting course credit in U.S. colleges and universities). Please send your written case reports to me through our Moodle portal; each is due by the start of the class period on the date listed in the syllabus. Should you have a problem with your computer, bring a hard copy of the assignment to class; please double space and staple the assignment if you use this option. Turn in assignments by the start of class (10:00) on the due date. If you miss the class when an assignment is due, submit your assignment by the due date and time. **I do not accept late assignments;** do not turn them in (see exception below regarding serious illness), and please… don't ask me to make an exception for you.

1) At the first class we will be assigning discussion leaders for many of the articles. Each person will serve as the discussion leader for 3 articles, each of which is at least 2 weeks apart from the other two. As discussion leader, you are responsible for synthesizing your knowledge and demonstrating your grasp of the material covered in the article and through the semester up to that point. You do this by facilitating the discussion in class, not by lecturing to your peers. A tip sheet for leading a journal club discussion is included in your readings for the first week of class (PsyD outcome C; PhD outcome 1-1).

   This assignment helps you delvemore deeply into articles; leading a discussion is an excellent way to ensure you understand what the author was trying to communicate as well as encourages you to develop your own opinions about the subject. It also increase your professional verbal fluency.

2) The community agency paper (4-5 pages) requires you to make a site visit to one palliative care agency or service with which you are currently *unfamiliar*. Be prepared to give a 5-minute presentation to the class focused on highlights about the site you visit. Your visit *must include* meeting with at least one licensed mental health professional (counselor, psychiatric nurse, psychiatrist, psychologist, social worker) who is a member of the palliative care team (30 points) (PsyD outcome C; PhD outcome 1-4).

   The purpose of this assignment is to get you out of the classroom and into the real-world experience of how palliative care is provided in the area. It also exposes you to the world of interprofessional teams and the roles that psychologists may hold within these teams

   Write your paper as follows:

   Part A: One page describing the agency. Include name, address and neighborhood, website, who/why/how/when established, client population served, services offered, eligibility for services, staffing, fees, accessibility, funding, and whether or not a training program for mental health students is available. Reproduce enough copies of part A to distribute to the entire class. Coordination of site visits with your classmates is crucial: no more than one person in the class may visit the same site.

   Part B: Three to four pages describing your reactions to the experience: first impressions, how you were received, what it might feel like for you as a staff member there, what current staff as well as the mental health professional you interview think a psychologist could contribute to their palliative care team, and impressions when leaving.

   My suggestion is to make arrangements with the agency you select well before the assignment is due, particularly so you can schedule time with the licensed mental health professional on site.

   Please, remember to write a thank you note to the person who meets with you. It's simply good manners, as well as being wise networking behavior. Acknowledging the staff person's time and energy, of which you were the recipient, will cause you to stand out in the staff member's mind as someone who is thoughtful and professional. Both are aspects that are valued when recommending someone for an interview… or offering a job. Health care is actually a small world, and you never know when you might cross paths in the future with this person. And finaly, it's simply the right thing to do.

3) Choose two of the following options, one from section 1 and one from section 2; do not turn in either assignment before session 8 of the course. Section 3 offers an extra credit option. If you have a different idea of what you'd like to do for one of these sections, please feel free to talk with me about it; I'm very open to a project you generate that address the pedagogical intention of the assignment (20 points each) (PsyD outcome B, C, and F; PhD outcome 1-3 and 1-4).

Section 1 (personal/social aspects)

These assignment options are designed to help you integrate the didactic information with your own personal experience, offering a chance for a greater level of critical reflection.

3-1-a) Complete your own advance directive and durable medical power of attorney. Include a short (5-6 pages) reflection paper outlining your cognitive, affective, physical, spiritual, behavioral, and/or social responses to completing these legal documents. By definition, part of this paper will include the reactions of the people who will serve as your health care proxy(ies) and your health care provider with whom you discuss the advance directive.

3-1- b) Create your own funeral, memorial service, or celebration of life ritual, as well as a rationale for the choices you made, including the person(s) who will be leading the event and their response when you asked them to take on this role. As a time frame to focus your work, the funeral would be held on the last day of our class this semester. The place and cause of your death for this assignment are up to you.

3-1-c) Put together your own eulogy (minimum 500 words). You may decide the time, place, and cause of your death. This may be in written, audio, or video format (electronic formats only). Please let me know where the eulogy would be published, spoken, and/or played, and why you chose that venue. Include a section that describes the eulogist(s), why you chose the person(s), what the person(s) said when you asked for her/his/their willingness to take on this role, and your reflection on the response. You may not deliver your own eulogy.

3-1-d) Write a reflection paper (5-6 pages) about your work affecting your relationships with loved ones: meaningful relationships, communication and expressing feelings; time dedicated to family and friends; issues of forgiveness and gratitude; how you would like to be remembered after your death, and what you are doing to contribute towards this remembrance.[8] Share this reflection paper with at least one other person who is affected by how your work affects your relationship, and include that person's response - and your critical reflection on the response - as a 2-3 page addendum to your reflection paper.

Section 2 (clinical/policy/teaching aspects)

These assignment options are designed to give you the opportunity to consider a variety of roles psychologists might hold within palliative care and the activities in which you might engage when you function in that role.

3-2-e) Design an information brochure about an aspect of palliative care you believe needs to be better understood by a target audience. Use a quarter-fold format (8.5" x 14" paper) for the brochure. Include a separate bibliography and a rationale for why you chose this topic, the intended target audience, and the means of distribution (be specific!).

3-2-f) Construct a proposal for a 50-minute grand rounds presentation on a palliative care topic to be given to medical interns and residents. The topic cannot be covered in depth during our own class sessions. Include a rationale, learning goals, and a bibliography for the presentation.

[8] Jünger, S., & Payne, S. (2011). Guidance on postgraduate education for psychologists involved in palliative care. *European Journal of Palliative Care, 18*(5), pp. 238-252.

3-2-g) Respond to the following clinical scenario. Your response (5-6 pages) is not about having a right or wrong answer, but rather to make you think about these issues in some depth and to cogently communicate those thoughts. The answers, therefore, should be given in the form of a discussion.

- 70 year old retired coal mine engineer diagnosed with non small cell lung cancer.
- Her disease is bulky but resectable. Her oncologist estimates a 60% chance of living five years without cancer if she is treated. The patient is otherwise healthy. She accepts surgery followed by adjuvant chemotherapy and radiation therapy.
- Describe how she may suffer over the next five years in each of the following domains. Identify in your discussion those areas in which her family or friends might share her suffering, whether physical, emotional, spiritual, psychological, and/or financial.

3-2-h) Working as a duet, you and a partner present a 45-minute learning module to our class about an area in palliative care that is not focused on in the syllabus (it may be mentioned or touched on slightly). Include an assessment form that will be filled out and returned by your colleagues in class. You classmates' scores will comprise 50% of your grade. If you would like to pursue this option, please see me for a template of an assessment form you can use. I must know if you would like to use this option by the fourth class in order to add it to the schedule later in the semester.

3-2-i) Research the palliative care benefit (including, but not limited to, hospice) for your insurance plan. If you are not currently insured, investigate the benefit provided by either Medicare or Medi-Cal. As part of this reserach, delineate how to access the benefit, what services are covered, what services are not covered, out-of-pocket expenses, who is reimbursed for what services (be sure to address reimbursement for psychotherapy), and how this service is affected by the implementation of the Affordable Care Act (ACA). Identify what you want to change if you find deficiencies or missing aspects of good palliative care. Tackle this research as if you are doing it for yourself or a loved one, so be thorough and think about different scenarios for which you want to understand what care is provided.

3-2-j) Help a consenting adult (parent, acquaintance, or relative) engage in planning advance care[9] through use of *Making Your Wishes Known: Planning Your Medical Future* <www.makingyourwishesknown.com>, an online tool that combines values clarification exercises with an algorithm that generates a personalized advance directive. Write a 5-6 page critical reflection paper from both your perspective and that of the person with whom you assisted in completing the directive.

4) As we are having discussions in class, we'll come upon a topic that isn't familiar and not necessarily covered in the readings; it would help us to have more information, hence a spontaneous leaning opportunity (SLO). Write a 500-700 word answer to an palliative care-related question that arises in class and post to the SLO forum within 3 days. Be sure to tie your answer to the topic that was being discussed. You'll have 2 of these SLOs each semester. As part of your class participation grade, classmates who did not write the answer are to read and briefly respond on line through the Moodle class forum; please write your response within 3 days of the SLO posting. This means that the selection, posting, and responses to a SLO occur within one week. Or, in more concrete terms, the SLO gets chosen in class on Tuesday; you have until Friday to write it; the rest of the class has until Monday to comment on it. After Monday the ability to comment is closed (PsyD outcomes B, C, and F; PhD outcomes 1-1, 1-3, and 1-4).

These assignments help tailor the course to individual students' interests, illustrate the strengths of a collaborative learning community, and increase your written subject fluency and feedback skills.

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[9] Levi, B. H., Wilkes, M., Der-Martirosian, C., Latow, P., Robinson, M., and Green, M. J. (2013). An interactive exercise in advance care planning for medical students, *Journal of Palliative Medicine, 16*(12), 1523-1527. doi:10.1089/jpm.2013.0039.

Here are a few guidelines when you write your SLOs:

- Don't cut and paste information; you won't learn by doing that. Read, comprehend, and digest the information, and then write your entry based on your understanding. Remember what I stated earlier: I'm interested in what you think.
- Use at least two resources from the professional literature, and cite them; this keeps you safe from the perception of plagiarism and requires you to consider two (possibly) different viewpoints. It also gives others the opportunity to follow up if they want more information.
- Seek out differing opinions if they're available, briefly summarize them, then tell us which one you're leaning toward and why.
- Relate the SLO to your own clinical situation and/or the topic we were discussing in class.
- What is particularly salient for you in what you learned through this SLO? If you ask a question (that's not specific to a classmate), be sure to answer it.
- Tell us what you thought about what you learned; what's your viewpoint, and what prompts you to hold that view? That will gives us as a group more of a chance to have an ongoing dialogue.

For responses, think about these considerations (not all will apply to every SLO):

- Do you have questions about the basic information presented in the SLO? If so, what are they?
- What are additional ways of this SLO relating to the discussion in class?
- How does this SLO relate to your practicum experience? Is there anything to consider doing differently at your site based on what you learned from your classmate's research?

The last 45 minutes of each class are devoted to *collaborative conversations*. These are designed to nurture your ability to critically self-relect, an attribute that is linked to increased competence for health care providers. Specifically, reflective learning can improve professionalism and clinical reasoning, and reflective practice can contribute to continuous practice improvement and better management of complex health systems and patients.[10,11] As Jünger and Payne (2011) assert, "psychologists in palliative care need to be able to have close, empathic and meaningful relationships with team members and with patients and families (who can be adults or children), while at the same time maintaining their internal congruence" (p. 246).

These conversations are not graded or evaluated; they provide the opportunity to give consideration to what you are learning and to put it in a larger context of your own life and your role as a psychologist. These are conversations, not therapy, and they are designed to increase your efficacy in a pallitive care setting. The topic of each week's conversation is listed in the syllabus (PsyD outcome B and C; PhD outcome 1-4).

The purpose of these conversations is to teach you about the variety of views that people hold about topics in this field (which will be useful when working in this area), give you a chance for critical self-reflection, and contribute to an ongoing self-care focus.

[10] Mann, K., Gordon, J., Macleod, A. (2007). Reflection and reflective practice in health professions education: A systematic review. *Advances in health sciences education: Theory and practice, 14*(4), 595–621. doi: http://dx.doi.org/10.1007/s10459-007-9090-2

[11] Aronson, L. (2011). Twelve tips for teaching reflection at all levels of medical education. *Medical Teacher, 33*(3), 200-205. doi: 10.3109/0142159X.2010.507714

Extra credit options

A. Complete *one* additional assignment from section 3-1 or 3-2 (10 points).

B. Go on an arranged class field trip to Maitri, a hospice and respite care facility in San Francisco. We will go on a day that can accommodate the most people in class; that will likely be a Saturday or Sunday. The date will be determined in class and by the availability of hospice staff. If you decide to visit Maitri as part of this field trip, it is not available for your use as a community agency to fulfill assignment #2. Be prepared to critically reflect on your experience in class at the first class meeting following the field trip (10 points).

4. Appraisal

Feedback and evaluation

Students are sometimes uncertain about the difference between feedback and evaluation. Feedback, in this class, is an ongoing conversation between all of us, transparent in nature, and serves to educate the recipient as well as the rest of the group. You will receive written feedback as part of your SLOs from both me and your classmates. Here is an example of public feedback I might post in the forum to a SLO:

> *Topic: How to maintain confidentiality with a hospice patient at home.*
>
> I'm glad you chose this subject, Aloysius. Your description of the dilemma you raised in class in which you found yourself trying to keep your conversation confidential was specific, and your reporting of your experience in this setting was both humorous and detailed.
>
> You also asked your classmates two thoughtful questions about the situation in which you found yourself. In addition to the reporting, I would like to have read more about your own reactions and responses to this dilemma, including knowing what your answers to the two questions are. Letting us know what position you hold contributes to a more vivacious forum interchange.
>
> By linking this ethical quandary to the appropriate sections in the ethics code, you made the subsequent discussion much easier, which was very helpful.

This type of feedback is designed to help you and your classmates improve and learn from one another throughout the semester.

Readings are the didactic basis of the course. Through reading and discussions of articles as well as completion of assignments, you will acquire the scientific and theoretical knowledge base to meet course learning outcomes. To be successful in this course, keep up with readings, read thoughtfully, engage in discussions, and enter into the spirit with which assignments are given.

Evaluations come in the form of scores for work submitted that takes into account the feedback you've received and then a summative process encompassing scores received throughout the entire semester. All evaluations are private. The hallmark of a good evaluation is that it is not a surprise, and I will strive to make sure my ongoing feedback (as well as that of your classmates) is reflected in your evaluation.

Grading

The total points required for specific letter grades and the points available for class assignments are below.

200-188 points: A	175-170 points: B	157-151 points: C
187-182 points: A-	169-164 points: B-	≤150 points: F
181-176 points: B+	163-158 points: C+	

Assignment	Points possible
Assignment 1 (discussion leader x 3) (various due dates)	45
Assignment 2 (community agency paper) (due Session 8)	30
Assignment 3-1 (personal/social aspects paper) (due as early as Session 8 and as late as Session 12)	25
Assignment 3-2 (clinical/policy/teaching aspects paper) (due as early as Session 8 and as late as Session 12)	25
Spontaneous learning opportunity (SLO; 2x15) (various due dates)	30
Participation [including forum SLO responses (3 points per class)]	45
Total points	*200*

Class participation

Sharing ideas and engaging in intellectual dialogue are requirements of the course. Participation in class discussion and forum responses are important components of my ability to evaluate your competence. Through your participation you contribute to others' learning and advance your own understanding. It is one way in which you demonstrate your mastery of class material, course objectives, and your ability to engage in problem solving and professional learning behaviors.

The class is designed using small group discussion as well as problem-based learning to help facilitate class participation. Throughout the course you are responsible for being familiar with and participating in discussions of assigned readings and SLO posts. Participation in class discussion is evaluated based on:

- Preparation – you read the article, are familiar with its content, and are prepared to discuss it;
- Willingness – you contribute to class discussion and comment on other classmates' SLOs.
- Quality of contribution – you grasp and understand the readings, synthesize concepts, explore and question meaning, and apply concepts.

Written assignments

Please use APA format for your written work.

I want you to focus your critical skills and synthesize what you are learning from the readings and class discussions. Mastery of basic skills of grammar and composition are assumed at this level of education. Please write in the first person (using *I*) and not in the third person (using *the writer* or *we* or *psychologists*). Don't just rephrase other authors' work – give your own perceptions or ideas. Please don't simply recap what is in the article or chapter. Be sure you include concepts from readings and class discussions as appropriate.

In the past, my students have been puzzled as to why they got a grade on an assignment that was lower than they expected. If I have asked for certain aspects to be addressed in your writing, you skip an aspect at your own peril: your grade will be lower if an aspect I've asked you to respond to is not addressed. In a worst case scenario (which rarely happens), I will ask you to rewrite the assignment, incorporating my feedback to the previous draft.

Here's the biggest single suggestion I can make about your writing assignments (other than to check your "writing hygiene" - spelling, punctuation, grammar, sentence and paragraph structure, etc.): tell me about your thinking. I'm interested not only in the issues upon which you've chosen to focus, **but *why* you've chosen them, and *what* you think about them, and *how* they have an impact on your development as a psychologist.**

Missed assignments will result in a lower grade or failure of the class, depending on the work missed. Missing more than one assignment can result in failing this class, at the discretion of the instructor. If, however, you are *seriously ill* and provide a doctor's note, the assignment can be made up. Contact me as soon as possible if you find yourself in this situation.

If writing is difficult for you please inform me and we will work together as needed to help you meet this requirement.

Oral assignments

Your ability to cogently speak in a group will stand you in good stead throughout your career. In situations as varied as rounds, team meetings, and departmental educational activities, the verbal fluency you display reflects on your own ability as well as gives an indication, particularly in interprofessional settings, of how psychology as a profession expects its practitioners to conduct themselves. There are resources[12] available to help you make your oral contributions effective; we'll also talk about tips and techniques in class.

If speaking in class is difficult for you please inform me and we will work together as needed to help you meet this requirement.

Attendance and behavioral expectations

I expect you to attend all classes in their entirety; it is impossible to make up what has transpired. I define missing class as being late to class or leaving class for 15 minutes or more. That said, if you miss two classes in a semester, I will ask you to write a 10-page paper on professionalism in psychology (there's quite a wealth of literature on this subject) due two weeks after the missed second class. A third missed class will result in a 15 page paper on a current ethical "hot topic", due three weeks after the missed third class or by the last day of the semester, whichever is sooner. If you do not turn in either remediation paper on time or miss four classes in a semester, I will ask you to drop or withdraw from the course. If the last day to withdraw from the course has passed, you will receive a failing grade. The final dates to drop or to withdraw are listed in the catalogue. Missing the final class of the semester will result in an additional loss of 20 points.

You may fail the course by reason of difficulty in meeting the behavioral expectation or requirements of the class, such as timely completion of assignments, attendance, or for violations of ethical and professional standards of care. Demonstration of professional behavior includes following the APA Ethical

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[12] Jacobs, L. F. and Hyman, J. S. (2010). *15 strategies for giving oral presentations*. Accessed at http://www.usnews.com/education/blogs/professors-guide/2010/02/24/15-strategies-for-giving-oral-presentations

Principles for psychologists and code of conduct; adhering to school guidelines as listed in the Student Handbook, the Professional Training Manual, and complying with other directives from the CSPP/Alliant administration. In addition, professional behavior includes respectful and responsible speech and actions, completing assignments in a timely way, communicating directly should issues or problems arise, and maintaining professional boundaries, such as the confidentiality of patients and classmates.

On my part, I will communicate directly and privately with you if I have any concerns about your professionalism. My goal in this communication is to identify a lapse in professionalism, make sure you understand the impact of the lapse, and to work with you to identify options to address the specific lapse as well as reflect on its implications in order to support your further development as a psychologist. My responsibility (and commitment) as your professor is to provide specific methods of support for you to succeed in this class and to achieve a clear identity as a psychologist; conversations about professionalism are held in the spirit of identifying pathways toward success and skills that support a proactive stance toward lifelong learning.

Please do not eat during class.

You are expected to perform within professional standards as determined by ethical codes, legal considerations, and accepted professional practice. See the AIU Policies and Procedures section, required in every syllabus for each AIU class, reproduced below.

5. AIU Policies and Procedures

Policies Related To Class Attendance, Lateness, Missed Exams or Assignments

The University expects regular class attendance by all students. Each student is responsible for all academic work missed during absences. When an absence is necessary, students should contact the instructor as courtesy and to check for assignments. See the University Catalog for the complete policy on attendance.

Responsibility to Keep Copies

Remember – it is good practice to keep copies of ALL major assignments/papers you turn in. On rare occasions, work may be lost because of computer failure or other mishaps.

Respectful Speech and Actions

Alliant International University, by mission and practice, is committed to fair and respectful consideration of all members of our community, and the greater communities surrounding us. All members of the University must treat one another as they would wish to be treated themselves, with dignity and concern.

As an institution of higher education, Alliant International University has the obligation to combat racism, sexism, and other forms of bias and to provide an equal educational opportunity. Professional codes of ethics (e.g., from the APA for psychology students) and the Academic Code shall be the guiding principles in dealing with speech or actions that, when considered objectively, are abusive and insulting.

Academic Code of Conduct and Ethics

The University is committed to principles of scholastic honesty. Its members are expected to abide by ethical standards both in their conduct and in their exercise of responsibility towards other members of the community. Each student's conduct is expected to be in accordance with the standards of the University. **The complete Academic Code, which covers acts of misconduct including assistance during examination, fabrication of data, plagiarism, unauthorized collaboration, and assisting other students in acts of misconduct, among others, may be found in the University Catalog.** The University reserves the right to use plagiarism detection software.

Confidentiality: Due to the fact that actual clinical material will be presented and discussed in this course, confidentiality must be maintained throughout the semester and beyond. To preserve client confidentiality, you should not use your client's actual name in your presentations. In addition, no names of the agency in which the client is seen should appear on any written reports. In the unlikely circumstance that you personally know a client being presented, it is your responsibility to excuse yourself from class during that presentation and quietly letting the professor know. Privacy among classmates should also be maintained. Countertransference and other personal issues often emerge in the course of clinical and ethical discussions; please treat these discussions as private and do not share such information outside of the classroom.

Evaluation of Students' Professional Development and Functioning

In CSPP, multiple aspects of students' professional development and functioning (e.g., cognitive, emotional, psychological, interpersonal, technical, and ethical) will be evaluated throughout the process of education and training in our professional psychology and MFT programs. This kind of comprehensive evaluation is necessary in order for faculty, staff, and supervisors to appraise the professional development and competence of their students. See the University Catalog for the complete CSPP policy on Evaluation of Student Competence: A. Student Disclosure of Personal Information.

Disability Accommodations Request

If you need disability-related accommodations in this class, please see your professor privately. All accommodations must be requested in a timely manner (at least 2 weeks ahead of time) with a letter of support from Alliant's Office of Disability Services. If you have questions about accommodations, please contact the Office of Disability Services (Dr. Sureli Patel).

Policy on Course Requirements During Religious Holidays

Alliant International University does not officially observe any religious holidays. However, in keeping with the institution's commitment to issues of cultural diversity as well as humanitarian considerations, faculty are encouraged to appreciate students' religious observances by not penalizing them when they are absent from classes on holy days. Alliant International University faculty will be sensitive to these matters. Students should be similarly respectful of faculty members' right to observe religious days.

Resources for Obtaining Tutoring or Other Student Support Services

Tutors are available to help students with course-based or exam-based needs. Contact the Director of Student Support Services for information on obtaining tutoring or other student support services.

Policy on Electronic Devices

A student's use of electronic devices that is irrelevant to class activities interferes with learning and distracts others. Although you are permitted to bring personal devices (cell phones, PDAs, laptops, sound recorders, and other electronic devices) to class, they must only serve class needs (e.g., typing on a laptop for the purpose of taking notes; using a device to record the instructor's presentations). Students may check email or their phone, and surf the internet during break time only, not during class time, films, presentations, exercises or discussions. Student may take notes on the computer and do searches for class-specified searches from the instructor. Your full participation and focus is needed to make this a meaningful class experience. Students who are being distracted by electronics use by their colleagues are encouraged to raise this issue with them, and to inform the instructor. Please set your cell phones to "sound off" or vibrate mode before class begins. (My addition: If any of these standards are not met, I will ask you to leave the device out of our classroom.)

Problem Solving Resources

If problems arise with faculty, other students, staff, or student support services, students should use the University Problem Solving Procedures located on the web at: <http://www.alliant.edu/academic/studentproblemsolving/Student_Grievance_Policy.pdf> or contact the University Ombudsperson.

6. My hopes for the semester

Throughout this course we'll spend considerable time laying a foundation conducive to respectful but challenging discussions through which we all can grow. I hope we will grapple with complicated, emotional, and thought-provoking topics as a community, and to understand that learning and teaching come from shared experiences and self-reflection.

For me, one of the delights of teaching is that I learn so much. I look forward to working with you this semester; **please** make use of my email and phone, and be sure to schedule appointment hours when needed. Welcome!

7. Class schedule

Session 1 Introduction

American Psychological Association (2013). Guidelines for psychological practice in health care delivery systems. *American Psychologist, 68*(1), 1-6. doi: 10.1037/a0029890

The APA Working Group on Assisted Suicide and End-of-Life Decisions (2000). *Report to the Board of Directors of the American Psychological Association.* Available at http://www.apa.org/pubs/info/reports/aseol.aspx.

Hall, S. & Payne, S. (2010). Palliative and end-of-life care. In D. French, K. Vedhara, A. A. Kaptein, and J. Weinman (Eds). *Health psychology* (2nd ed.) (pp. 398-409). Essex, England: John Wiley and Sons. ISBN-13: 978-1405194600

Nydegger, R. (2008). Psychologists and hospice: Where we are and where we can be. *Professional Psychology: Research and Practice, 39*(4), 459-463. doi: 10.1037/0735-7028.39.4.459

Strada, E. A. (2013). Developing a healing presence. In *The helping professional's guide to end-of-life care: Practical tools for emotional, social, and spiritual support for the dying* (pp. 17-32). Oakland, CA: New Harbinger Publications. ISBN-13: 978-1608821990

Collaborative conversation: What am I doing to keep myself physically healthy (sleep, diet, exercise, relaxation, relationships)? In what ways, if any, has this changed since I started graduate school?

Session 2 The context of palliative care in the U.S.

California HealthCare Foundation (2012). *Final chapter: Californians' attitudes and experiences with death and dying*. Available at http://www.chcf.org/publications/2012/02/final-chapter-death-dying *(For your reference)*

Field, M. J., & Cassel, C. K. (Eds.). (1997). Summary. In *Approaching death: Improving care at the end-of-life.* Washington, DC: National Academy Press (pp. 1-13). Retrieved from http://www.nap.edu/openbook.php?record_id=5801&page=1

Haley, W. E., Larson, D., Kasl-Godley, J., Neimeyer, R., & Kwilosz, D. (2003). Roles for psychologists in end-of-life care: Emerging models of practice. *Professional Psychology: Research and Practice, 34*(6), 626– 633. doi:10.1037/0735-7028.34.6.626

Kasl-Godley, J. E. (2011). Introduction to end-of-life care for mental health professionals. In S. H. Qualls and J. E. Kasl-Godley (Eds.). *End-of-life issues, grief, and bereavement: What clinicians need to know* (pp. 1-25). Hoboken, NJ: John Wiley & Sons. ISBN-13: 978-0470406939

Newman, T. (2007). *Suggestions for leading a journal club*. UCSF Department of Pediatrics. San Francisco, CA: University of California, San Francisco. (*for your reference)*

Collaborative conversation: Natural aging (accepting signs of aging and loss of media-dictated beauty).

The syllabus is subject to change

This schedule is the general structure and content of the course.
You should remember that the exact content and schedule of the syllabus is subject to change without prior notice to meet your needs or mine, or other requirements.
We may spend more time on some topics as needed, and conversely, may move more quickly over other topics.

Session 3 Pain

Bell, C. L., Kuriya, M., & Fischberg, D. (2011). Pain outcomes of inpatient pain and palliative care consultations: Differences by race and diagnosis. *Journal of Palliative Medicine, 14*(10), 1142-1148. doi:10.1089/jpm.2011.0176

Kirsh, K. L. (2010). Differentiating and managing common psychiatric comorbidities seen in chronic pain patients. *Journal of Pain and Palliative Care Pharmacotherapy, 24*(1), 39–47. doi: 10.3109/15360280903583123

Molton, I. R. & Terrill, A. L. (2014). Overview of persistent pain in older adults. *American Psychologist, 69*(2), 197-207. doi: 10.1037/a0035794

Passik, S. D. & Theobald, D. E. (2000). Managing addiction in advanced cancer patients: Why bother? *Journal of Pain & Symptom Management, 19*(3), 229–234. doi:10.1016/S0885-3924(00)00109-3

Portenoy, R. K. (2006). Three-step analgesic ladder for management of cancer pain. *Oncology Special Edition, 9*, 193-197. Available at www.clinicaloncology.com/download/10983.pdf *(For your reference)*

Timmons, W. N.. (2011). Pharmacological management of pain. In S. H. Qualls and J. E. Kasl-Godley (Eds.). *End-of-life issues, grief, and bereavement: What clinicians need to know* (pp. 128-147). Hoboken, NJ: John Wiley & Sons. ISBN-13: 978-0470406939

Wallio, S. C. & Twillman, R. K. (2011). Nonpharmacological approaches to pain and symptom management. In S. H. Qualls and J. E. Kasl-Godley (Eds.). *End-of-life issues, grief, and bereavement: What clinicians need to know* (pp. 148-167). Hoboken, NJ: John Wiley & Sons. ISBN-13: 978-0470406939

Collaborative conversation: Prospect of living with pain, physical degradation and deformity; my own feelings when caring for patients suffering from pain, physical degradation and deformity.

Session 4 Culture

Due: Name of community agency. If you plan to do assignment 3.2-h, your choice of subject is due.

Bullock, K. (2011). The influence of culture on end-of-life decision making. *Journal of Social Work in End-Of-Life & Palliative Care, 7*(1), 83-98. doi: 10.1080/15524256.2011.548048

Davies, B., Contro, N. Larson, J., & Widger, K. (2010). Culturally-sensitive information-sharing in pediatric palliative care. *Pediatrics, 125*(4), e859-e865. doi: 10.1542/peds.2009-0722

Norris, W., Wenrich, M. D., Nielsen, E. L., Treece, P. D., Jackson J. C., & Curtis, J. R. (2005). Communication about end-of-life care between language-discordant patients and clinicians: Insights from medical interpreters. *Journal of Palliative Medicine, 8*(5), 1016–1024. doi:10.1089/jpm.2005.8.1016

Parrish, M., Cárdenas, Y., Epperhart, R., Hernandez, J., Ruiz, S., Russell, L., Soriano, K., & Thornberry, K. (2012). Public hospital palliative social work: Addressing patient cultural diversity and psychosocial needs. *Journal of Social Work in End-Of-Life & Palliative Care, 8*(3), 214-228. doi: 10.1080/15524256.2012.708113

Collaborative conversation: Prospect of losing my own independence and mobility; accepting dependency in others. What have I learned about dependency and other aspects concerning the end of life from my upbringing? From my acculturation as a psychologist?

Session 5 Application

Film (shown in class): Grainger-Monsen, M. (Producer and director). (2003). Mohammad Kochi. In *Worlds Apart* [DVD]. (Available from Fanlight Productions, 4196 Washington Street, Boston, MA 02131; 800.937.4113 or www.fanlight.com)

Collaborative conversation: Role in my own family: Being a child, a parent, a partner, a relative; how do I react when one of my loved ones is suffering?

Session 6 Psychological distress

Johnson, K. S., Tulsky, J. A., Hays, J. C., Arnold, R. M., Olsen, M. K., Lindquist, J. H., & Steinhauser, K. E. (2011). Which domains of spirituality are associated with anxiety and depression in patients with advanced illness? *Journal of General Internal Medicine, 26*(7), 751-758. doi:10.1007/s11606-011-1656-2

Jordan, K. D. & Okifuji, A. (2011). Anxiety disorders: Differential diagnosis and their relationship to chronic pain. *Journal of Pain and Palliative Care Pharmacotherapy 25*(3), 231–245. doi: 10.3109/15360288. 2011.596922

Kasl-Godley, J. E. (2011). Serious mental illness. In S. H. Qualls and J. E. Kasl-Godley (Eds.). *End-of-life issues, grief, and bereavement: What clinicians need to know* (pp. 85-115). Hoboken, NJ: John Wiley & Sons. ISBN-13: 978-0470406939

Marchesi, C. & Maggini, C. (2007). Socio-demographic and clinical features associated with demoralization in medically ill in-patients. *Social Psychiatry and Psychiatric Epidemiology, 42*(10), 824-829. doi: 10.1007/s00127-007-0230-z

Rosenfeld, B., Abbey, J. G., & Pessin, H. (2005). Depression and hopelessness at the end of life: Assessment and treatment. In J. L., Werth, Jr., & D. Blevins (Eds.), *Psychosocial issues near the end of life: A resource for professional care providers* (pp. 163-182). Washington, DC: American Psychological Association. ISBN: 978-1-59147-236-0

Collaborative conversation: How do I deal with emotional/physical suffering when I am on my own? In what ways do I feel helpless, and what resilient strengths do I have? How do I get assistance from others when I am suffering?

Session 7 Cognitive changes

American Psychological Association (2012). Guidelines for the evaluation of dementia and age-related cognitive change. *American Psychologist, 67*(1), 1-9. doi:10.1037/a0024643 *(For your reference)*

Fick, D., Agostini, J., & Inouye, S. (2002). Delirium superimposed on dementia: A systematic review. *Journal of the American Geriatric Society, 50*(10), 1723-1732. doi:10.1046/j.1532-5415.2002.50468.x

Gagnon, P. R. (2008). Treatment of delirium in supportive and palliative care. *Current Opinion in Supportive and Palliative Care, 2*(1), 60-66. doi: 10.1097/SPC.0b013e3282f4ce05

Rao, S., Ferris, F. D., & Irwin, S. A. (2011). Ease of screening for depression and delirium in patients enrolled in inpatient hospice care. *Journal of Palliative Medicine, 14*(3): 275-279. doi:10.1089/jpm.2010.0179

Collaborative conversation: Dignity: What are the cornerstones of my own dignity? When is my body in dignity? When is my ego in dignity? How can I help preserve the dignity of patients? Is dignity something deep within me or is it something that can be taken away or fostered by others?

Session 8 Religion and spirituality

Due: Community agency paper and 5 minute mini-presentation to our class about the agency

Doka, K. (2011). Religion and spirituality: Assessment and intervention. *Journal of Social Work in End-Of-Life & Palliative Care* 7(1), 99-109. doi: 10.1080/15524256.2011.548049

Kamper, R., Van Cleve, L., & Savedra, M. (2010). Children with advanced cancer: Responses to a spiritual quality of life interview. *Journal for Specialists in Pediatric Nursing, 15*(4), 301-306. doi: 10.1111/j.1744-6155.2010.00253.x.

Puchalski, C., Ferrell, B.; Virani, R., Otis-Green, S., Baird, P., Bull, J., Chochinov, H., Handzo, G., Nelson-Becker, H., Prince-Paul, M., Pugliese, K., & Sulmasy, D. (2009). Improving the quality of spiritual care as a dimension of palliative care: The report of the Consensus Conference. *Journal of Palliative Medicine,12*(10), 885-904. doi:10.1089/jpm.2009.0142

Smith-Stoner, M. (2007). End-of-life preferences for atheists. *Journal of Palliative Medicine, 10*(4), 923-928. doi: 10.1089/jpm.2006.0197

Strada, E. A. (2011). The cultural context of spirituality and meaning. In S. H. Qualls and J. E. Kasl-Godley (Eds.). *End-of-life issues, grief, and bereavement: What clinicians need to know* (pp. 43-63). Hoboken, NJ: John Wiley & Sons. ISBN-13: 978-0470406939

Collaborative conversation: Religious and spiritual beliefs and needs: Understanding the difference between beliefs and certainties; my own beliefs and spirituality; how do I nurture my spiritual self? How do I ensure that I do not impose my beliefs on patients?

Session 9 Grief and bereavement

Due: Assignment 3-1 and 3-2 (and 3-3 if using for extra credit) may be turned in.

Ghesquiere, A., Mart´i Haidar, Y. M., & Shear, K. M. (2011). Risks for complicated grief in family members. *Journal of Social Work in End-of-Life & Palliative Care, 7*(2-3),216–240. doi: 10.1080/15524256.2011.593158

Neimeyer, R. A., Hogan, N., & Laurie, A. (2008). The measurement of grief: Psychometric considerations in the assessment of reactions to bereavement. In M. Stroebe, R. O. Hansson, H. Schut and W. Stroebe (Eds.), *Handbook of bereavement research: Advances in theory and intervention*. (pp. 133-161). Washington, DC: American Psychological Association. ISBN-13: 978-1433803512

Norton, M. I. & Gino, F. (2014). Rituals alleviate grieving for loved ones, lovers, and lotteries. *Journal of Experimental Psychology: General, 143*(1), 266–272. doi:10.1037/a0031772

Otis-Green, S. (2011). Grief and bereavement care. In S. H. Qualls and J. E. Kasl-Godley (Eds.). *End-of-life issues, grief, and bereavement: What clinicians need to know* (pp. 168-180). Hoboken, NJ: John Wiley & Sons. ISBN-13: 978-0470406939

Worden, J. W. (2009). Understanding the mourning process. In *Grief counseling and grief therapy* (4th Ed). (pp. 37-56). New York: Springer. ISBN-13: 978-0826101204

Collaborative conversation: Personal bereavement: Am I in bereavement? When someone I loved died, what were my needs? What do I think my needs would be if someone I loved died? Who and what would I need around me to feel comforted?

Everybody has got to die but I have always believed an exception would be made in my case.

William Saroyan

Session 10 Family caregivers

Feldman, D. B. & Llamas, J. (2011). Working with family caregivers of persons with terminal illness. In S. H. Qualls and J. E. Kasl-Godley (Eds.). *End-of-life issues, grief, and bereavement: What clinicians need to know* (pp. 64-84). Hoboken, NJ: John Wiley & Sons. ISBN-13: 978-0470406939

Holst, L., Lundgren, M., Olsen, L., & Ishøy, T. (2009). Dire deadlines: Coping with dysfunctional family dynamics in an end-of-life care setting. *International Journal of Palliative Nursing, 15*(1), 34-41. PMID: 19234429

Hudson, P., Remedios, P., Zordan, R., Thomas, K., Clifton, D., Crewdon, D., Crewdson, M., Trauer, R., Bolleter, A., Clarke, D. M., & Bauld, C. (2012). Guidelines for the psychosocial and bereavement support of family caregivers of palliative care patients. *Journal of Palliative Medicine, 15*(6), 696-702. doi:10.1089/jpm.2011.0466

Merluzzi,T. V., Philip, E. J., Vachon, D. O., & Heitzmann, C. A. (2011). Assessment of self-efficacy for caregiving: The critical role of self-care in caregiver stress and burden. *Palliative & Supportive Care, 9*(1), 15-24. doi: 10.1017/S1478951510000507

Torke, A. M., Petronio, S., Sachs, G. A., Helft, P.R. & Purnell, C. (2012). A conceptual model of the role of communication in surrogate decision making for hospitalized adults. *Patient Education and Counseling, 87*(1), 54–61. doi: 10.1016/j.pec.2011.07.027

Waldrop, D. P. (2011). Crisis in caregiving: When home-based end-of-life care is no longer possible. *Journal of Palliative Care, 27*(2), 117-125. PMID: 21805946

Collaborative conversation: Acceptance of my own dead body: How do I imagine my body after death? How would I like my body be treated after death? My own caregiving: How do I give care to people in my personal life, outside my professional role? How do I accept care, and how do I thwart it?

Session 11 Ethics

Billings, J. A. (2011). Double effect: A useful rule that alone cannot justify hastening death. *Journal of Medical Ethics, 37*(7), 437-440. doi:10.1136/jme.2010.041160

Canetto, S. S. (2011). Physician-assisted suicide in the United Sates: Issues, challenges, roles, and implications for clinicians. In S. H. Qualls and J. E. Kasl-Godley (Eds.). *End-of-life issues, grief, and bereavement: What clinicians need to know* (pp. 263-284). Hoboken, NJ: John Wiley & Sons. ISBN-13: 978-0470406939

Johnson, W. B., & Barnett, J. E. (2011). Preventing problems of professional competence in the face of life-threatening illness. *Professional Psychology: Research and Practice, 42*(2), 285-293. doi: 10.1037/a0024433

Le, B. H. & Chapman, M. D. (2011). Competence and capacity at the end of life: Uneasy paternalism. *Medical Journal of Australia, 195*(8), 476-7. PMID: 22004401

Peruzzi, N., Canapary, A., & Bongar, B. (1996). Physician-assisted suicide: The role of mental health professionals. *Ethics and Behavior 6*(4):353-366. doi:10.1207/s15327019eb0604_6

Collaborative conversation: Living a meaningful life: Do my present activities contribute towards a sense of fulfillment and meaning? Am I wasting a lot of time on activities that are meaningless to me? What are my goals in life? What is really important to me? If I knew that I were to die shortly and looked back on my life, would I have a sense of having lived well? If not, what can I change?

Session 12 Advance planning

Due: Assignments 3-1 and 3-2 (and 3-3 if using for extra credit) must be turned in by this date

Baumrucker, S. J., Stolick, M., Morris, G. M., Stilin, L., VandeKieft, G., Mingle, P., & Oertli, K. A. (2011). A cognitively impaired patient without a surrogate: Who makes the decision? *American Journal of Hospice & Palliative Medicine, 28*(8), 583-587. doi: 10.1177/1049909111420858.

Fraser, J., Harris, N., Berringer, A. J., Prescott, H., & Finlay, F. (2010). Advanced care planning in children with life-limiting conditions—the Wishes document. *Archives of Disease in Childhood, 95*, 79-82. doi: 10.1136/adc.2009.160051.

Gabriel, M. S. & Kennedy, S. (2011). Advance care planning. In S. H. Qualls and J. E. Kasl-Godley (Eds.). *End-of-life issues, grief, and bereavement: What clinicians need to know* (pp. 116-127). Hoboken, NJ: John Wiley & Sons. ISBN-13: 978-0470406939

McCormick, A. J. (2011). Self-determination, the right to die, and culture: A literature review. *Social Work, 56*(2), 119-128. doi:10.1093/sw/56.2.119

Tung, W-C. (2011). Hospice care in Chinese culture: A challenge to home care professionals. *Home Health Care Management & Practice, 23*(1), 67-68. doi: 10.1177/1084822310383000.

Werth, J. L., Lewis, M. M., & Richmond, J. M. (2009). Psychologists' involvement with terminally ill individuals who are making end-of-life decisions. *Journal of Forensic Psychology Practice, 9*(1), 82-91. doi: 10.1080/15228930802427130

Collaborative conversation: Uncertainty and lack of control: How do I deal with uncertainty? What are my personal resources and coping mechanisms to deal with difficult situations? What are my beliefs about advance care for myself?

Session 13 Interprofessional teamwork

Heinemann, G. D., & Zeiss, A. (2007). A model of team performance. In G. D. Heinemann & A. M. Zeiss (Eds.). *Team performance in health care: Assessment and development* (pp 29–42). New York: Kluwer Academic/Plenum. ISBN-13: 978-0306467073

Hyer, L., Babcock, C. W., Robinson, L. E., & Ackermann, R. (2011). Transitions model: Melding of psychotherapy and palliative care using teams. *Clinical Gerontologist: The Journal of Aging and Mental Health, 34*(5), 379-398. doi: 10.1080/07317115.2011.595573

Interprofessional Education Collaborative Expert Panel (2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel.* Washington, D.C.: Interprofessional Education Collaborative. Available at www.asph.org/userfiles/collaborativepractice.pdf *(For your reference)*

Kasl-Godley, J. E. & Kwilosz, D. (2011). Health-care teams. In S. H. Qualls and J. E. Kasl-Godley (Eds.). *End-of-life issues, grief, and bereavement: What clinicians need to know* (pp. 201-228). Hoboken, NJ: John Wiley & Sons. ISBN-13: 978-0470406939

O'Connor, M. & Fisher, C. (2011). Exploring the dynamics of interdisciplinary palliative care teams in providing psychosocial care: "Everybody thinks that everybody can do it and they can't". *Journal of Palliative Medicine, 14*(2), 191-196. doi:10.1089/jpm.2010.0229

Reeves, S., Goldman, J., & Oandasan, I. (2007). Key factors in planning and implementing interprofessional education in health care settings. *Journal of Allied Health, 36*(4), 231-235. PMID:18293805

Remke, S. S. & Schermer, M. M. (2012). Team collaboration in pediatric palliative care. *Journal of Social Work in End-Of-Life & Palliative Care, 8*(4), 286-296. doi: 10.1080/15524256.2012.735551

Collaborative conversation: How do I deal with conflict with others in my profession? In other professions? How do I see myself interacting with other professionals who have more or less experience or social standing than I perceive myself having? How have other professionals' reactions to me been helpful or problematic? What are the reactions I have had with other professionals that have been less than helpful?

Session 14 Research, policy, and advocacy

Acquaviv, K. D.& Egan, K. A. (2006). *Hospice research basics: A manual for hospice agencies*. National Hospice and Palliative Care Organization. Available at http://www.nhpco.org/i4a/pages/index.cfm?pageid=3771

Board of Directors (2007). *Statement on palliative care research ethics*. American Academy of Hospice and Palliative Medicine. Available at http://www.aahpm.org/positions/default/researchethics.html

Casarett, D. J., Dy, S., Spence, C., & Lupu, D. (2011). Foreword: Quality improvement efforts: Advancing the science of palliative care. *Journal of Pain and Symptom Management, 42*(5), 649-651. doi: 10.1016/j.jpainsymman.2011.08.001

Radbruch, L., Payne, S., de Lima, L., & Lohmann, D. (2013). The Lisbon challenge: Acknowledging palliative care as a human right. *Journal of Palliative Medicine, 16*(3), 1045-1048. doi:10.1089/jpm.2012.0394

Twilman, R. K. & Lewis, M. M. (2011). Advocating for policy change: The role of mental health providers. In S. H. Qualls and J. E. Kasl-Godley (Eds.). *End-of-life issues, grief, and bereavement: What clinicians need to know* (pp. 252-262). Hoboken, NJ: John Wiley & Sons. ISBN-13: 978-0470406939

Zimmermann, C., Riechelmann, R., Krzyzanowska, M., Rodin, G., & Tannock, I. (2008). Effectiveness of specialized palliative care: a systematic review. *JAMA: Journal of the American Medical Association, 299*(14): 1698-1709. doi: 10.1001/jama.299.14.1698

Collaborative conversation: What does being an advocate mean? How comfortable am I serving as a patient advocate? In what situations do I find myself feeling uncomfortable about indicating problems within the system? In what situations am I comfortable challenging accepted ways of providing care? How do I respond when my personal standard of caregiving cannot be accomplished due to institutional or systemic limitations?

Session 15 Self care

Jones, S. H. (2011). A self-care plan for hospice workers. *American Journal of Hospice & Palliative Medicine, 22*(2), 125-128. doi: 10.1177/104990910502200208

Meier, D. E. & Beresford, L. (2006). Preventing burnout. *Journal of Palliative Medicine, 9*(5), 1045-1048. doi:10.1089/jpm.2006.9.1045

Pereira, S. M., Fonseca, A. M., & Carvalho, A. S. (2011). Burnout in palliative care: a systematic review. *Nursing Ethics, 18*(3), 317-26. doi: 10.1177/0969733011398092

Showalter, S. E. (2010). Compassion fatigue: What is it? Why does it matter? Recognizing the symptoms, acknowledging the impact, developing the tools to prevent compassion fatigue, and strengthen the professional already suffering from the effects. *American Journal of Hospice & Palliative Medicine, 27*(4), 560-566. doi: 10.1177/1049909109354096

Strada, E. A. (2011). Professional self-care. In S. H. Qualls and J. E. Kasl-Godley (Eds.). *End-of-life issues, grief, and bereavement: What clinicians need to know* (pp. 294-309). Hoboken, NJ: John Wiley & Sons. ISBN-13: 978-0470406939

Collaborative conversation: My own death: If I were dying, how would I like to feel? Who and what would I need around me to die well? What does dying well mean for me?

Session 16 Application

Semester in review

Peterson-Iyer, K. (2009). *From chronic to critical: A Latino family confronts end-of-life decisions*. Markkula Center for Applied Ethics, Santa Clara University, Santa Clara, CA. Available at http://www.scu.edu/ethics/practicing/focusareas/medical/culturally-competent-care/chronic-to-critical.html

Please read this ethics case presentation and the four reflections by Silvia Austerlic, Marc Tunzi, John Silve, and Karen Peterson-Iyer that follow it. You will randomly be assigned to one of four reflection groups in class, so be sure you are familiar with each of the reflections as well as the case itself.

Collaborative conversation: How do I handle endings in a professional setting? In the spirit of critical reflection, what are the most important aspects I take away from this series of collaborative conversations?