

CE Corner

Three new APA guidelines broaden the view on treating PTSD and trauma

BY STEPHANIE PAPPAS

A TRIO OF NEW APA guidelines on treating post-traumatic stress disorder (PTSD) and complex trauma aim to help psychologists broaden their practice with adults who have experienced traumatic events and guide clinicians on how to personalize treatments while still relying on evidence-based practice.

The latest *Clinical Practice Guideline for the Treatment of PTSD in Adults* was approved by the APA Council in February, joining the professional practice *Guidelines for Working with Adults with Complex Trauma Histories* and *Guidelines on Key Considerations for Working With Adults With PTSD and Traumatic Stress Disorders*, both approved in August 2024. The latter two guidelines are the first of their kind, while the *Clinical Practice Guideline for the Treatment of PTSD in Adults* is an update of the 2017 APA guideline on the same subject.

All three guidelines expand on the treatment of PTSD and trauma. While the 2017 guideline worked from only one systematic review of research, the updated guideline now draws from 15 systematic reviews of interventions and takes into account a broader array of outcomes than PTSD symptoms alone. Meanwhile, the new professional practice guidelines focus on broader competencies around working with persons who have been exposed to trauma. These guidelines do not recommend certain interventions but provide frameworks for clinicians to think about training, professional development, and the context in which they might meet traumatized persons. For example, is the trauma a one-time, life-threatening accident, or an ongoing personal trauma, as in domestic

violence or childhood sexual abuse? Might the person be involved with the legal system, possibly exacerbating their problems? Are there cultural considerations or generational patterns of trauma at play?

The result is three guideline documents that complement each other, coming at a time when psychologists are more attuned than ever to the ubiquity of traumatic experiences.

“The world has been going through chronic trauma since 2020,” said Robin McLeod, PhD, senior director for strategic relations and leadership on the Practice team at APA. “It’s not only the pandemic but national and world conflicts that have led to political disruption, war, and displacement. We know that chronic trauma has a huge impact on long-term physical health and that it is our young people who are most impacted. Psychologists, recognizing this, are honing their ability to integrate an understanding of trauma into their work with everyone. These guidelines provide clinical and professional support for this integration.”

Clinical practice with PTSD

The newly approved clinical practice guideline focuses on interventions for post-traumatic stress disorder. Compared with the previous guide-

line, the new document pays more attention to complex presentations of PTSD. And while the critical outcomes the guideline development panel looked at involved the reduction in PTSD symptoms such as intrusive, distressing memories of the trauma, outbursts of anger, or sleep disturbances, they also considered the impact of interventions on other important outcomes, including substance use, affect

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Learning objectives

After reading this article, CE candidates will be able to:

- 1 Identify interventions for PTSD and trauma with the strongest evidence base.
- 2 Discuss special considerations that psychologists should weigh when providing trauma-informed care.
- 3 Define complex trauma and explain ways in which psychologists may need to adjust their approach in treating complex trauma survivors.

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dysregulation, suicidal ideation, and dissociation.

“There was more emphasis on including outcomes that address complexity,” said Lori Zoellner, PhD, a professor of psychology at the University of Washington who chaired the guideline panel. “We paid attention to clinically meaningful change, quality of life, and functioning. So we purposely took a broad approach.”

Drawing from 15 systematic reviews, the guideline developers found three interventions that reached the highest standard for evidence. Psychotherapy over pharmacotherapy defines the recommended interventions. Adults with PTSD can be treated with cognitive processing therapy (a cognitive behavioral therapy-based program that walks patients through processing trauma by examining trauma-related beliefs), prolonged exposure therapy (an approach that guides patients through facing trauma-related reminders and memories), and trauma-focused cognitive behavioral therapy (a combination that often includes psychoeducation, relaxation, cognitive restructuring, and exposure therapy components).

“These interventions were rated as recommended because there are many high-quality studies that show large effects,” Zoellner said. “They’re done by independent research groups, and they have a consistent pattern of findings across both the critical outcomes and the important outcomes, and the quality of science is generally rated as either moderate or high. They have good science behind them.”

The second tier of interventions is also viewed as effective, with the guideline likewise suggesting the use of these interventions. The research base for these second-tier interventions is not as strong: The studies may not be as high in quality or

showed more variability for important outcomes. Among the suggested interventions were eye movement desensitization and reprocessing (EMDR), which guides patients to revisit traumatic memories while engaging in bilateral movements with their eyes or hands; cognitive therapy, which involves reevaluating trauma-related beliefs; and narrative exposure therapy, which aims to help patients build a narrative to contextualize their trauma. The guideline also suggests offering selective serotonin reuptake inhibitors (SSRIs) or serotonin and norepinephrine reuptake inhibitors (SNRIs).

The panel also delved into the evidence for many emerging treatments that have become popular, particularly MDMA-assisted therapy and ketamine for PTSD. They found that, so far, the evidence base is simply insufficient to recommend for or against these treatments. Many of the studies that have been done are small or at risk of bias, or the treatment protocols are unclear. Other interventions and comparative effectiveness studies were also reviewed, and the evidence base for those is growing, Zoellner said. “We’re awaiting better clinical trials,” she added.

The guideline also urges clinicians to consider barriers to treatment and ways to overcome those barriers, and to share decision-making with patients, considering factors like the setting where the treatment will be delivered and the time and resources the patient must devote to therapy. The guideline also outlines some key factors that effective therapies seem to share, such as teaching patients to manage negative emotions about themselves.

“The point is to help these people let go of some of their symptoms so that [they] can get back to a quality of

KEY POINTS

1

Guidelines for treating PTSD and trauma are increasingly focusing on the broader context of the trauma and a wide array of symptoms and related outcomes a patient might experience.

2

For treating PTSD symptoms, cognitive processing therapy, prolonged exposure therapy, and trauma-focused cognitive behavioral therapy show the strongest evidence to date.

3

Emerging treatments such as MDMA-assisted therapy or ketamine are not yet supported by sufficient evidence.

4

A strong grounding in trauma-informed care and an understanding of how trauma affects developmental phases and manifests differently over the life span can help psychologists treat complex trauma cases.

life and a life they want to live,” said Priscilla Schulz, LCSW, a clinical social worker in Seattle and vice chair of the guideline committee.

Professional practice for PTSD

Meanwhile, the *Guidelines on Key Considerations for Working With Adults With PTSD and Traumatic Stress Disorders* gives professionals a broader base for approaching practice with people who have experienced trauma.

“Our job was not to approve any specific type of therapy,” said guideline panel chair Lenore Walker, EdD, ABPP, a forensic psychologist and professor emeritus at Nova Southeastern University in Florida, “but rather to

address how the general practitioner who is going to work with somebody who has faced trauma should behave—the guidelines are to help them in making all kinds of choices.”

The guideline starts by urging psychologists to take a cross-disciplinary, culturally responsive approach to assessing and treating trauma, keeping up with the rapidly evolving research in this area. Patients may come into the psychologist’s office with preexisting notions of what trauma is and how to treat it, possibly gleaned from social

media and self-help books. Some of that information may be accurate, while some is not, and psychologists may need to help patients sift the good from the bad. Most clinical training programs are light on education around trauma, Walker said, but there are numerous continuing-education options available. Such programs can help clinicians understand the biopsychosocial, cultural, and intersectional complexities of trauma, as can seeking consultation from more experienced mentors and colleagues. Professional

peer-to-peer support can be particularly important for preventing secondary trauma and burnout, the guideline notes. Even steps such as taking more breaks on days when seeing trauma survivors can help.

Given the regulations around treating victims of violence—such as mandatory reporting laws for child abuse—a large portion of the guideline focuses on legal frameworks. Laws vary by state, and psychologists are encouraged to understand their legal responsibilities around what must be reported and how to assess whether a patient might be a threat to themselves or to others. Psychologists may also find themselves working with patients who are entangled in the legal system, Walker said. Practitioners may want to familiarize themselves with the court system to be able to discuss the impact of this involvement on the patient’s mental health and day-to-day life and logistics. They may also want to make choices about treatment with legal proceedings in mind; for example, choosing to treat trauma with hypnosis or exposure therapy might alter the patient’s memory of the traumatic event, which might affect their ability to pursue a legal case.

The guideline encourages psychologists to consider how patients from different cultures might experience and express trauma. A holistic assessment strategy, pulling from multiple sources of information, may help psychologists consider a patient’s life circumstances and overall health.

The guideline also encourages psychologists to adhere to the principles of trauma-informed care. Trauma-informed care recognizes that most people with behavioral health disorders have some experience of trauma in their lives. This approach encourages screening patients for

The clinical practice guideline for PTSD urges clinicians to address barriers to treatment and to share decision-making with patients, considering factors like the time and resources patients devote to therapy.



trauma history and responding to trauma with a mixture of compassion and respect. People who have experienced trauma already have their own forms of resilience and coping skills, and clinicians can build their patients' confidence and trust by acknowledging what has worked for them.

The guideline outlines some specific types of trauma that might bring a person to a therapist, such as sexual harassment, immigrating because of war or persecution, or racism and intergenerational discrimination. Psychologists can also consider the impact of systemic racism and generational trauma on their patients, as well as the impact of barriers to getting treatment and care. For example, telehealth might be a good option for a veteran whose combat-related trauma triggers anxiety, hypervigilance, or aggression when driving, or for a person who has a history of medical trauma and thus experiences anxiety in a clinic setting.

The guideline underscores that “each trauma is different, and each person is different,” Walker said.

Complex trauma

The other professional practice guideline, jointly produced with the International Society for the Study of Trauma and Dissociation, focuses on adults with complex trauma histories. The complexity of trauma is along a continuum, but generally someone with complex trauma is likely to have experienced multiple traumatic events or to have been victimized repeatedly, typically in an interpersonal, intentional way, such as in an emotionally or physically abusive relationship. Often, trauma that happens earlier in development, or in multiple developmental phases across the life span, presents with more complex sequelae.



Taken together, the three guidelines provide psychologists with a strong sense of the evidence base for treatments as well as the complexity of treating individuals with their own histories, goals, and symptoms.

These factors are included in the diagnosis of complex PTSD, which is included in the 11th edition of the *International Classification of Diseases (ICD-11)* of the World Health Organization. As in the *Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition)* definition of PTSD, a diagnosis of complex PTSD requires exposure to or experiencing events or circumstances that overwhelm the ability to cope, including those involving direct interpersonal and emotional threats. These result in the development of symptoms that meet the original three criteria of PTSD (reexperiencing the trauma in the present, numbing and shutting out reminders of the trauma, and physiological hyperarousal and hypervigilance). But three

additional criteria under the heading “disturbances in self-regulation” are also required. These are difficulties in identifying and regulating emotions, negative self-concept and low self-worth, and problems maintaining or forming relationships.

The *DSM-5* does not have a separate diagnosis called complex PTSD, but the developers of the *DSM-5* and the developers of the *ICD-11* worked together to make the *DSM-5* PTSD criteria and *ICD-11* complex PTSD criteria somewhat similar. For example, the *DSM-5* PTSD diagnosis includes components such as estrangement from others and negative views of self. Clinicians and researchers debate whether these conditions are fully different.

Whether or not a person meets the diagnostic criteria for complex PTSD, a complex trauma history can lead to more complicated symptoms, said Christine Courtois, PhD, ABPP, a counseling psychologist and consultant on trauma psychology and treatment who chaired the complex trauma guideline development panel. Often, trauma that happens earlier in development, or in multiple developmental phases across the life span, presents with more complex symptoms. For example, it may lead to the development of dissociation as a defense and coping mechanism.

“When you’re treating complex PTSD, you have more things to treat,” Courtois said. “Because many of these individuals didn’t get what they needed in childhood to help them develop themselves in a positive sense and to develop emotional regulation skills, that becomes part of the therapy.”

To assist clinicians in treating these patients, the guideline uses the acronym HISTORY. “H” stands for taking a humanistic approach, acknowledging that complex trauma patients may have experienced inhumane treatment at the hands of those they should have been able to trust, including authority figures and professionals (recognized as betrayal or relational trauma). Psychologists can redress these betrayals not only by choosing interventions to undo past harms but by helping patients become and feel safe in the present day, fostering their personal agency, and reinforcing their sense of self-efficacy.

“I” stands for integrative solutions, encouraging psychologists to take a personalized, patient-centered approach to treatment. This might mean, for example, augmenting traditional evidence-based therapies with evidence-informed, nontraditional

therapies such as mindfulness or yoga. Or it might mean helping a patient tackle present-day problems in relationships or daily functioning before digging into the root of the trauma.

“S,” for “sequence,” also addresses the importance of assessing a patient’s readiness before beginning an intervention aimed at addressing the trauma history. “It’s important to have a base of safety and to teach some stabilization skills,” Courtois said.

The “T” in HISTORY stands for “timeline,” emphasizing the importance of taking a developmental view. This can include considering both when the trauma occurred and the person’s current stage of development. For example, a high school student may present different symptoms than a person near the end of life, Courtois said. As older adults experience health problems or cognitive decline, they may find past traumas resurfacing, including traumas they have never told anyone about.

Whatever the presentation, the guideline urges a transdiagnostic view of symptoms and outcomes. Therefore, the “O” of the guideline acronym stands for “outcomes” and encourages psychologists to assess all problems of a patient and tailor treatment according to the individual’s unique needs. Consistent with a patient-centered approach, there is no “one size fits all,” said Paul Frewen, PhD, a clinical psychologist at Western University in Ontario who cochaired the development of the complex trauma guideline. “We need this flexibility to meet the person where they are,” Frewen said.

All this work is predicated on the therapeutic relationship (the “R” of the acronym), which emphasizes the importance of the therapeutic alliance in predicting outcomes. It is important to be responsive, reliable, trustworthy, and consistent, Courtois said, in order

to provide the individual with a different relational experience that can become a template for the patient’s outside relationships.

Finally, the guideline encourages psychologists to help patients find the “why” (or the “Y” in the acronym) for what happened to them. Exploring these existential questions can help people reappraise the trauma and understand that they were not to blame.

Taken together, these three guidelines should give psychologists a strong sense of the evidence base for treatments as well as the complexity of treating individuals with their own histories, goals, and symptoms.

“While trauma makes a person feel little and small, squashed, tiny,” Frewen said, “through therapy they’re able to become more fully themselves, and open up and broaden and build.” ■

FURTHER READING

Effects of current treatments for trauma survivors with posttraumatic stress disorder on reducing a negative self-concept: A systematic review and meta-analysis

Banz, L., et al.
European Journal of Psychotraumatology, 2022

Treating complex traumatic stress disorders in adults

Ford, J. D., & Courtois, C. A. (Eds.)
Guilford Press, 2020

Therapeutic alliance in psychological therapy for posttraumatic stress disorder: A systematic review and meta-analysis

Howard, R., et al.
Clinical Psychology & Psychotherapy, 2022

Enhancing Learning through Commitment to Change

Greg J. Neimeyer, Ph.D.

The rapid proliferation of new knowledge in psychology has placed renewed demands on professional practitioners to keep pace with ongoing advances. Overall, knowledge may remain current in professional psychology for as little as about 6-7 years, with more rapidly diminishing durability in key areas of practice, such as psychopharmacology, child health, forensics, substance use, or neuropsychology, among others (Neimeyer, Taylor & Rozensky, 2014). This means that, in the absence of a commitment to ongoing professional development, many practitioners may begin to experience knowledge obsolescence even while they are still in the early stages of their career (Neimeyer, Taylor & Rozensky, 2012).

BEST PRACTICES

In response, the field of professional psychology, together with other allied health professions, have redoubled their efforts to formulate sets of “best practices” that can enhance learning and the translation of that learning into practice (Institute on Medicine, 2010; Taylor and Neimeyer, 2017). The collective objective of these best practices is to enhance the comprehension, retention, and application of new knowledge in support of ongoing professional competence. Some of these practices focus on the value of adapting the learning strategies to individuals’ unique learning styles, presenting information multiple times utilizing different media, and providing opportunities for individuals’ input, application and behavioral rehearsal of the material, in addition to receiving peer, or instructor, review and feedback (Neimeyer & Taylor, 2014; Taylor and Neimeyer, 2017).

In addition to identifying current best practices, the allied health fields have long dedicated themselves to the development and evaluation of novel mechanisms for enhancing new learning, as well, drawing from a wide range of literatures with common objectives. Research within the science-of-learning, adult education, and performance enhancement literatures have been particularly productive in identifying and assessing novel methods of learning and facilitating the translation of that learning into

practice. *Benchmarking* and *self-assessment* are two examples of educational practices that have arisen as mechanisms designed to facilitate quality assurance and ongoing professional development (Neimeyer and Taylor, 2014).

Benchmarking and Self-Assessment. *Benchmarking* refers to the express comparison of one’s own work with the work of other professionals in the field. Benchmarking can be understood as the systematic process of evaluating work based on best practices and using evidence-based practice (EBP) to improve performance. In a typical benchmarking procedure, a psychologist might be given videotapes of peers who are conducting a procedure, such as a substance use screening. The videos are pre-determined to depict varying levels of quality. They might range from depicting relatively poor, informal questioning through more thorough, systematic, structured interviews. The psychologist is then asked to evaluate his or her screenings in relation to those he or she has seen, and given information about key components that are present, and absent, in each of the video “benchmarks.” Benchmarking provides an anchor against which psychologists can compare themselves, increasing the accuracy of their self-assessment and incorporating elements of the “higher” benchmarks into their own practice.

Research has demonstrated the effectiveness of benchmarking in relation to improving the accuracy of self-assessment, which is a critical pre-condition for evaluating current clinical skills and needs. Lane and Gottlieb (2004), for example, found that when medical residents viewed videotapes of their performance, their self-assessment accuracy increased significantly. And their accuracy increased still more when they watched the videos with a faculty member. Similarly, Martin et al., (1998) found that comparing one's own performance to the performance of others increased the accuracy of self-assessment. In their study, these researchers invited family practice residents to conduct mock interviews with a mother suspected of physically abusing her child. The residents were then asked to rate their performance. Next, residents watched their videotaped interview, in addition to watching four benchmark interviews depicting varying levels of competence. After watching the benchmark interviews, the relationship between the residents' self-ratings and the independent ratings of the supervisor was significantly stronger.

Self-assessment can take many different forms. All forms share in common express efforts to reflect upon, and evaluate, one's own current skills and/or future professional needs and interests. The Quality Assurance Program in Ontario, Canada, is one example of a well-articulated program of self-assessment (Morris, 2011). The Quality Assurance Program requires that each psychologist undertakes a self-review every other year, though the completion of a stipulated Self-Assessment Guide and a Continuing Professional Development Plan. Through a series of questions, psychologists critically evaluate their strengths, growth areas, and gaps in their learning. After conducting the self-assessment, they develop their own personal plan to remediate areas of identified weakness and to enhance their overall professional competence, sharing their plans with a colleague who reviews it and provides

input. The Continuing Professional Development Plan is designed to 1) promote continuing competence and quality improvement, 2) remedy gaps in knowledge and skills identified in the self-assessments, 3) address changes in practice environments and workplace needs, and 4) incorporate evolving standards of practice and advances in technology. These Continuing Professional Development Plans are subject to peer review by members of the College of Psychology of Ontario according to stipulated regulatory requirements.

Both benchmarking and self-assessment reflect the considerable effort that can accompany efforts designed to promote professional growth and development. Facilitating new learning, and the translation of that knowledge or skill into practice can be an effortful process, requiring reflection, formulation and deliberate application. Transitioning new learning to practice often requires an individual to reflect on how new knowledge or skills may apply to their own experience and to formulate ways in which the new material can be modified, adapted, or utilized within their own professional contexts or workplace environments. If the value of this effort is justified by the anticipated improvement or outcomes that may follow from it, then individuals are more prone to commit themselves to changes in what they do, or how they go about doing it.

Although some mechanisms for triggering change are designed to be intensive and may require considerable time, others are designed as brief reflective exercises that can occur immediately after, or even during, a learning event. A longstanding literature on the concept of a Commitment to Change illustrates the value of utilizing this simple technique in the service of generating greater learning and the translation of that learning into actual practice (Mazmanian & Mazmanian, 1999).

COMMITMENTS TO CHANGE (CTCS)

CTCs have been the subject of attention for the last few decades, but only recently have they been imported into the fields of allied health, or more recently still within psychology. CTCs are generally generated following an educational event such as attending a lecture, participating in a workshop, or reading an article (Wakefield, 2004). To complete a CTC, participants are asked to identify a set of possible changes they would like to make in their own practice based on the educational event. They are asked to formulate these changes in specific, behavioral form, which requires them to reflect on the relevance and applicability of the new information, and to adapt its application to their own interests and experience. They are then asked to indicate a level of commitment to each of the changes they have formulated, utilizing a rating scale that reflects their commitment to change, from low (1) to high (5). In the Commitment to Change procedure, participants are often reminded of their commitments 1-2 months

later, and asked to indicate if they actually enacted, or attempted to enact, each of their stipulated CTCs and to describe their experience or outcomes.

The effectiveness of the CTC procedure seems to be related to its three steps. The timing of the administration, immediately after the learning event, provides the participant an opportunity to reflect on the most salient elements of the material and to formulate it in terms that are most relevant to their own experience, interests, or needs. Rating the level of commitment provides a concrete mechanism for reflecting on the importance or value of the change, and anchors the individual in a level of expectation about completing it. And the subsequent follow-up provides a sense of accountability and the opportunity to reflect on the translation of the material into practice, or the barriers that may have impeded or prevented that translation.

THE BACKGROUND ON CTCs

CTCs have been the subject of attention in relation to the organizational change literature for several decades, as a tool for facilitating critical shifts in organizational structure, processes or style. Within the allied health literatures, medicine was among the first to explore the utility of CTCs as a mechanism for facilitating the translation of new knowledge into actual clinical practice. Within this literature, the actual performance of CTCs varies widely, from 47-87% (Wakefield, 2004), based on a number of identified factors. These factors include the extent to which individuals feel as if the CTCs are relatively easy to do, and the extent to which they feel as though they have personal control over completing them (Fidler et al., 1999, Lockyer et al., 2001). The greater the environmental or institutional constraints, the less likely individuals are to be able to follow through on their commitments and accomplish the behavioral changes they have formulated (Parochka and Paprockas, 2001). A number of studies have demonstrated that the CTC procedure can trigger actual changes in practice-related behavior, including the specific prescriptions that physicians write following educational programs (Wakefield et al., 2003), and the specific interventions utilized by occupational therapists over the course of their work with their clients (Lowe, Rappolt, Jaglal, & Macdonald, 2007).

The precise mechanisms involved in triggering this translation into practice are not fully known, but recent work has begun to address them. Herbert, Lowe and Rappolt (cited in Lowe, Hebert & Rappolt, 2009), for example, wondered whether reflection alone at the end of a new learning experience was sufficient to promote practice change, or whether the express formulation of a commitment of change was an essential element. Reflection has long been a key component of ongoing professional development programs, as reflected in the Mann et al., (2009) systematic review of reflection within continuing medication education courses. In their study, Hebert et al. (2009) asked half of their participants to complete CTCs while the other half

were prompted to reflect on the workshop using the Critical Incident Questionnaire (CIQ). Two months following the workshop, there was a modest difference favoring the CTC group over the reflection-only group. The percentage of those who demonstrated significant change was significant in both groups, but it favored those who had formulated specific commitments to change. Overall, 67% of the individuals who used CTCs made changes in practice, compared to 50% of those in the CIQ group who reported doing likewise.

A recent study of the relationship between reflection and behavior change in continuing medical education provides further evidence in this regard (Ratelle, et al., 2017). In a cohort study of attendees at a national hospital continuing medical education course, 223 participants provided reflection scores for each presentation they attended, and formulated commitment-to-change statements at the conclusion of each course. Reflection scores consisted of ratings, on a 5-point scale, about the extent to which the presentation had prompted reflection, re-consideration, deliberation or critical re-evaluation of their practices. A 3-month post-course survey was conducted to determine whether planned CTCs were successfully implemented, and whether they were related to higher levels of reflection.

Overall, participants indicated that 65.5% of the CTC statements were implemented. Reflection scores correlated significantly with the number of planned CTC statements ($r=.65$, $p<.01$), suggesting the potential role of the CTC procedure in enhancing reflection and, potentially, translation into actual practice. In addition, higher reflection scores were related to the greater availability of opportunities for audience response and the use of clinical case illustrations. The researchers concluded that, “we found that reflection strongly correlates with CTC” and that “continuing education “curricula that stimulate reflections may actually promote positive patient care behaviors” (Ratelle et al., 2017, p. 166).

SUMMARY

Educators or learners who are interested in enhancing learning, and the translation of that learning into practice, may increase the retention and translation of material by incorporating CTCs into their programs. Although the overall effectiveness of CTCs as a tool to enhance the integration of new learning into practice is still under study, the current evidence is promising. The incorporation of simple reflective questions into a learning experience may itself be useful, as when the psychologist asks, “How can I use this new knowledge?”, “How does this apply to my practice and to what I do?”, or “What might I do differently based on what I have learned today?” Although simple reflection itself appears to facilitate both learning and the translation of that learning into practice, the express formulation of potential changes and a commitment to those changes may add further value (Lowe et al., 2009). Overall,

the formulation of CTCs represents a relatively simple mechanism for promoting reflection, anchoring expectations regarding adoption, and leveraging new learning into novel practice behaviors. Simple extensions to the CTC procedure that may provide additional benefit include conducting surveys of post-course behaviors to assess compliance with the CTCs, encouraging reports to colleagues or other peers regarding CTCs in order to build in additional elements of accountability, or establishing timelines for the completion of CTCs. With continued utilization and examination, Commitment-to-Change procedures may join the ranks of other processes, procedures and techniques that jointly constitute what has increasingly come to be recognized as the set of “Best Practices” in the field of ongoing professional education and continuing professional competence.

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