

CE

CONTINUING EDUCATION HELPING WOMEN WITH SERIOUS MENTAL ILLNESS GAIN GREATER HEALTH AND AUTONOMY

BY TORI DEANGELIS

Serious mental illness, or SMI, is almost twice as common among women as it is among men: Some 7% of U.S. women have one or more of these disorders compared with 4% of U.S. men, according to the Substance Abuse and Mental Health Services Administration (SAMHSA). The reasons are complex, ranging from gender-based violence to paternalistic practices within the medical and mental health systems to environmental circumstances that leave women in more vulnerable positions than men.

CE credits: 1

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

1. Describe the main elements of recovery-oriented care for women with serious mental illness, or SMI.
2. Explain the importance of feminist and trauma-informed perspectives in working with women with SMI.
3. Discuss key forms of intervention with this population, both at individual and systemic levels.

For more information on earning CE credit for this article, go to www.apa.org/ed/ce/resources/ce-corner.

SMIs may include but are not limited to major depressive disorder, bipolar disorder, schizophrenia spectrum disorders, post-traumatic stress disorder, and personality disorders, sometimes with co-occurring substance use problems. In recent years, SAMHSA and the National Institute of Mental Health have defined SMI in functional terms as “a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.”

Besides difficulties related to symptoms and activities of daily living, many women with SMI also face significant environmental hardships that can exacerbate these problems, including societal marginalization and stigma, gender discrimination and sexism, and high rates of domestic violence, homelessness, poverty, and single parenthood, according to psychologists who specialize in working with this population.

Despite their high level of need, however, women with SMI tend to be vastly underserved, and when they do receive treatment, it is often delivered in ways that fail to recognize their selfhood or optimize their recovery, these psychologists said.

This includes treatment by psychologists, said Erika Carr, PhD, an associate professor of psychiatry at the Yale School of Medicine and lead chair of the *APA Guidelines for Psychological Practice with Women with Serious Mental Illness*, a set of 14 treatment recommendations approved by APA’s Council of Representatives in 2022.

“Psychologists have some of the best talents and skills and are probably the top profession equipped to work with women with serious mental illness,” Carr said, “yet there aren’t a lot of us doing this work.” Ironically, part of the reason is that psychologists themselves may stigmatize those with SMI (Stuber, J. P., et al., *Psychiatric Services*, Vol. 65, No. 4, 2014), and anecdotally, even those who work with them.

Fortunately, there are excellent theoretical frameworks and interventions—including recovery-oriented care and trauma-focused and feminist approaches—that can help women with SMI get healthier, lead more fulfilling lives, and in some cases have symptoms remit entirely, Carr said. And now, psychologists who want to become more involved in this work can become board-certified in serious mental illness, through both the American Board of Serious Mental Illness Psychology and the American Board of Professional Psychology.

While it may seem counterintuitive, it is important to note that these approaches can be more cost-effective than treatment as usual, added Meaghan Stacy, PhD, an associate professor of psychiatry at Yale and a member of the guidelines task force. That is an important argument to make with institutions that say they cannot afford a change from more restrictive and prescribed forms of treatment to more egalitarian ones, she said. (See, for example, Bighelli, I., et al., *World Psychiatry*, Vol. 17, No. 3, 2018; *Rehabilitation for Adults with Complex Psychosis*, National Institute for Health and Care Excellence, 2020; and

Chandler, D., et al., *Psychiatric Rehabilitation Journal*, Vol. 22, No. 4, 1999).

“There are feasible, effective, and cost-effective psychosocial interventions that are shown to reduce symptoms, improve quality of life, enhance community functioning, and promote recovery,” Stacy said.

A RECOVERY FOCUS

Much of what psychologists need to learn about optimal treatment of women with SMI involves a shift in perspective, Carr said. That shift moves away from a hierarchical, paternalistic approach that sees these women as unruly patients who need to be controlled—sometimes literally with restraints, medication, and seclusion—toward a holistic, egalitarian approach that respects these women’s autonomy, nurtures their strengths, values their multiple identities, and gives them power over their own treatment.

Known as recovery-oriented care, this approach started as a consumer-driven social justice movement in the 1960s and 1970s in response to critiques of the prevailing medical model. In 2012, SAMHSA created an official definition of recovery as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” It also noted 10 tenets of recovery-oriented service delivery: providing hope, offering person-driven mental health services, holding respect for the individual, recognizing and amplifying the person’s strengths and responsibilities, addressing trauma, understanding and



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integrating the role of culture, providing a relational approach, incorporating peer support, offering holistic treatment, and understanding that recovery and healing occur through many pathways.

This framework applies well to women with SMI, said Marcia Hunt, PhD, an adjunct associate professor in psychiatry at Yale and chair of APA’s task force on serious mental illness and serious emotional disturbance. “For me, recovery is about being most strongly led by the person I’m talking with,” Hunt said. “Although I might have training, experience, and expertise, the person knows themselves better than I do, and I will never know them in the same way that they know themselves. So that is the partnership, and that is where I think treatment needs to begin.”

For example, a provider’s treatment goals might be to support women with SMI in taking their medications and attending therapy, but the women themselves may seek goals more related to their daily lives, Carr explained.

“They may say, ‘I want a job again, I want my own apartment where I can lay my head and have my own privacy, I want to have a companion again.’” When a provider starts a relationship by helping them reach those goals, it may be easier for patients to see the potential benefits in more conventional forms of treatment, Carr said. They may come to see on their own that if they take their medications or attend support groups, it can help them feel more stable and better able to have relationships, or it may provide networking that can help them find better housing, for example.

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Another key aspect of SMI recovery focuses on people's functioning rather than on their diagnosis, Hunt noted. For example, one individual with an SMI may really want to develop friendships but rarely leaves her house because she is terrified of social interactions due to feelings of paranoia. For her, "working with her desire for friendships rather than specifically addressing feelings of paranoia and seeing where that conversation leads would be really important," Hunt said. Conversely, if a woman with bipolar disorder who is prone to manic episodes says she is worried that those episodes might lead her to spend rashly and have indiscriminate sex, the focus should be "on those behaviors—on what she can do when those episodes kick in, how we can help her notice the signs of mania early enough, and how to protect her physically," Hunt said. "A focus on functioning is typically more empowering and motivating than a focus on diagnoses, which can lead to feelings of hopelessness or helplessness and trigger biases that do not support recovery," she added.

The recovery model also recognizes that the recovery process is not linear and will undoubtedly involve time, side paths, and bumps in the road, as well as progress, said Carr. In addition, it taps the involvement of peers and the community and supports people in engaging as citizens, "where in the past, people with SMI were very much ostracized," she said. "Welcoming people with SMI fully into the community can greatly alter their experience of trauma, stigma, and oppression."

A LENS ON WOMEN'S ISSUES AND REALITIES

Other important lenses for treating women with SMI, per the APA guidelines on treating women with SMI, include a feminist perspective, a trauma-informed perspective, and an intersectional perspective.

A feminist perspective recognizes that all women face forms of sexism and gender discrimination, and that those realities may lead to mental health problems that are often amplified for women with mental health vulnerabilities, said guidelines co-chair Lauren Mizock, PhD, a clinical psychologist in San Francisco who is on the doctoral faculty at Fielding Graduate University.

There is a long history of sexism in the medical and mental health fields, and research corroborates that these biases are alive and well, she added. For example, studies show that women are much more likely to be diagnosed with mental disorders than men, even when controlling for self-reported symptoms and symptom presentation (Riecher-Rössler, A., et al., *Archives of Women's Mental Health*, Vol. 21, 2018). Research also finds that being female in and of itself significantly predicts who is prescribed psychotropic medications for mood (*Women's Mental Health: An Evidence-Based Review*, World Health Organization, 2000).

In a related vein, many or most women with SMI have significant histories of gender-related trauma, but providers rarely acknowledge, assess for, or treat it, Mizock added. For example, one study found that 51% to 97%

KEY POINTS

1

Working successfully with women who have serious mental illness, or SMI, includes a focus on recovery, gender-related issues, and trauma history.

2

Supporting these women's humanity and autonomy and partnering with them in all aspects of treatment are key to this approach.

3

This approach recognizes the importance of tending to individuals' intersectional identities, including those related to race, culture, socioeconomic status, and sexual expression and orientation.

4

Few psychologists currently work with women with SMI, but with additional training in these areas, they can make a vast difference in the health and well-being of this highly underserved population.

of women with SMI have a history of physical and/or sexual assault (Goodman, L. A., et al., *Journal of Traumatic Stress*, Vol. 14, 2001), while another shows that 64% of women with SMI experienced sexual assault during their lifetime compared with 26% of men with SMI (Mueser, K., et al., *Journal of Consulting and Clinical Psychology*, Vol. 66, No. 3, 1998). Research also suggests that childhood trauma seems to predict the onset of psychosis both in men and women (Mayo, D., et al., *Frontiers in Psychiatry*, Vol. 8, 2017).

"It is important to be aware that a majority of these women have had experiences of abuse and violence and are at risk of various disadvantages and that providers attune their care based on their history and where it has led them," Mizock said.

Also pertinent to treatment conceptualization for women with SMI, say the guidelines, is assessing the presence and significance of intersectional identities, including differences in race, ethnicity, class, privilege, sexuality, sexual orientation, age, disability, and religion. For example, a White, lesbian, affluent woman with SMI has far different experiences and resources than a Black trans woman with SMI who is living in poverty, has experienced a history of abuse, and has limited access to quality care. It is also important to consider that some women with SMI may be at even greater risk of mental health problems given their environmental circumstances, including those in the criminal justice system and women who are immigrants or refugees, say the guidelines:

“Psychologists are encouraged to facilitate treatment options that . . . help women realize that their experience is fraught with a sociopolitical context, rather than seen singularly through a pathological lens, where the problem is thought to only reside in the person.”

A PLACE FOR ALL PSYCHOLOGISTS

There are many ways psychologists can get involved in improving care for women with SMI, said Stacy. A good start is getting educated on the topic: She and the other SMI guidelines authors encourage psychologists to read the SMI guidelines as well as related guidelines (see sidebar). These documents and the recovery approach in general are aligned with the social justice aspects of APA’s strategic plan, Stacy added.

For individual treatment, several successful evidence-based interventions are compatible with a recovery-based approach, many of which psychologists are familiar with in other applications, Carr said. An example is cognitive behavioral therapy for psychosis, or CBTp, which helps people with schizophrenia and related disorders examine and challenge their experiences of psychosis and develop coping strategies to manage their symptoms. Studies show the treatment helps improve depression, self-esteem, and psychological well-being and leads to fewer hospitalizations. It has also been found to prevent first-episode psychosis in those at elevated risk of developing it (Agbor, C., et al., *Cureus*, Vol. 14, No. 9, 2022).

Another successful treatment for some forms of SMI is dialectical behavioral therapy, particularly

APA GUIDELINES HELPFUL IN TREATING WOMEN WITH SMI

To improve quality of care for women with SMI, practitioners can start by reading some key APA guidelines. These APA guidelines cover a variety of different aspects of treating women with SMI:

- **2017** *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality*
- **2017** *Clinical Practice Guideline for the Treatment of PTSD*
- **2018** *Guidelines for Psychological Practice with Women and Girls*
- **2019** *Guidelines for Psychological Practice for People with Low-Income and Economic Marginalization*
- **2021** *APA Resolution on Advancing Health Equity in Psychology*
- **2022** *Psychology’s Role in Advancing Population Health*
- **2022** *Guidelines for Psychological Practice with Women with Serious Mental Illness*

FURTHER READING

Women with serious mental illness: Gender-sensitive and recovery-oriented care

Mizock, L., & Carr, E. Oxford University Press, 2021

Recovering the U.S. mental healthcare system: The past, present, and future of psychosocial interventions for psychosis

Stacy, M., & Davidson, C. A. (Eds.) Cambridge University Press, 2022

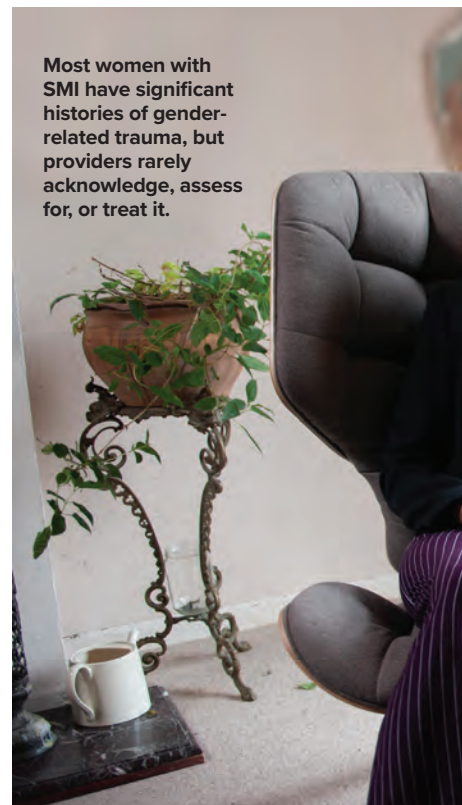
Women with serious mental illness in therapy: Intersectional perspectives (special issue)

Mizock, L., & Kaschak, E. *Women & Therapy*, 2015

The prevalence of childhood trauma in psychiatric outpatients

Devi, F., et al. *Annals of General Psychiatry*, 2019

Most women with SMI have significant histories of gender-related trauma, but providers rarely acknowledge, assess for, or treat it.



for those who have borderline personality disorder, substance use disorder, or exhibit suicidal behavior (Peprah, K., & Argaez, C., *Dialectical Behavioral Therapy for Adults with Mental Illness: A Review of Clinical Effectiveness and Guidelines*, Canadian Agency for Drugs and Technologies in Health, 2017). And if a patient has a history of trauma, evidence-based treatments for trauma can also be highly effective, Carr noted.

It is also important to help women with SMI create plans in case things get out of control, such as behavior health advance directives, Hunt added. Like health advance directives, these directives (also called psychiatric or mental health advance directives) allow people to express



their preferences on where and with whom they want to receive care and what treatments they are willing to receive, she explained.

Establishing these plans can give patients a sense of security and autonomy and psychologists a road map to help them feel more confident about providing these more egalitarian forms of treatment, Hunt added. That's because the plans allow patients and providers to discuss in detail, ahead of time, any repercussions that may come about in relation to a patient's expressed decisions.

"Talking about these things, not being afraid to talk about them, can help providers feel less worried about advocating for patients' treatment wishes in times of crisis," she said. (See Resources for more.)

Environmental interventions that address systemic barriers are at least as important as individual treatments, the SMI guidelines also point out. Programs such as supported employment and supported housing can help women with SMI gain greater stability in their lives, which in turn can aid their mental health (Killaspy, H., et al., *World Psychiatry*, Vol. 21, No. 1, 2022). And in general, the guidelines note that "psychologists are recommended to take on diverse roles rather than staying fastidious to traditional roles." For example, they are encouraged, when possible, to act as case managers who get involved in women's activities of daily living and to work on interdisciplinary teams, which can help to

ensure that women with SMI get the help, care, and resources they need to thrive.

On a larger scale, psychologists can become involved in advocacy efforts for this population, as well as in efforts to change the thinking and practices in systems that may negatively affect women with SMI. Stacy, for example, trains Yale postdocs as part of an interdisciplinary curriculum on SMI; consults with mental health organizations on how to incorporate these models into their systems and performance; and gives talks nationally and abroad on gender differences in mental health, biases within the mental health system, and sociocultural factors that precipitate and perpetuate SMI.

Learning more about women with SMI is important for the field at large, Stacy added. All psychologists will encounter women with SMI at various points in their career, and given their expertise in human behavior, the mind, and sociocultural influences, it makes sense for clinicians, researchers, and administrators to take a deeper dive.

On a personal level, there is great satisfaction in helping women who face significant challenges to gain better health and greater autonomy, Carr added.

"The reason people do this work is because they're passionate about it," she said. "They believe in the value of cultural responsiveness and the reality that people with SMI are marginalized. The work may be harder than other kinds of work, but it's also rewarding. And if we're not there, we're not the voice for the change that needs to occur." ■

RESOURCES

A practical guide to psychiatric advance directives

Substance Abuse and Mental Health Services Administration

Advance directives for behavioral health

Substance Abuse and Mental Health Services Administration

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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