CE

CONTINUING EDUCATION THE HEALING POWER OF NATIVE AMERICAN CULTURE

BY HEATHER STRINGER

The COVID-19 pandemic and the Black Lives Matter movement have raised consciousness about the country's persistent health inequities, but one group is often overlooked in efforts to reduce these disparities: American Indian and Alaska Native people. Data reveal troubling realities about the long-standing and escalating mental health conditions affecting the 3.7 million people in this population.

CE credits: 1

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

1. Learn about psychological and physiological health disparities in Native American communities.
2. Discuss limitations of the Western models of treatment in addressing mental health issues in American Indian and Alaska Native populations.
3. Describe how to embrace Native American values, customs, and beliefs in research and clinical settings.

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

Alcohol-induced deaths were highest among American Indian and Alaska Native people at 172 per 100,000, followed by Latinx people at 26.6, Whites at 25.8, and Blacks at 18.4, according to national data from 2016. These deaths could be caused by alcoholic liver disease, mental and behavioral disorders due to alcohol use, degeneration of the nervous system, or other conditions related to alcohol consumption (Spillane, S. et al., *JAMA Network Open*, Vol. 3. No. 2, 2020). The largest escalations in suicide rates from 1999 to 2017 occurred in American Indian and Alaska Native women and men, with increases of 139% and 71%, respectively. By comparison, the increases for White women and men were 68% and 40%, and even less for other racial and ethnic groups (Curtin, S. C., & Hedegaard, H., *Health E-Stats*, 2019).

COVID-19 also disproportionately affected tribal communities. They experienced the largest drop in life expectancy of any racial and ethnic group in the United States during the pandemic. In 2021, the life expectancy for American Indian and Alaska Native people was 65.2 years—equal to the life expectancy of the total U.S. population in 1944 (Arias, E., et al., *Vital Statistics Rapid Release*, No. 23, 2022). The average life expectancy was 70.8 for Blacks, 76.4 for Whites, and 77.7 for Latinx people in 2021. Despite high rates of health conditions, the Indian Health Service (IHS)—a federal program that provides care to more than 2.5 million American Indian and Alaska Native people—has far less funding per patient than Medicare, Medicaid, or the Veterans Health Administration (VA). IHS per capita spending in 2017 was $4,078 for IHS patients, compared with $8,109 for Medicaid patients and more than $10,000 for Medicare and VA patients (*Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs*, U.S. Government Accountability Office, 2018).

Although these health disparities may seem intractable, Native American psychologists suggest that progress has been slow in part because the mental health profession needs to embrace a new paradigm to better serve American Indian and Alaska Native people. "The traditional understanding of mental health issues and the models for treating them are still rooted in a Western perspective," said Art Blume, PhD, a clinical psychology professor at Washington State University who is Cherokee and Choctaw. "In psychology, we focus on treating the individual and promoting autonomy as a marker for health and well-being, but this is not necessarily the worldview of Indigenous people." Traditionally, many tribes have viewed the world as an interdependent system in which the cosmos, the natural environment, and the community are connected to wellness, Blume added.

Rather than adapting empirically validated treatments from mainstream psychology, Blume is among a cadre of psychologists who are calling for the development of innovative treatment approaches based on American Indian and Alaska Native values and worldviews. As a start, practitioners and researchers must

CATHERINE_JONES/GETTY IMAGES

embrace cultural humility and a willingness to learn how the history of subjugation, oppression, and dispossession has affected tribal communities, said Harvard University's Joseph Gone, PhD, a professor of anthropology and of global health and social medicine who is also past-president of the Society of Indian Psychologists. "Our way of life was considered hopelessly backwards and savage, and we were expected to become farmers and ranchers and learn reading, writing, and arithmetic," said Gone, who is a member of the *Aaniiih*-Gros Ventre Tribal Nation of Montana. "The deep damage from the loss of identity contributed to postcolonial disorders such as suicide, trauma, and addiction."

Mental health professionals can begin to equip themselves to foster healing in Native American populations by understanding the history of colonialism, learning about the values and traditions of tribal communities, and incorporating spirituality and other sources of strength into treatment. There are 574 federally recognized American Indian and Alaska Native tribes in the United States, and psychologist should be aware that the strategies vary within each community because tribes differ in their beliefs (U.S. Department of the Interior, Indian Affairs, 2022).

"By understanding that what we have learned in school is quite limited in helping these communities, we can begin to see how much they can teach us," Blume said. "We can learn Indigenous wisdom and explore the strengths that helped them overcome major challenges in history."

KEY POINTS

1. **Researchers recommend that the field of psychology work to develop treatment approaches based on Native American values and worldviews.**
2. **Therapists can start by giving Native American patients time to share whether and how they want to bring their Indigenous perspective into therapy and what their tribal identity means to them.**
3. **It is important to develop and use culturally sensitive assessment tools to avoid misdiagnosing Native American patients.**
4. **Psychologists who spend time in tribal communities and participate in gatherings can build trusting relationships that facilitate discussions about mental health challenges.**

AN APOLOGY FROM PSYCHOLOGY

To initiate the process of reconciliation and healing, APA formed an Indigenous Apology Work Group in 2020. The apology, which was approved by the Council of Representatives in February 2023, acknowledges the history of maltreatment, including "destructive harms and forced actions, such as sterilizations, relocations, culture-negating boarding schools, adoptions and removal of Native children from their families and culture and adoption by non-Native parents, intentional infliction of smallpox and introduction of alcohol, termination of sovereign tribes." The apology also lists psychology's specific harms. For example, "psychologists provided ideological support for and failed to speak out against the colonial framework of the boarding and day school systems for First Peoples of the Americas." The work group also created a list of 46 recommendations, such as honoring Native understandings and practices associated with common psychological concepts and supporting the development of assessment tools and interventions by Indigenous psychologists.

In 2021, APA became a liaison member to the Committee on Native American Child Health (CONACH), an American Academy of Pediatrics initiative focused on issues facing American Indian and Alaska Native children. Stephen Gillaspy, PhD, senior director of health and health care financing at APA, recruited four psychologists in 2022 to participate in the committee's consultation site visits in IHS areas. The CONACH team interacts with frontline health care providers to learn about the needs in each community and innovative models of care, which inform the organization's advocacy priorities.

THEPALMER/GETTY IMAGES

BUILDING TRUST IN TRIBAL COMMUNITIES

Psychologists who work with American Indian and Alaska Native people are slowly pioneering paths that can promote healing. Iva GreyWolf, PhD, who is Assiniboine and Anishinabe, has spent more than 3 decades immersing herself in remote Indigenous communities in Alaska and Montana, and much

A Navajo teacher works with students in the classroom. During the COVID-19 pandemic, many Native American youth helped care for family members, leaving less time for schoolwork.

of her work took place in informal settings rather than in an office. Gatherings are common in these communities, and she would volunteer to help with dishes, serve food, or do other tasks. "I joined them in senior centers, berry picking, and beading, and in those contexts, people gained trust and became comfortable talking about their concerns and struggles," said GreyWolf.

After confiding in her, individuals were sometimes interested in meeting in her office. But the traditional financial penalties for missing appointments did not apply because GreyWolf understood the obstacles people faced in terms of transportation, funds, and weather. She also learned that humor was an integral part of the culture that had helped people survive and could also reduce barriers. "Learning to laugh at myself when I made a mistake was important," she said. When she and her husband sat together at a community potluck, some members of a tribe joked about asking her to bring a pie to the next gathering as a fine for sitting with a spouse at a gathering. She learned that the fine was a jovial way of letting her know that it was seen as possessive, and the tribe valued mixing with other members during events.

VALUING COLLECTIVISM

Their deep commitment to family was sometimes a challenge for Native American students during the COVID-19 pandemic, said Angela Enno, PhD, director of training, programming, and outreach at the University of Utah's University Counseling Center. During the pandemic, she worked as a therapist at Northern Arizona University and saw many American Indian students who were expected to return to their tribal communities for months at a time to care for family members who were sick. She advocated for these students when professors were hesitant to make allowances for late assignments or missed exams. "These students lacked Internet access, and they were grieving the loss of older relatives who had been versed in the teachings, history, language, and identity of the tribe," she said.

Although family responsibilities may have conflicted with the demands of school, the focus on collectivism also had advantages for Native American young people who returned to intergenerational households during the pandemic. Studies suggest that people 65 and older were more resilient psychologically than younger people during the pandemic, with lower rates of anxiety disorder, depressive disorder, or trauma or stress-related disorders than young age groups (Vahia, I. V., et al., *JAMA*, Vol. 324, No. 22, 2020).

"We have so much data showing that access to culture improves mental health for Native

Americans, and access to culture comes from the elders," said Enno. When students struggled with depression and other mental health conditions, the wisdom of elders included staying busy by getting up early, chopping wood, caring for the animals, and praying, said Enno.

LEARN ABOUT TRIBAL DIFFERENCES

Although Native Americans may share certain values, the customs and beliefs in each tribe can vary. For this reason, Enno allows time for cultural sharing at the outset of the first session with these clients rather than starting with a series of questions. "I give them a chance to ask about me and to talk about what their tribal identity means to them," said Enno, who is a first-degree descendent of the Turtle Mountain Chippewa in North Dakota. This means her father is a tribal member and she is not. "I explore the extent to which they want to bring their Indigenous perspective into therapy."

During the pandemic, she also learned to be flexible when working with Native Americans who were experiencing grief. "Psychologists usually tend to encourage clients to talk about the loved one who died and to express emotions. But in some tribes, there is a circumscribed time of talking and crying, and then you are expected to move on for cultural and spiritual reasons that can vary tribe to tribe," said Enno. Some of her clients wanted to learn strategies for containing emotions and finding joy again because they wanted to honor their Native traditions related to grieving.

The role of men and women may also differ in tribes, said Melissa Tehee, JD, PhD, an associate professor of psychology at Utah State University and a member of the Cherokee Nation. She is from a matrilineal tribe in which women are outspoken and traditionally a husband moved in with the wife's family after marriage. The meanings of different animals also vary depending on someone's tribal affiliation. In one slide presentation, Tehee had planned to include an image of an owl, but she decided against it after discovering that this animal could signify danger for members of certain tribes. Now she checks in about tribal affiliations and beliefs before meetings or trainings to learn about the meaning of certain animals or other spiritual references she plans to include.

REDUCING THE RISK OF MISDIAGNOSIS

Learning about the values, spirituality, and communication styles in Native American communities helps providers connect with patients and avoid misdiagnosing them. Interpersonal behavior that is culturally appropriate can sometimes be viewed as symptoms of autism spectrum disorder, said B. J. Boyd, PhD, a senior psychologist for the Chickasaw Nation in Oklahoma and a member of the Cherokee Nation. "Native American children who avoid eye contact or take longer to answer a question may be acting appropriately, but this can be misconstrued as signs of autism," Boyd said. "In Western culture, children are usually expected to answer promptly to let adults know they have been heard." Boyd ensures each patient is evaluated in a culturally sensitive manner.

He has also seen how non-Native health care providers assume patients are exhibiting symptoms of mental illness or drug problems when in fact the patients are discussing their

THEPALMER/GETTY IMAGES

FURTHER READING:

A new psychology based on community, equality, and care of the Earth: An Indigenous American perspective
Blume, A. W.
Bloomsbury Publishing, 2020

Understanding Indigenous perspectives: Visions, dreams, and hallucinations
Morse, G. S., & Lomay, V. T.
Cognella, 2021

Community mental health services for American Indians and Alaska Natives: Reconciling evidence-based practice and alter-Native psy-ence
Gone, J. P.
Annual Review of Clinical Psychology, 2023

The association between adverse life events, psychological stress, and pain-promoting affect and cognitions in Native Americans: Results from the Oklahoma Study of Native American Pain Risk
Huber, F. A., et al.
Journal of Racial and Ethnic Health Disparities, 2022

mental health struggles in spiritual terms. Boyd worked with one Native American patient who was suffering from anxiety, and the man shared with providers that the birds and squirrels in his yard helped him understand his illness. "I had to intervene and stop providers from diagnosing him with schizophrenia because he was simply finding meaning and comfort to help him process his illness," said Boyd.

INITIATING CULTURE CONVERSATIONS

As psychologists seek to better serve Native Americans, changes in the approach to care have the potential to improve the well-being of people from a wide range of racial and ethnic groups. Tehee's research team at Utah State University recently partnered with a local elementary school to help students learn more about Native American culture, and the year-long project included exercises that helped students share about their own culture. "We found that over time, learning about other cultures increased the students' connections to their own culture," Tehee said. The students also increased their level of cultural empathy, or the ability to understand the experiences of people from a different culture (Litts, B. K., et al., *International Society of the Learning Sciences*, 2020).

By incorporating discussions about culture earlier in education, Tehee hopes to develop a generation of culturally competent citizens who are more curious about their own and others' cultures. "This opens up space for all the students to experience a sense of belonging," she said.

Practitioners can better understand patients by appreciating their role in typical Native American family structures, where the focus is on collectivism rather than individual achievement (opposite).

Psychologists can encourage Native American patients to learn about and participate in their cultural observances, such as traditional tribal gatherings.

"If they are feeling more connected to others, they will be more likely to let someone know if they are struggling rather than remaining silent." These conversations about culture can take place in classrooms, research labs, clinical settings, and social gatherings, and it is critical to start by "recognizing your limitations in understanding," said Gone. He encourages psychologists to be open to treating clients from any background and to be willing to openly share their limited ability to serve people from different cultural affiliations.

"By doing that, we are beginning to rehabilitate the deep sense of inferiority and shame among Native Americans that resulted from colonial subjugation as we form new relationships with marginalized communities and individuals." ■

GREGOR HOHENBERG/LAIF/REDUX

AMERICAN PSYCHOLOGICAL ASSOCIATION

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 heath, 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 feels 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 psychologists 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.

ABOUT THE AUTHOR

Greg J. Neimeyer, Ph.D. is professor emeritus at the University of Florida in Gainesville, Florida, where he has served as the Director of Training and Graduate Coordinator, while practicing in the Family Practice Medical Residency Training Program in the Department of Community Health and Family Medicine. Past Chair of the Executive Board in the Council of Counseling Psychology Training Programs in the United States, Dr. Neimeyer's research has focused on aspects of ongoing professional development and lifelong learning. A recipient of the American Psychological Association's Award for Outstanding Research in Career and Personality Research, Dr. Neimeyer has also been inducted into the Academy of Distinguished Teaching Scholars. He currently serves as the Director of the Office of Continuing Education and the Center for Learning and Career Development atq the American Psychological Association in Washington, D.C.

REFERENCES

Fidler, H., Lockyer, J.M., Towes, J., and Violato, C. (1999). Changing physicians' practices: the effect of individual feedback. Academic Medicine, 74, 702-714.

Institute on Medicine (2010). Redesigning continuing education in the health professions. Washington, D.C.: Academies Press.

Lane, J.L., and Gottlieb, R.P., (2004). Improving the interviewing and self-assessment skills of medical students: Is it time to readopt videotaping as an educational tool? Ambulatory Pediatrics, 4, 244-248.

Lockyer, J.M., Fidler, H., Ward, R., Basson, R.J., Elliot, S., and Toews, J., (2001). Commitment to change statements: A say of understanding how participants use information and skills taught in and educational session. The Journal of Continuing Education in the Health Profession, 21, 82-89.

Lowe, M., Hebert, D., and Rappolt, S. (2009). ABCs of CTCs: An introduction to Commitments to Change. Occupational Therapy New, 11, 20-23.Lowe, M., Rappolt, S., Jaglal, S., and Macdonald, G. (2007). The role of reflection in implementing learning from continuing education into practice. Journal of Continuing Education in the Health Professions, 27, 143-148.

Mann, K., Gordon, J., and MacLeod, A. (2009). Reflection and reflective practice in health professions education: A systematic review. Advances in Health Science Education, 14, 595-621

Martin, D., Regehr, G., Hodges, B., and McNaugton, N. (1998). Using videotaped benchmarks to improve the self-assessment ability of family practice residents. Academic Medicine, 73, 1201-1206.

Mazmanian, P.E., and Mazmanian, P.M. (1999). Commitment to change: theoretical foundations, methods, and outcomes. Journal of Continuing Education in the Health Professions, 19, 200-207.

Morris, R., (2011). Self-Assessment Guide and Professional Development Plan: Facilitating Individualized Continuing Professional Development. In G.J. Neimeyer and J.M. Taylor (Eds.), Continuing Professional Development and Lifelong Learning: Issues, Outcomes and Impacts (pp. 101-133). Hauppauge, New York: Nova Science Publishers.

Neimeyer, G.J., and Taylor, J.M. (2014). Ten trends in lifelong learning and continuing professional development. In N.J. Kaslow and W.B. Johnson (Eds.), The Oxford Handbook of Education and Training In Professional Psychology. New York: Oxford University Press.

Neimeyer, G.J., Taylor, J.M. and Rozensky, R. (2012). The diminishing durability of knowledge in professional psychology: A Delphi Poll of specialties and proficiencies. Professional Psychology: Research and Practice, 43, 364-371.

Neimeyer, G.J., Taylor, J.M., Rozensky, R.H. and Cox, D.R. (2014) The diminishing durability of knowledge in professional psychology: A second look at specializations. Professional Psychology: Research and Practice, 45, 92-98.

Parochka, J., and Paprockas, K. (2001). A continuing medical education lecture and workshop, physician behavior and barriers to change. The Journal of Continuing Education in the Health Professions, 21, 110-116.

Ratelle, J.T., Wittich, C.M, Yu, R.C., Newman, J.S., Jenkins, S.M., and Beckman, T.J. (2017). Relationships between reflection and behavior change in CME. Journal of Continuing Education in the Health Professions 37, 161-167.

Taylor, J.M., and Neimeyer, G.J. (2017). Continuing education and lifelong learning strategies. In S. Walfish, J.E. Barnett, and J. Zimmerman (Eds.), Handbook of Private Practice (pp. 602-618). New York: Oxford University Press.

Taylor, J.M., and Neimeyer, G.J. (2016). Continuing education and lifelong learning strategies. In J.C. Norcross, G.R. VandenBos, and D.K. Freedheim (Eds.), APA Handbook of Clinical Psychology, 5, (pp.135-152). Washington, D.C.: APA Books.

Wakefield, J.G. Commitment to change: Exploring it role in changing physician behavior through continuing education. Journal of Continuing Education in the Health Professions, 24, 197-204.