

CE Corner

Diagnosing and Treating Obsessive-Compulsive Disorder

BY ZARA ABRAMS

UMA CHATTERJEE has had unwanted, distressing thoughts for as long as she can remember. As a child, she repeated a series of prayers 39 times hoping to keep her parents safe. As a young adult, fear of financial ruin sometimes kept her in the grocery store for 8 hours comparing prices. But she was not diagnosed with obsessive-compulsive disorder (OCD) until age 22 and did not receive the recommended treatment until age 25.

Chatterjee's story is not uncommon. OCD affects nearly 10 million people in the United States, but more than 80% of cases are estimated to be undiagnosed, according to an analysis of more than 10 million electronic health records. Of those with a diagnosis, as few as 2% may be receiving the recommended treatment (Deusser, R., et al., *America's OCD Care Crisis*, International OCD Foundation [IOCDF], 2025). Research suggests that on average, people with OCD have symptoms for nearly 13 years before they are correctly diagnosed (Ziegler, S., et al., *PLOS One*, Vol. 16, No. 12, 2021).

"Patients with OCD often suffer for many years before receiving an accurate diagnosis, sometimes getting treatments that perpetuate the condition or—even worse—being hospitalized when they disclose scary intrusive thoughts that are misinterpreted as indicating suicidality or homicidality," said Tamar Gordon, PhD, a licensed clinical psychologist specializing in OCD who founded and directs Gordon Therapy Group in New York City.

Misdiagnosis and underdiagnosis are largely due to misconceptions about OCD, both by the public and among

health care providers, as well as insufficient training to help clinicians distinguish it from other conditions, such as generalized anxiety disorder (GAD), post-traumatic stress disorder (PTSD), and psychotic disorders. Many people living with OCD struggle in silence, either too ashamed to disclose

obsessions or not realizing that something is wrong.

Compared with the general population, people with OCD face a suicide rate that is nearly 5 times higher and an 82% higher rate of premature death (Fernández de la Cruz, L., et al., *BMJ*, Vol. 384, 2024). Better understanding of how to screen for, diagnose, and treat OCD is a critical step toward connecting these individuals with potentially life-saving care.

"Providers don't need to specialize in OCD to be able to help," said Chatterjee, who is now conducting research on OCD as a neuroscience doctoral student at the University of Wisconsin–Madison and advocating for improved recognition of the condition. "By questioning what they know about this condition and continuing to learn about it, they have tremendous power to relieve the hopelessness and pain that many people with OCD are secretly living with."

CE CREDITS: 1

Learning objectives

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

- 1 Describe obsessive-compulsive disorder (OCD) and several common symptom themes.
- 2 Discuss why OCD is underdiagnosed and name several conditions with overlapping symptoms.
- 3 Explain how OCD is treated, including through medications and tailored cognitive behavioral therapies.

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The OCD Cycle

Popular understanding of OCD often reduces the condition to a strong preference for order or cleanliness. In reality, it is a distressing and often debilitating disorder that can span many different themes, from contamination concerns and repeated checking to intrusive moral, sexual, or relationship-related concerns.

KEY POINTS

1

Obsessive-compulsive disorder (OCD) involves a cycle where intrusive and distressing thoughts trigger mental or behavioral acts aimed at reducing that distress.

2

People with OCD spend an average of 13 years with symptoms before they are diagnosed and face a risk of suicide that is 5 times higher than the general population.

3

Exposure and response prevention, a widely recommended behavioral treatment for OCD, helps patients learn to coexist with intrusive thoughts without trying to neutralize, avoid, or control them.

People with OCD experience obsessions—persistent and intrusive thoughts, urges, or images—that cause significant distress or anxiety, often by triggering intense doubt, guilt, or shame. To reduce that distress, they perform compulsions—repetitive behaviors or mental acts—that are not realistically connected to the feared outcome they aim to prevent but are instead a way to gain certainty and relieve doubt. The obsessions or compulsions are either time-consuming, cause significant distress or impairment, or both.

Distress is often anxiety but can also include disgust, obsessional guilt (guilty feelings about something that has not occurred), or “not just right experiences,” which are overwhelming feelings that something is wrong. Some people have the same intrusive

thoughts every day, while others have thoughts that change.

OCD can occur at any age, but it typically starts between ages 7 and 12 or between the late teen and early adult years, around age 20. Prevalence rates do not differ substantially across sexes, races, or ethnicities (“About OCD,” IOCDF). Severity can range from mild, with manageable symptoms that cause little daily disruption, to extreme, with symptoms that are incapacitating.

Many people with OCD experience intrusive thoughts that are horrific or taboo, such as the fear they may kill themselves, harm a loved one, or sexually harm a child in their care. Importantly, these thoughts are ego-dystonic, or inconsistent with a person’s values or identity (as opposed to ego-syntonic thoughts or urges, which feel acceptable or desirable). Distinguishing between the two is critical, because people with OCD are sometimes unnecessarily hospitalized or reported to authorities after sharing ego-dystonic thoughts they have no intention of acting on.

“Clinicians need to know what intrusive thoughts are and how to identify them—and they need to be comfortable discussing taboo topics,” Gordon said.

Compulsions (sometimes called rituals) can be behavioral, such as repeatedly checking locks, but they can also be covert and internal. Covert compulsions include rumination, silent counting or praying, neutralizing a “bad” thought with a “good” one, or mentally reviewing memories to ensure something bad did not happen.

“Rituals may look like things many of us do on a day-to-day basis, but they tend to be extreme in nature, and the primary goal is to get rid of an internal feeling,” said Nathaniel Van Kirk, PhD,



a licensed clinical psychologist and program director of the OCD Institute at McLean Hospital in Belmont, Massachusetts. “Performing rituals actually reinforces obsessions—making them more intense, more frequent, and harder to [tolerate].”

Though OCD is not classified into formal subtypes, it presents in several common symptom themes. These include contamination (where a fear of germs or toxins leads to excessive cleaning or avoidance of certain places), harm (where a fear of causing injury to self or others leads to repeated checking of memories, objects, or situations), not just right experiences (where things feel uneven, incomplete, or not quite right),



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sexual taboos (fear that one will act in an unacceptable sexual manner, leading to avoidance or mental checking), and scrupulosity (excessive concerns about blasphemy or religious wrongdoing).

Getting diagnosis right

Primary-care providers and mental health clinicians can help identify people who may have OCD using brief scales such as the OCI-4, a four-item version of the obsessive-compulsive inventory scale, or simply by routinely asking patients whether they

have intrusive thoughts, said Dean McKay, PhD, a professor of psychology at Fordham University and a clinician specializing in OCD (*Journal of Anxiety Disorders*, Vol. 78, 2021). Patients can then be referred to a trained provider for in-depth assessment.

Diagnosing OCD requires distinguishing obsessions—intrusive, unwanted thoughts, images, or urges that cause significant distress or anxiety—from worries, such as concerns about finances or social responsibilities. Clinicians must also assess

the presence of compulsions and the extent to which they interfere with daily functioning. Central to diagnosis is identifying whether compulsive behaviors are performed in direct response to obsessions.

“If clinicians focus on the content of a ritual rather than the purpose it serves, OCD can be overlooked,” Van Kirk said. “Compulsions can take many forms, but they are defined by their function—efforts to reduce distress or neutralize unwanted thoughts and obsessional fears.”

OCD is often missed because, on the surface, it can look like several other conditions. GAD is among the most common, because obsessions often cause significant anxiety. Seeking safety from intrusive thoughts can also look like PTSD, which can co-occur with and complicate OCD. Because obsessions can seem fantastical, they may also be confused with delusions, leading to a misdiagnosis of schizophrenia or another psychotic disorder.

Treatments for GAD can involve cognitive strategies aimed at reducing perceived threat or increasing a sense of safety. With OCD, however, providing reassurance is counterproductive. While it may briefly lower distress, reassurance functions like a compulsion, reinforcing a patient’s drive to seek certainty. When applied to OCD, cognitive behavioral therapies not specifically designed for the condition may therefore worsen symptoms, according to work by McKay (*Clinical Psychology: Science and Practice*, Vol. 28, No. 1, 2021).

In children, OCD can be mistaken for attention-deficit/hyperactivity disorder. One young patient of Gordon’s feared forgetting things, so he repeatedly checked his backpack to make sure each item was in place, leading to inattention at school.

“Autism spectrum disorders can also involve repetitive thoughts and behaviors, but a key distinction is that these interests are pleasant or ego-syntonic or used as a way to regulate the nervous system, whereas obsessions are unpleasant and frightening,” said Fred Penzel, PhD, a licensed clinical psychologist and expert in treating OCD who founded and directs Western Suffolk Psychological Services in Huntington, New York.

Experts do not all agree on what conditions are related to OCD on a fundamental level. The latest edition of the *Diagnostic and Statistical Manual of Mental Disorders*, the *DSM-5*, lists several related conditions, including hoarding disorder (where people have difficulty discarding possessions) and body dysmorphic disorder (where people are preoccupied with perceived flaws in their physical appearance). Many also believe that illness anxiety disorder, formerly called hypochondriasis, bears key similarities to OCD. There is also evidence for substantial overlap between OCD and Tourette syndrome (Mansueto, C. S., “OCD and Tourette Syndrome: Re-examining the Relationship,” *IOCDF*, 2008).

Treating OCD

Exposure and response prevention (ERP), a specialized form of cognitive behavioral therapy developed for treating OCD in the 1960s, remains the first-line treatment. Estimates from research studies and clinical experts suggest that between 65% and 80% of patients respond well to ERP, while others partially benefit or do not benefit (Ong, C. W., et al., *Journal of Anxiety Disorders*, Vol. 40, 2016).

During ERP, a trained clinician guides a patient to systematically face what they fear in growing degrees of

intensity while resisting performing the rituals they typically use to neutralize those fears. By doing so, patients gradually increase their tolerance for uncertainty and learn to coexist with their intrusive thoughts.

“Patients learn that it’s possible to have the thought and carry on with life rather than twisting themselves out of shape to avoid feeling fear,” Penzel said.

While the underlying principles do not change, treatment with ERP can take on many forms depending on a patient’s symptoms. A

clinician might guide someone with contamination-related OCD to touch doorknobs or shake hands with another person. For a person with intrusive thoughts about suicide, treatment may involve imaginal scripts that ask the patient to sit with feared scenarios—such as handling knives—without attempting to neutralize or escape their distress. After completing a course of ERP, patients learn strategies to manage symptoms on their own, with follow-up or booster sessions recommended to maintain progress over time.

Exposure and response prevention therapy can be augmented by tailored cognitive therapies as well as medication, where appropriate.



ERP can be adapted for children by including game-like elements, such as incentives tied to completing exposures, said C. Alec Pollard, PhD, a licensed clinical psychologist and founding director of the Center for OCD and Anxiety-Related Disorders at St. Louis Behavioral Medicine Institute. Providers also work closely with parents to reduce accommodation, or behaviors that unintentionally reinforce a child's symptoms, such as doing extra laundry to assuage contamination fears.

Misconceptions about ERP include the belief that it is too distressing to undergo, and some people with OCD avoid seeking help because they fear the treatment will be intolerable. But when delivered correctly by a trained provider—such as those recommended by the International OCD Foundation, a leading global authority on the condition—ERP “is probably the most compassionate thing you can do for someone who suffers from OCD,” McKay said.

Selective serotonin reuptake inhibitors (SSRIs) are also effective in reducing OCD symptoms and are typically prescribed in higher doses than used to treat depression. Research suggests that about half of patients with OCD respond to SSRIs, with a 40% to 50% decrease in symptom severity (Poskar, S., “Medication Treatment for Obsessive Compulsive Disorder in Adults,” IOCDF). Most psychologists view SSRIs as a way to enhance ERP rather than as a standalone treatment.

“Medication is a good way to turn down the volume on the OCD—reducing distress enough for patients to engage in ERP,” Van Kirk said. In severe or extreme cases of OCD, other medications, such as antipsychotics, may also be helpful.

Several tailored cognitive therapies can be used to augment ERP.

These include addressing the over-importance of thoughts (placing excessive weight on intrusive or fantastical thoughts), thought-action fusion (the belief that thinking about an event makes it more likely to happen), and overestimation of threat (the belief that one faces greater risks than others).

Acceptance and commitment therapy can also help patients engage more fully with ERP, Gordon said, by providing tools for tolerating uncertainty and distress. In some cases, she also teaches coping skills—such as mindfulness and grounding exercises—to help patients stay with exposures. Not all providers use coping skills, because some view them as bordering on reassurance.

A new treatment approach known as inference-based cognitive behavioral therapy (I-CBT) may offer a further adjunct to ERP or an alternative for patients unwilling to do ERP. This metacognitive approach focuses “upstream” on how obsessions form, teaching patients to question the faulty reasoning that gives rise to them. In a randomized controlled trial, I-CBT led to symptom improvement comparable with other cognitive behavioral treatments that included ERP (Aardema, F., et al., *Psychotherapy and Psychosomatics*, Vol. 91, No. 5, 2022).

Ongoing research aims to make ERP more effective across the board, including by finding ways to help the roughly 40% of patients who do not respond adequately. A new line of inquiry also seeks to understand how past trauma can complicate or exacerbate OCD, as well as how to respond to it. Chatterjee is among those using human brain tissue and animal models to identify neurobiological targets for treatment (specific brain-based mechanisms that

therapies or medications could act on to reduce OCD symptoms), an area where options remain limited.

“OCD is severely underfunded and understudied—even compared with other mental health conditions,” Chatterjee said. “There are many people who aren’t helped, or helped enough, by existing treatments. We need more research into the biology of OCD for those who continue to struggle.” ■

FURTHER RESOURCES

Speaking of Psychology:
OCD myths and realities,
with Dean McKay, PhD,
and Uma Chatterjee
APA, 2023

Research roundup:
Effective technology-
enhanced treatments
for pediatric obsessive-
compulsive disorder
Marzalik, J. S.
APA, 2021

Resources for professionals
International OCD
Foundation, 2026

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.

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 at the American Psychological Association in Washington, D.C.

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