

CE Corner

New Guidelines for Psychology's Role in Pediatric-to-Adult Health Care Transitions

BY KIRSTEN WEIR

FOUR IN 10 children and adolescents in the United States have a chronic health condition, according to data from the 2023 National Survey of Children's Health. These range from common conditions like asthma to rarer illnesses such as childhood cancer and congenital heart disease. Most of these children will manage these conditions into adulthood and throughout their lives. The transition from pediatric to adult health care, however, can be a tricky time for adolescents and young adults.

As adolescents with chronic diseases become adults, they must develop the skills to manage their own health needs and navigate a complex health care system. The transition can be difficult logistically and emotionally, both for young adult patients and family members who have, until that point, been largely responsible for their child's health and safety. "It is a significant cultural shift that involves changing relationships, beliefs, expectations, knowledge, and skills," said Siddika Mulchan, PsyD, a pediatric psychologist at the University of Connecticut School of Medicine and Connecticut Children's who works with children with cancer and blood disorders, including sickle cell anemia.

As a cochair of the APA Div. 54 (Society of Pediatric Psychology) Adolescent and Young Adult Transition Taskforce, Mulchan and her colleagues developed APA's new *Guidelines for Psychology's Role in Pediatric to Adult Health Care Transition*. The guidelines detail how psychologists

can make those shifts safer and more successful for patients, families, and providers.

Young people with chronic illnesses often receive multidisciplinary care, with professionals including nurses,

social workers, and various medical specialists each playing a part in facilitating the shift to adult care. Often, there are opportunities for psychologists to play larger roles in supporting patients, caregivers, and other providers through the transition process, said Lisa Schwartz, PhD, a clinical psychologist at Children's Hospital of Philadelphia and the Perelman School of Medicine at the University of Pennsylvania, and one of the three cochairs of the Adolescent and Young Adult Transition Taskforce. Indeed, psychologists' unique skill sets make them a natural fit for that role. "Successful health care transition is not just about making sure patients have the skills and knowledge [to manage their medical conditions]. It is also building intrinsic motivation, aligning priorities and expectations, and improving communication between patients, parents, caregivers, and providers," she said. "There is a huge role

for behavioral science in these transitions."

CE CREDITS: 1

Learning objectives

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

1

Describe the challenges young adult patients face when transitioning from pediatric care to adult health care.

2

Discuss the features of successful health care transitions and the potential risks associated with a less successful transition process.

3

Describe the roles that psychologists can play in facilitating the successful transition to adult care.

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On the threshold

After years of having their health needs managed by parents or other caregivers, young adults with chronic conditions are tasked with a host of new responsibilities, from finding new doctors and acquiring health insurance to behaviors

like monitoring blood sugar and maintaining medication regimens. That presents a sharp increase in responsibility in an already challenging time, Mulchan said. “The period of adolescence and young adulthood is so stressful and fraught, with a lot of change,” she said. “It is a difficult time to also be undergoing a change in your health care team.”

Pediatric care also has its own culture that is vastly different from adult care, Mulchan added. Pediatric providers tend to be more flexible with appointments and spend more time with patients. A warm, patient-centered approach is usually the norm; indeed, for many patients and their families, pediatric care providers come to feel like family. Against that backdrop, engaging with unfamiliar providers can be emotionally draining. And while they are leaving that trusted care team behind, young adults are also gaining more independence and taking more responsibility for their own health decisions. In a best-case scenario, young adult patients maintain continuity of care through that shift and settle into a new routine. “When transition is a success, patients are showing up to adult care appointments, asking questions of their providers, following medical regimens autonomously, and are engaged in their care,” Mulchan said. “They have a sense that they have transitioned into a new medical home.”

When the transition does not go so smoothly, however, the consequences can be dire. The transitional period has been linked to increased complications from conditions such as spina bifida and lupus, for instance. Among people with sickle cell disease, mortality rates are highest between the ages of 19 and 24 (Cassidy, M., et al., *BMJ Open*, Vol. 12, No. 12, 2022). Similar difficulties can occur across health

conditions, from Type 1 diabetes to cystic fibrosis to congenital heart disease. “Without the hand-holding of the pediatric support system, without care being driven by parents, it is a cliff that people often fall off,” Schwartz said.

A structured planning process can reduce the risks of transition and improve health outcomes for young adults with medical conditions. However, research suggests that most youth and young adults with special health care needs do not receive the support they need to transition successfully (White, P. H., et al., *Pediatrics*, Vol. 142, No. 5, 2018). “Youth with chronic medical conditions often have brief conversations, or sometimes no conversations, with any provider about the transition process,” said Frances Cooke, a clinical psychology graduate student at Catholic University in Washington, D.C., who is training to work with youth with chronic medical conditions and also a cochair of the guidelines task force.

Organizations such as the American Academy of Pediatrics and the American Academy of Family Physicians have also developed professional practice standards to improve health care transitions and health outcomes for young adult patients. “However, those guidelines don’t always emphasize the need for psychologists to play a role,” said Paul Kettlewell, PhD, a retired pediatric psychologist and a member of the APA Committee on Professional Practice and Standards, which reviewed the new guidelines. “Psychologists should be central to this process,” he added.

To address that need, the Adolescent and Young Adult Transition Taskforce and Div. 54 developed APA’s new guidelines in consultation with Got Transition, a federally funded national resource center on transitioning

KEY POINTS

1

Forty percent of youth receive care for a chronic health condition, such as asthma, sickle cell disease, heart problems, or Type 1 diabetes. For many, health outcomes suffer during the transition from pediatric to adult care.

2

APA’s *Guidelines for Psychology’s Role in Pediatric to Adult Health Care Transition* detail psychologists’ roles in facilitating the transfer to adult care.

3

Successful transition involves structured planning, tracking progress toward skill development, intervening as needed, and assessing success after transfer.

4

Members of the health care transition team should pay attention to cultural and family contexts and barriers such as health literacy, insurance coverage, and access to quality care.

from pediatric to adult health care. The center had previously created an evidence-based framework to help physicians facilitate the shift to adult care (White, P., et al., *Six Core Elements of Health Care Transition™* 3.0, Got Transition, 2020). APA’s new guidelines were designed to complement such resources by providing best practices for psychologists, particularly those working in hospital settings who may encounter youth with health conditions.

“The fact is, psychologists have been engaging in this work for a long time, spearheading a lot of the research and clinical work in health care transition,” Mulchan said. Having professional practice guidelines in hand offers best practices to enable them to do that work even more effectively.

Planning ahead

Careful planning is critical for a smooth transition from pediatric to adult health care, the guidelines emphasize. “If transition is an afterthought, it is very unlikely to be successful,” Mulchan noted. Accordingly, several items in the new guidelines emphasize this planning process. The first step is often helping families understand that transition is both necessary and beneficial. “Pediatric providers are not trained to care for adult bodies and adult needs. For patients to get the best quality care, they need adult providers,” she added. “It can be really helpful to frame this as a positive for patients and families.”

Beginning well in advance of the transition, psychologists can work

with families and medical teams to develop a transition statement or guide. That guide can serve as a personalized road map from the planning stages through the completed transfer to adult care. In addition to discussions of medical interventions and goals of care, such guides can highlight specific skills and milestones to work toward during the transitional period, in areas such as social support, psychological functioning, family functioning, social drivers of health, beliefs about self-care, and a patient’s level of self-efficacy in disease management.

Transition guides differ from person to person, depending on a person’s medical needs and their personal goals,

values, and cultural preferences. To help families create that road map, psychologists can engage patients and their families in conversation to understand how they define a “successful” transition, Cooke said. “There is no one behavior or benchmark that will look the same for every patient,” she added.

The guidelines also describe the role psychologists can play in facilitating communication between patients, families, and care teams—including both pediatric and adult providers—as they work together to develop a transition statement. Psychologists can act as a communication liaison to help everyone speak the same language and work toward the same goals.

The APA guidelines emphasize that careful planning is critical for a smooth transition from pediatric to adult health care. A crucial step is helping families understand that transition is both necessary and beneficial.



The sticking points

Health care transition is a gradual process that can take several years, experts say. Ideally, adolescents have time to mature and practice the skills necessary to manage their health and medical care. Such abilities are wide ranging, including intellectual and executive functioning skills as well as disease-specific behaviors such as checking blood sugar levels or following medically tailored diet plans. The guidelines describe the role that psychologists can play to assess whether patients are ready and provide extra support when they need to work

on their skills. “Two of the things our field does really well are assessment and intervention development,” Schwartz said. “As psychologists, we can be involved in setting up an infrastructure and standardized protocol to assess readiness for transition over time, then using that assessment to identify targets for intervention.”

Schwartz and her colleagues developed a framework to support this work, the Social-Ecological Model of Adolescent and Young Adult Readiness for Transition (SMART) framework, which they validated in a group of adolescent and young adult survivors of

childhood cancer (*JAMA Pediatrics*, Vol. 167, No. 10, 2013). The model considers preexisting factors, such as medical status, insurance access, and sociodemographic factors, as well as more modifiable elements such as self-efficacy, expectations, emotions, and knowledge. More recently, the researchers updated the model to include additional factors to improve health equity and validated the model in a population of adolescents and young adults with sickle cell disease (*JAMA Pediatrics*, Vol. 178, No. 3, 2024). The model can be a guiding framework for assessing transition readiness,

After years of having their health needs managed by parents or other caregivers, emerging adults with chronic conditions are tasked with a host of new responsibilities, such as monitoring their blood sugar and maintaining medication regimens.



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especially among youth who are experiencing health disparities.

While SMART offers one framework, there is no one right way to measure transition readiness, Schwartz said. Different health systems and even different departments within a single hospital may have their own protocols for measuring readiness and intervening where needed. What is important, she added, is having a clear system in place to pinpoint and modify factors that interfere with successful transitions.

One patient, for instance, might not have the know-how to manage their medical care yet. Another might know what they need to do but struggle with high anxiety about leaving their pediatric providers behind. For others, the problem might be that they are butting heads with their parents because of differing expectations around moving to adult medical care. In each case, psychologists can determine the sticking points in need of extra attention. “Once we identify those targets, we can facilitate the necessary interventions and also serve as a liaison between the family and the medical team to share concerns about any targets in need of intervention,” Schwartz said.

Smooth transitions

There’s no perfect age for transitioning to adult care, experts say. For some patients, the shift may come in the late teens. Others may not be ready until their early 20s. Psychologists can help families identify when the time is right to cross the bridge to adult care, then support them on their way. The guidelines describe ways that psychologists can aid in the transfer process—by addressing patient concerns, engaging families in shared health care decision-making, and facilitating coordination between pediatric and adult providers. “It can be really challenging

to make the transition when a child has a strong relationship with their pediatric providers. And it can feel really challenging to communicate years of knowledge and complex medical information to someone new,” Cooke said.

Psychologists can help with a warm handoff, consulting with and educating adult providers to help them better understand the patient’s pediatric experience to improve the continuity of care. They can also work with patients to support their health and health care behaviors and address mental health challenges such as anxiety or depression that arise. When a patient’s self-management skills are still developing, a psychologist might even advocate for delaying transfer to adult care for a set period while they take active steps to improve those skills.

Throughout these activities, members of the transition team should pay careful attention to cultural and social contexts and barriers, Cooke said. The ideal degree to which parents are involved in the care of their young adult child, for instance, could vary significantly from culture to culture and family to family. And some patients may face health care barriers that make the transition process uniquely challenging. Factors such as health literacy, transportation access, insurance coverage, and access to quality health care can all affect transition outcomes (McKenzie, R. B., et al., *Population Health Management*, Vol. 22, No. 1, 2019). “The new guidelines outline the ideal best practices—but a family will not be able to benefit from those best practices if they are experiencing barriers within the health care system,” Cooke noted.

Psychologists can help identify and address the risks and identify areas of resilience. For a patient facing challenges with health literacy, for instance, strong family support can

help bridge any gaps in understanding. Psychology professionals can also help address health care inequities in their institutions, according to the task force members. “We can help to combat stigma and bias through things like the use of inclusive language—with families and in institutional communications—and addressing institutional policies that may contribute to health care inequities,” Cooke said.

The guidelines recommend psychologists gather feedback on the transition process from patients, families, and providers once young patients have moved into their adult “medical home” to ensure that any barriers are addressed and eventually aid other families going through this process, Mulchan said.

“We have done so much from the medical side of things to ensure these children survive to adulthood,” Mulchan added. “We shouldn’t neglect all the things we need to do from a psychosocial standpoint to help these patients have the skills, the knowledge, and the readiness to effectively continue managing their health.” ■

FURTHER READING

Six core elements of health care transition™ 3.0

White, P., et al.
Got Transition, The National Alliance to Advance Adolescent Health, 2020

Improving the transition from pediatric to adult healthcare: A scoping review on the recommendations of young adults with lived experience

Cassidy, M., et al.
BMJ Open, 2022

Supporting the health care transition from adolescence to adulthood in the medical home

White, P. H., et al.
Pediatrics, 2018

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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