

CE

CONTINUING EDUCATION PROGRAMS ON RACIAL EQUITY

In this special issue of the *Monitor*, we present a CE that diverges from our usual format. Instead of focusing on a single subject, we are highlighting seven pivotal CEs from the past several years, each dedicated to the challenges faced by different marginalized groups and how psychologists can help.

In each CE article, psychologists from the marginalized group provide overviews, insights, and context. They offer valuable skills and practical strategies for enhancing quality of care, from understanding cultural nuances to addressing systemic barriers.

Our goal with this compilation is to equip psychologists with the knowledge and skills necessary to foster inclusive and effective therapeutic environments. By highlighting these CEs, we aim to draw attention to this valuable information, encourage practitioners to complete the training and earn a continuing-education credit for each, and inspire ongoing learning and commitment to cultural competence in the field.

We hope this collection serves as a valuable resource for both seasoned practitioners and those new to the field, encouraging a deeper understanding and appreciation of the diverse experiences of the patients psychologists serve.

Find all seven of these CEs at
www.apa.org/ed/ce/resources/ce-corner.

The Healing Power of Native American Culture

Learning Objectives

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

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

Key Points

- Researchers recommend the field work to develop treatment approaches based on Native American worldviews.
- 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.
- It is important to use culturally sensitive assessment tools to avoid misdiagnosing Native American patients.
- Psychologists who spend time in tribal communities and participate in gatherings can build trusting relationships that facilitate discussions about mental health challenges.

“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.”

—Art Blume, PhD, clinical psychology professor, Washington State University

Further Reading

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



Promoting Mental Health in Asian American Teens

Learning Objectives

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

- Identify the components of racial-ethnic socialization and preparation for bias in Asian American and Pacific Islander families.
- Learn about cultural stressors and mores across a heterogeneous population.
- Learn strategies to help Asian American teens identify and address racial dilemmas.

“That [model minority] stereotype has been so pervasive that people don’t see the vulnerabilities, or the struggle, or really even the need, to focus on this population.”

—Tiffany Yip, PhD, professor of psychology, Fordham University

Key Points

- Psychological issues unique to Asian American teens can include feeling invisible, feeling pressured to fulfill the “model minority” stereotype, and navigating microaggressions and racist encounters.
- Therapists can work with parents of these teens to help them understand the reality of discrimination and not minimize it, as well as help teens respond to microaggressions.
- As a therapist working with Asian American teens and families, displaying cultural competence and building trust and rapport are more important than one’s ethnicity.
- Successful therapy with Asian American families and teens involves setting practical goalposts so patients feel they are gaining something immediately useful and valuable from the treatment.

Further Reading

- **The healing trauma workbook for Asian Americans: Heal from racism, build resilience, and find strength in your identity**
Hsu, H. H., New Harbinger Publications, 2024
- **Decolonizing mental health practice: Reconstructing an Asian-centric framework through a social justice lens**
Millner, U. C., et al., *Asian American Journal of Psychology*, 2021
- **Gendered Racial Microaggressions Scale for Asian American Women: Development and initial validation**
Keum, B. T., et al., *Journal of Counseling Psychology*, 2018
- **Navigating marginalization and invisibility as Asian Americans in the U.S.**
Mistry, J., & Kiyama, F., *American Psychologist*, 2021
- **Promoting pride but missing the need for preparation for bias: Racial-ethnic socialization among Indian American families living in the southeast U.S.**
Patel, P., et al., *Asian American Journal of Psychology*, 2022
- **Reducing mental health disparities by increasing the personal relevance of interventions**
Hall, G. C., et al., *American Psychologist*, 2021

Increasing Supervisor Savvy Around Culture, Race, and Identity

Learning Objectives

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

- Identify emerging models, theories, and ideas on bringing racial, cultural, and identity factors into supervision and the supervisory relationship.
- Discuss practical ways that supervisors can bring ideas like critical consciousness and cultural humility into their work with supervisees and their clients.
- Describe the state of the field in adopting these approaches.

“I see supervision as a process that invites deep appreciation for the super complexity of culture by asking explicitly about how issues of cultural difference, power, and oppression play out in the lives of our clients and in the therapeutic work in which we’re engaging.”

—Jeffrey Ansloos, PhD, associate professor and Canada research chair in critical studies in Indigenous health, University of Toronto

Key Points

- Psychology is still in the early stages of understanding how to best bring racial, cultural, and identity factors into supervision.
- Many supervisors practice supervision the same way they experienced it, so getting training on new approaches is vital.
- Culturally responsive supervision includes learning about social justice perspectives such as critical consciousness and decolonization.

- The work is important because society, students, and clients require it for self-awareness, mental and physical health, and psychological empowerment.

Further Reading

- **Critical consciousness in vocational psychology: A vision for the next decade and beyond**
Cadenas, G. A., & McWhirter, E. H., *Journal of Career Assessment*, 2022
- **Lens on international clinical supervision: Lessons learned from a cross-national comparison of supervision**
Falender, C., et al., *Journal of Contemporary Psychotherapy*, 2021
- **Indigenous peoples and professional training in psychology in Canada**
Ansloos, J., et al., *Canadian Psychology/Psychologist canadienne*, 2019
- **Liberation psychology: Theory, method, practice, and social justice**
Comas-Díaz, L., & Torres Rivera, E. (Eds.), APA, 2020



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- **Attending to racial trauma in clinical supervision: Enhancing client and supervisee outcomes**
Pieterse, A. L., *The Clinical Supervisor*, 2018
- **Multidimensional ecosystemic comparative approach (MECA)**
Falicov, C. J., in Lebow, J., et al. (Eds.), *Encyclopedia of Couple and Family Therapy*, Springer, 2017

Effective Therapy With Black Women

Learning Objectives

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

- Describe the intersectional challenges facing Black women and understand the impact of racism on Black women's mental health.
- Explain the Strong Black Woman schema and adultification bias.
- Identify interventions that can reduce stress and improve coping among Black women.

“[The Strong Black Woman schema] helps us to be resilient. It helps us to keep going in the middle of difficult circumstances. But the consequence is that strength often means not paying attention to feelings of distress, not paying attention to the impact of familial, relationship, and race-based trauma and how it impacts our thoughts, feelings, and behavior.”

—Inger Burnett-Zeigler, PhD, clinical psychologist and associate professor, Northwestern University Feinberg School of Medicine

Key Points

- Black women face a unique type of gendered racism.
- Therapists should understand how systems of oppression and racism operate in society and in their own training.
- Community support and strategies for coping with stress can be healing for Black women.

Further Reading

- **Underneath the mask of the Strong Black Woman schema: Disentangling influences of strength and self-silencing on depressive symptoms among U.S. Black women**
Abrams, J. A., et al., *Sex Roles*, 2019
- **Nobody knows the trouble I've seen: The emotional lives of Black women**
Burnett-Zeigler, I., *Amistad*, 2021
- **The unapologetic guide to Black mental health: Navigate an unequal system, learn tools for emotional wellness, and get the help you deserve**
Walker, R., New Harbinger Publications, 2020
- **14 mental health resources for the BIPOC community**
Wilkins, V., *Travel + Leisure*, May 25, 2021



Helping Black Men and Boys Gain Optimal Mental Health

Learning Objectives

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

- Describe how Black men's mental health is challenged by racism.
- Discuss the most critical intervention points for Black men's mental health.
- Describe successful treatment types for Black men, both traditional and innovative.

"We should place less emphasis on whether Black men are resistant to therapy and more on understanding the contexts in which they already feel comfortable talking about their feelings and traumas. If a Black man is able to find a treatment that is culturally responsive, that he understands, and that embraces the uniqueness of his difference, he is more likely to use that service."

—Howard C. Stevenson, PhD, clinical psychologist and director, Racial Empowerment Collaborative, University of Pennsylvania

Key Points

- Black men have less access to and poorer quality of mental health care than White men despite significant needs.
- For contextual reasons, including poverty and racism, Black men are more likely to endorse traditional masculinity norms such as toughness than White men.
- Interventions that are culturally competent, understand and address diversity among Black men, and use trauma-informed principles hold the most promise.

Further Reading

- **Black men need friends: Social support moderates the connection between gendered racism and psychological distress**
Ramseur, K. II, et al., *Psychology of Men & Masculinities*, 2024
- **Exposure to neighborhood violence and suicidal thoughts and behaviors among adolescents in the USA: Findings from a population-based study**
Baiden, P., et al., *School Mental Health*, 2024
- **Mental health among African Americans: Innovations in research and practice**
Turner, E. A., Lexington Books, 2019
- **Recovering your sacredness**
Tello, J., Sueños Publications, 2018
- **The racial healing handbook**
Singh, A. A., New Harbinger Publications, 2019
- **Increasing the visibility of providers of color**
Calkins, H., *Monitor on Psychology*, September, 2020
- **Community needs and recommendations for multilevel mental health interventions among young Black men with previous trauma exposure**
Bauer, A. G., et al., *Journal of Consulting and Clinical Psychology*, 2022
- **My grandmother's hands: Racialized trauma and the pathway to mending our hearts and bodies**
Menakem, R., Central Recovery Press, 2017

How to Discuss Race With Black Teens and Their Families

Learning Objectives

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

- Learn strategies to help Black teens process and problem-solve racial dilemmas.
- Identify the components of ethnic-racial socialization and their protective benefits in raising Black children.
- Better understand how to introduce the element of race when there is a dichotomy between psychologist and patient.

"[Ethnic-racial socialization] is a process by which race-related messages about the meaning or the value of race and racism are transmitted [to adolescents] by their parents, clinicians, and everybody around them. It's been found to be one of the most critical development processes of Black youth."

—Thomas Vance, PhD, postdoctoral psychology fellow, New School for Social Research

Key Points

- Ethnic-racial socialization is a critical developmental process for Black youth, helping them to prepare for and cope with racial stressors and discrimination.

- To effectively support Black teens and their families, psychologists must become comfortable discussing ethnic-racial socialization and racial identity, incorporating those concepts into therapy.
- Once psychologists have identified racial stressors affecting Black teens, they should validate their experiences and work with them to develop appropriate responses.

Further Reading

- **Reclaim yourself: The homecoming workbook**
Bryant, T., TarcherPerigee, 2024
- **Black families in therapy: Understanding the African American experience (2nd ed.)**
Boyd-Franklin, N., The Guilford Press, 2006
- **The unapologetic guide to Black mental health**
Walker, R., New Harbinger Publications, 2020
- **Healing interpersonal and racial trauma: Integrating racial socialization into trauma-focused cognitive behavioral therapy for African American youth**
Metzger, I. W., et al., *Child Maltreatment*, 2021
- **Racial/ethnic discrimination and well-being during adolescence: A meta-analytic review**
Benner, A. D., et al., *American Psychologist*, 2018
- **Perceived racism and discrimination in children and youths: An exploratory Study**
Pachter, L. M., et al. *Health & Social Work*, 2010

How Psychologists Can Help Refugees

Learning Objectives

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

- Discuss the diverse circumstances immigrants and refugees face and list some of the common mental health concerns affecting these populations.
- Describe how psychologists can train and prepare to work with immigrant communities in clinical and forensic settings.
- Understand what clinical skills and strategies are helpful for assessing and treating immigrants and refugees.

“The most important thing that any clinician who’s working with immigrants can do is listen to the stories of individuals.”

—Laura Minero, PhD, licensed psychologist, *Yolotl Libre Therapy*

Key Points

- Immigrants may face a range of challenging circumstances, including racism, acculturation, and trauma.
- Training in culturally competent care and knowledge about immigration issues can help psychologists better support immigrants and refugees.
- Trauma-informed care, narrative therapy, and cognitive

behavioral therapy are effective treatment modalities for immigrant populations.

Further Reading

- **Refugee mental health**
Aten, J. D., & Hwang, J. (Eds.) APA Books, 2021
- **A guide to providing mental health services to immigrants impacted by changes to DACA and the COVID-19 pandemic**
Cadenas, G. A., et al., *Informed Immigrant*, 2020
- **Working with refugees from Syria and surrounding Middle East countries**
Abdulrehman, R., et al. *Clinic Psychology Public Mental Health Initiative*, 2016
- **Latinx Immigrant Health Alliance**
www.latinximmigranthealthalliance.org
- **Psychological science and immigration today**
APA Presidential Task Force on Immigration and Health, 2024



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.

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 way of understanding how participants use information and skills taught in an educational session. *The Journal of Continuing Education in the Health Professions*, *21*, 82-89.
- Lowe, M., Hebert, D., and Rappolt, S. (2009). ABCs of CTCs: An introduction to Commitments to Change. *Occupational Therapy Now*, *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 McNaughton, 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 its role in changing physician behavior through continuing education. *Journal of Continuing Education in the Health Professions*, *24*, 197-204.