

CE Corner

Fresh Thinking on Trauma Assessment

BY TORI DEANGELIS

ACCORDING TO A large-scale international survey of more than 68,000 people, around 70% of people have experienced at least one trauma in their lives, and 31% have been exposed to four or more traumatic events (Benjet, C., et al., *Psychological Medicine*, Vol. 46, No. 2, 2016). Furthermore, those most impacted by trauma tend to be among the most vulnerable financially, socially, and otherwise (Ravi, M., et al., *Mental Health Science*, Vol. 1, No. 4, 2023).

The high rate of trauma exposure suggests that many or most of those who enter therapy or otherwise work with a psychologist have faced one or more traumatic life events, said Charles Benincasa, PsyD, a clinical and trauma psychologist based in Everett, Washington, and a member of the APA Task Force on the Assessment of Trauma. But surprisingly, most graduate programs lack specific training in the assessment and diagnosis of trauma, particularly of complex presentations. Training often focuses solely on discussing trauma within the context of trauma-related diagnoses rather than recognizing trauma as a possible cause or complicating factor in a person's mental health presentation, he said.

Yet "if these factors are not included as part of the standard of assessment, we can miss really important aspects of understanding the experiences that people are coming to us with," Benincasa said.

To help fill this gap, he and other members of the trauma assessment task force developed the 2025 APA *Guidelines for Psychologists in the Assessment of Psychological Trauma*

in Adults, approved by APA's Council of Representatives in August. The document provides direction for gaining competency in trauma assessment, highlights important research developments in the area, and points to areas still in need of deeper understanding and further attention, including more

research on trauma types and symptoms and better instruments to gauge the many types of trauma that people experience, said Tyson Bailey, PsyD, cochair of the assessment task force and a clinical and forensic psychologist and trauma specialist in Everett, Washington.

"We have come a really long way in understanding how to properly understand and assess trauma," he said, "and we have a very, very long way to go. We hope these guidelines encourage people to use the knowledge we have and continue to grow the literature on recognizing the broad effects of trauma, because trauma and adversity are common and are disproportionately felt by people who are already marginalized."

In general, the aim of the guidelines is to help the field better understand the central role that trauma might play in some patient experiences and, in a related vein, the wide variation in trauma reactions that are not covered

by traditional diagnoses, Bailey added. For example, while the *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition) recognizes several trauma-related diagnoses, it does not recognize complex trauma—trauma resulting from repeated, prolonged exposure to stressors, particularly interpersonal ones, though the World Health Organization's *International Classification of Diseases*, or

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Learning objectives

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

- 1 Identify the basic knowledge, content, and processes that go into effective trauma assessment.
- 2 Discuss research that demonstrates the need for this service, including data linking trauma experiences to poorer mental and physical health outcomes.
- 3 Describe new thinking on trauma assessment, including why it is important to look beyond simple diagnostic categories and toward the person's whole experience.

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RESOURCES

Trauma psychology and assessment are generally not covered thoroughly enough in graduate school, so becoming competent in trauma assessment may require additional education and training, noted Tyson Bailey, PsyD, cochair of the APA task force that developed the 2025 *APA Guidelines for Psychologists in the Assessment of Psychological Trauma in Adults*. He recommends seeking additional education on interviewing skills as well as on tools to use and how to use them. Finding a mentor with expertise in this area can also help you learn how to assess trauma sensitively and accurately, he said. Here are some places to start:

APA Guidelines for Psychologists in the Assessment of Psychological Trauma in Adults
www.apa.org/practice/guidelines/adults-complex-trauma-histories.pdf

APA Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults
www.apa.org/ptsd-guideline

APA Guidelines for Working with Adults with Complex Trauma Histories
www.apa.org/practice/guidelines/adults-complex-trauma-histories.pdf

Guidelines on Key Considerations for Working With Adults With PTSD and Traumatic Stress Disorders
www.apa.org/about/policy/adults-ptsd-traumatic-stress-guidelines.pdf

APA Div. 56 (Trauma Psychology)
www.apa.org/about/division/div56

International Society for Traumatic Stress Studies
<https://istss.org>

Global Collaboration on Traumatic Stress
www.global-psycho-trauma.net

“trauma history is essentially a risk factor for any mental health diagnosis that one could have,” Frewen said. For example, a study of 9,000 adults found that those who had experienced four or more adverse events in childhood, such as ongoing neglect or abuse, were 4 to 12 times more likely to be suicidal, depressed, and to misuse substances than those without a trauma history (Felitti, V. J., et al., *American Journal of Preventive Medicine*, reprint, Vol. 56, No. 6, 2019). Other studies show that the greater the number of adverse childhood events one has experienced, the greater the risk of developing physical, psychosocial, neurobiological, and functional problems (Madigan, S., et al., *World Psychiatry*, Vol. 22, No. 3, 2023).

Integral to this expanded understanding is knowing that the person themselves may not know that trauma is at the base of their symptoms, Frewen added. A patient might enter therapy seeking help for symptoms like insomnia, mood instability, or relationship problems, for instance, “but not necessarily recognize that those symptoms tie to traumatic life events that they have experienced recently, at some point earlier in their life, or throughout their life,” he said. “It’s important for psychologists to be mindful of these possibilities.”

Considering trauma in this wider context also means opening the door to diagnoses and understandings that go beyond post-traumatic stress disorder (PTSD), said Constance Dalenbergh, PhD, director of the Trauma Research Institute and distinguished professor at Alliant International University, both in San Diego, and a member of the APA task force. Although much has been learned about trauma since PTSD entered the *DSM-3* in 1980, PTSD remains the go-to gauge for whether a traumatic reaction exists or not.

ICD-11, does (see March 2025 *Monitor* article on treating complex trauma).

To get at these core ideas, the task force organized the guidelines around three themes: **knowledge**—what psychologists need to know about the possible role that trauma plays in mental and physical health presentations and the instruments used to treat it; **content**—what psychologists should be looking to assess when they use available assessment techniques and measures; and **process**—the way psychologists should interact with clients when conducting assessments.

Knowledge—understanding the importance of trauma

In the knowledge domain, the guidelines underscore the importance of viewing trauma exposure as a possible

root cause of common presenting problems such as depression, anxiety, insomnia, relationship problems, and, in more extreme cases, dissociation and even psychosis, said Paul Frewen, PhD, an associate professor of psychiatry and psychology at Western University in London, Ontario, and a member of the trauma assessment task force.

In many cases, trauma does not cause long-term ill effects—most people recover naturally from single-incident traumas, with about 40% recovering within a year, according to the World Health Organization. However, the fact that trauma is so common, coupled with research showing high correlations between more complex trauma and mental and physical problems, means that



Research shows that support systems can be immensely valuable in helping people cope with and overcome traumatic experiences.

“People think that if you do or don’t have PTSD, it has implications for whether you were or were not traumatized,” she said. “But PTSD is only one way a person can react to trauma, and if you do have a trauma reaction, most of the time it is not PTSD.”

Instead, it behooves psychologists to consider and assess more broadly how trauma might manifest in a person above and beyond traditional diagnoses, Dalenberg noted. Assessors should stay alert to potential emotional, cognitive, behavioral, and interpersonal effects of trauma, such as general anxiety and depression, changes in cognition such as problems with logic and processing speed, and changes in level of trust.

Looking beyond diagnostic boxes and using different kinds of

instruments provides a wider and more humane lens on how trauma can affect people, Dalenberg added. An example is assessing a person’s belief system after they have experienced an interpersonal trauma. If the measure reveals that the person now trusts people less and sees the world as a more dangerous and unfriendly place, “that might not mean that the person has PTSD,” she said, “but it might mean they’ll have a much more damaged life because of that change.”

Content—conducting accurate assessments

In terms of testing itself, task force members recommend using a range of empirically validated interviews and questionnaires to get at a person’s trauma history and its current

manifestations. Reactions and symptoms to screen for include PTSD, anxiety, dissociation, depression, grief, substance misuse, anger and aggression, emotional dysregulation, cognitive changes, and changes in belief systems. It is also important to gather information on the type, frequency, and recency of the trauma—factors often missing from standard assessment instruments.

Dalenberg recommends beginning an assessment with a general psychosocial interview that weaves trauma-related questions throughout, then gradually moving to more specific tools that further explore what the broad assessment has suggested. For instance, the Trauma Symptom Inventory-2 can help assess a wide range of short- and long-term psychological effects of trauma, including PTSD, dissociation, somatization, attachment issues, and self-harm.

KEY POINTS

1

Accurate, compassionate trauma assessment entails expanding the use of assessment measures beyond simple diagnoses and toward people’s actual experiences.

2

Learning about and using multiple measures, plus clinical work and judgment, will lead to the most accurate assessments.

3

More work is needed to create assessment measures that capture the type, frequency, and recency of a person’s trauma experiences, as well as measures that are culture and language specific.

Good assessment also requires using instruments and other tools thoughtfully and using one's clinical judgment and understanding in interpreting them, Bailey added. The challenge is to synthesize the information you have—for example from interviews, assessment measures, records, and collateral sources—in ways that accurately capture a person's experience. A good trauma assessor “has a firm and grounded understanding of what the tools are and what they can and can't tell you,” he said, and also does their own work in making an informed assessment.

As an example, if an interviewer merely asks a person if they have ever been raped or sexually assaulted, it often leads to underreporting because the person does not necessarily use those words to describe their experiences, Frewen explained. A more useful approach is using validated instruments that ask specific questions about whether a person has ever experienced certain behaviors from others.

“It's much better to ask behavioral-type questions about whether a certain type of event has specifically happened, as opposed to asking questions in global terms that people can interpret in different ways,” he said.

In the forensic context, it is important to carefully weigh client responses on validity measures that assess the possibility that a person is feigning or exaggerating symptoms, Frewen added. While such measures are often used in this context because people may overplay symptoms to avoid legal consequences or to gain benefits, the scores need to be interpreted carefully for trauma survivors, he said.

That is because while people may feign extreme reactions that are known to be rare in the general population—for example, anger displays, dramatic somatic complaints, or

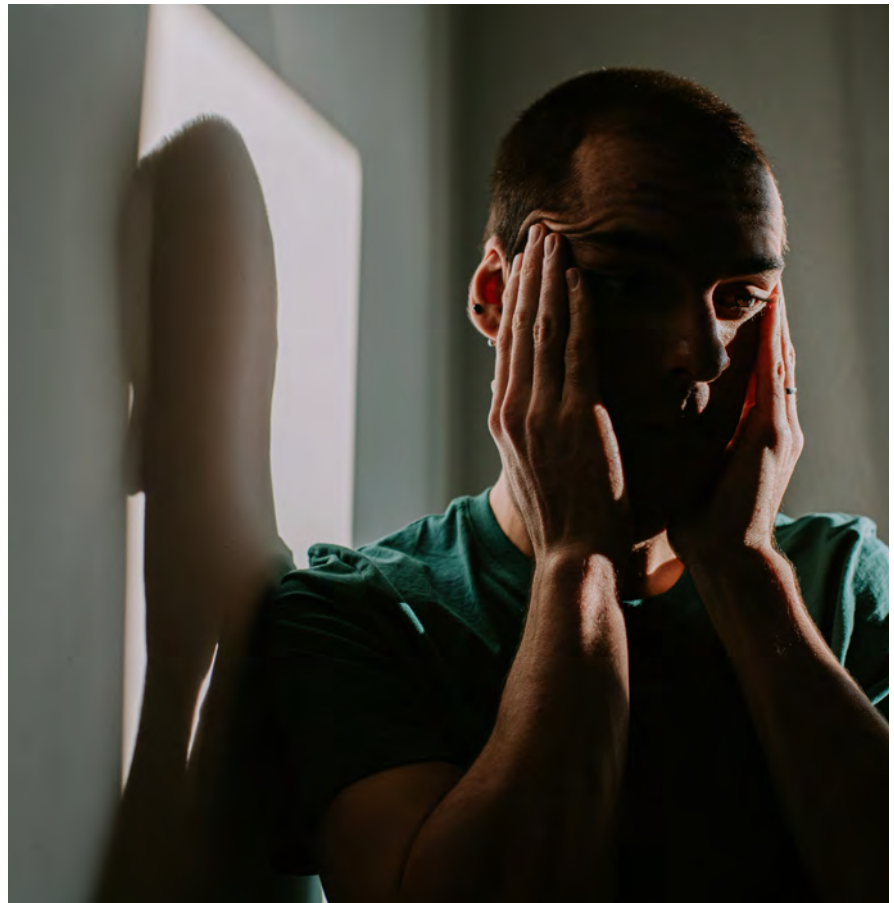
self-destructive actions—a person who has been traumatized through ongoing abuse, coercive control, or combat may actually experience these reactions. So to make an accurate determination, assessors should also include data from other instruments and the person themselves, Frewen said. Also important to keep in mind is the continued reality that people still often do not believe those who say they have been raped, he added.

Social support is likewise a vital area to assess because research shows that support systems can be immensely valuable in helping people cope with and overcome traumatic

experiences (Calhoun, C. D., et al., *Psychiatric Quarterly*, Vol. 93, No. 4, 2022). Benincasa recommends using questionnaires that ask about a person's level of support from family, other relationships, community, work, health care providers, and other sources. Psychological First Aid, an evidence-based approach to helping people after a crisis or trauma, recognizes this reality by helping to match people with resources aimed at reducing the odds that they will develop a sustained traumatic response over time, he noted.

Culture, language, and ethnicity are also key items to consider in trauma

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assessments, said Dalenberg. While the way that people process trauma in the body and emotions is probably universal, “different cultures understand bodily reactions and emotions in different ways and use different mechanisms and metaphors to describe them,” she said. “So how I interpret the changes that are happening within me will differ depending on my culture, and my secondary reactions to those changes will differ as well.”

In the case of immigrants who have come to this country to escape difficult conditions, psychologists should consider that many have never had a time in life when they have not faced traumatic stressors. It is important to think about how ongoing political persecution, loss of one’s home, war, migration, and resettlement can impact individuals, the guidelines note.

That said, current tools and methodologies for dealing with some of these issues are still very underdeveloped, said Bailey. In cases of language and cultural differences, using translated measures, a personal interview, and/or a professional translator are likely to be more helpful than current assessment instruments, he said.

“We hope that these guidelines spur the development of tools that are more robust and that address post-traumatic reactions more broadly, rather than focusing on one particular diagnosis,” he said.

Process—human dynamics

In terms of process, psychologists need to be aware of the human dynamics occurring during the assessment itself—in particular, what the person being assessed might be experiencing internally and in relation to the assessor, according to the guidelines. For example, external factors such as skin color, gender, age, or appearance might inadvertently make it difficult

for a person to trust or disclose information to you, Benincasa noted.

For example, he evaluates many people who have experienced interpersonal violence, and he recognizes that as a large-statured, bald, white man, “there’s a high likelihood that I might look like the person that my client is most afraid of,” he said. If the person does make that association, it can lead to an involuntary activation of their nervous system and make it harder for them to answer assessment questions accurately. In cognitive or neuropsychological testing, research shows that such nervous system activation makes it harder to complete tasks with high cognitive demand “because there is the distraction of the associations that are going on and of what’s happening in the nervous system,” Benincasa said.

Also important to keep in mind is that the person is probably experiencing post-traumatic symptoms during the assessment itself, and to think about timing one’s questions and level of detail accordingly. If a person seems to be having difficulty with the process, encourage them to take a break and do brief breathing or grounding exercises, Frewen advises.

Sometimes no matter how hard one works to create a trusting relationship with the person being assessed, there are times a patient simply cannot overcome internal obstacles to working with you, Benincasa added. If that is the case and future therapy or work is needed, help the person find a better match, he said. If that is not possible in the time allowed or for other reasons, use your clinical skills to discuss those issues and try and work through them with the person, he said.

Finally, if an assessment determines that the person needs additional therapy, act expediently, Frewen said. “It’s not a great help just to identify a problem without offering a solution,”

he said. “We’ve got to be ready to provide care if the person needs it.”

Gaining the right tools and knowledge can open the door to helping people heal their wounds at the source, Frewen added.

“If trauma isn’t there, great; move on,” he said. “But I think psychologists will be surprised to discover how often a trauma history is looming there. If we just treat traumatic reactions as a behavioral issue, and we don’t get to where this all came from in the beginning,” he added, “I think our treatment will be less effective.” ■

FURTHER READING

Trauma assessments:

A clinician’s guide

Carlson, E. B.
Guilford, 1997

Psychological trauma as a transdiagnostic risk factor for mental disorder: An umbrella meta-analysis

Hogg, B., et al.
European Archives of Psychiatry and Clinical Neuroscience, 2023

Development of a differential assessment guide to improve engagement with youths & families living with chronic trauma

Kagan, R., et al.
Journal of Child & Adolescent Trauma, 2022

Trauma assessment in outpatient psychotherapy and associations with psychotherapist’s gender, own traumatic events, length of work experience, and theoretical orientation

Lueders, J., et al.
European Journal of Psychotraumatology, 2022

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

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