

CE Corner

Managing countertransference with patients

Therapists' emotional responses, when examined thoughtfully, can deepen clinical insights and improve patient outcomes

BY ZARA ABRAMS

COUNTERTRANSFERENCE, A THERAPIST'S cognitive and emotional reactions to a patient, is now recognized as a phenomenon that can arise in virtually any form of psychotherapy. Rather than something to avoid, psychologists today view countertransference as an important facet of therapy to notice and manage, as well as an opportunity to harness for the patient's benefit.

"Countertransference doesn't mean you're doing something wrong. In fact, it regularly happens during therapy," said Kirsten Lind Seal, PhD, LMFT, a psychotherapist in private practice in Minneapolis, Minnesota, who leads CE workshops on countertransference. "The main thing is acknowledging and understanding its power to help and possibly harm, then deciding what to do about it."

If countertransference is not addressed, a therapist may act out their own unconscious patterns with a patient, such as meeting anger with defensiveness or detachment. But with proper preparation, including training on self-awareness, self-disclosure, and emotion regulation, therapists can learn to recognize countertransference when it arises. In some cases, engaging countertransference during a session can even advance the goals of treatment.

"Patients communicate their wishes, fears, and longings to us in all sorts of ways that are not verbal and not conscious," said Tamara Feldman, PsyD, a clinical psychologist who practices individual and couples therapy in Wellesley,

Massachusetts, and has published on countertransference. "Tuning in to countertransference—the feelings you experience with and about the patient—is essential to truly understanding them."

CE CREDITS: 1

Learning objectives

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

- 1 Define countertransference and describe how it may show up during therapy.
- 2 Explain how to identify countertransference and what factors prepare therapists to navigate it successfully.
- 3 Discuss when and how to address countertransference with patients, including when to seek consultation from a peer or supervisor.

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Understanding countertransference

In the psychoanalytic tradition, countertransference is best defined in relation to transference, a patient's unconscious projection of feelings about other people in their life (such as a parent or spouse) onto the therapist. The mirror of transference, countertransference describes the therapist's resulting feelings, thoughts, and reactions, which relate to their own experiences and triggers. Psychoanalysts view both as key tools in the therapeutic process, offering a window into the patient's inner self and relationships that often transcends what is spoken aloud in session.

In other forms of therapy, countertransference describes any feelings and reactions of the therapist toward the patient. That may include everything from anger, dread, or excitement to distraction and boredom. One

example: When a longtime patient of Lind Seal's continued to avoid social gatherings that he had originally decided to attend, after they had worked together for years on managing loneliness, she noticed she felt frustrated.

"I realized I was becoming irritated in a way that I imagined other people in his life had also become irritated with him," she said.

Countertransference can also manifest as positive feelings toward a patient, such as a maternal or protective instinct, said Janina Fisher, PhD, a licensed clinical psychologist and trainer of clinicians who delivers trauma-focused treatments. Though less often seen as problematic, these feelings are important to recognize, she said, because they can compromise a therapist's boundaries and objectivity.

While countertransference can arise in any form of therapy, not all practitioners are equally prepared to handle it. Training differs widely between graduate programs, courses, and supervisors. Research suggests that therapists trained in certain theoretical orientations, such as psychodynamic therapy compared to cognitive behavioral therapy, are more likely to expect and attend to countertransference during sessions. That is due in part to the strong emphasis psychodynamic training places on a therapist's emotional awareness as a tool for understanding the therapeutic relationship (Gordon, R. M., et al., *Clinical Psychology & Psychotherapy*, Vol. 23, No. 3, 2016).

Engaging countertransference

Unexamined countertransference can lead to missed opportunities to help a patient or—even worse—replicate the harmful dynamics that led them to therapy in the first place.

In a series of meta-analyses conducted between 2001 and 2018, psychologists Jeffrey Hayes, PhD, and Charles Gelso, PhD, explored what happens when therapists react behaviorally to feelings of countertransference, such as scolding a patient after feeling personally attacked. They found that patients had worse outcomes when their therapist showed more behavioral reactions toward them, compared with when the

therapist reacted less. But several therapist traits, including self-awareness and anxiety management, were associated with fewer countertransference reactions and better patient outcomes (*Psychotherapy*, Vol. 55, No. 4, 2018).

"The good news is that we don't have to be perfect," said Hayes, a professor of education and psychology at Penn State University. "We can be human, we can make mistakes, and all hope is not lost when we manifest countertransference behavior."

Early psychologists saw countertransference as a sign that the psychoanalyst needed more therapy. "But the idea that a therapist could maintain a benign, physician-like attitude all the time with all patients has not been clinically supported," said Nancy McWilliams, PhD, who has published extensively on psychoanalysis and has a private practice in Lambertville, New Jersey.

Instead, countertransference is increasingly seen as a process co-created by therapist and patient—a unique dyad with its own dynamics. That relational perspective informs psychologists' recommendations for identifying and addressing it.

Managing countertransference

To determine whether countertransference is at play with a given patient, Lind Seal suggests a series of questions for therapists to explore. During a session, do you feel irritated? Bored? Anxious? Surprisingly sad? Is this a feeling you have often, or is it limited to sessions with this particular patient?

"If the feeling is uncharacteristic and the exact trigger is not immediately obvious, that's the time to really investigate what's happening inside yourself," Lind Seal said.

Consider, for example, a female trainee treating an older male patient, said Beatriz Palma, PhD, a staff psychologist and groups coordinator at

KEY POINTS

- 1 Countertransference, a therapist's emotional and cognitive reactions to a patient, can arise in any form of psychotherapy.
- 2 Self-awareness, emotion regulation skills, and clear internal boundaries can help therapists navigate thoughts and feelings that arise when working with a patient.
- 3 Countertransference can offer powerful insights about a patient, which can deepen therapeutic work.

the University of Virginia's Counseling and Psychological Services (CAPS) who has done research and trained extensively in countertransference and how to manage it. The trainee, who comes from a culture with strong patriarchal norms and respect for authority figures, has become increasingly agreeable with the patient, keeping quiet during sessions and challenging him less than her other patients.

"In supervision, the trainee can explore where those behaviors stem from, any fears about what might happen if she 'rocks the boat,' and whether and how the dynamic should be discussed with the patient," Palma said.

Research by Hayes, Gelso, and others has helped identify a series of factors that can prepare therapists to navigate countertransference when it arises. First and foremost is self-awareness.

"Be in your own therapy, with the aim of knowing as much about yourself as possible, including what

buttons are pressed for you with different kinds of patients,” said Joyce Slochower, PhD, a private practitioner, professor emerita of psychology at the City University of New York, and faculty member at New York University’s postdoctoral program in psychotherapy and psychoanalysis. For example, if you know you tend to become more active when a patient behaves passively, you can more quickly realize when that occurs in a session, Palma said. That, in turn, can help illuminate the client’s own dynamics.

Strong emotion regulation skills, including those developed through mindfulness meditation, have also been shown to reduce

countertransference reactions among therapists (Hayes, J. A., et al., *Psychotherapy*, Vol. 55, No. 4, 2018). Palma suggests grounding techniques (sensing your feet on the floor, taking a deep breath before responding) and cognitive strategies (“this is just a thought”) to help manage intense reactions (including emotions, thoughts, and somatic responses), in the moment. These approaches help therapists pause and create space so that internal reactions do not translate into external behaviors.

A firm understanding of appropriate boundaries and self-disclosure is also key. If a therapist experiences countertransference, they may

sometimes react impulsively—for instance, by sharing personal information to explain or justify their feelings. While self-disclosure can be helpful in certain contexts, it is not always the best solution. For example, a therapist might disclose their trauma history in hopes of building rapport with a patient. But if that disclosure is driven by the therapist’s own emotional needs, it can shift focus away from the patient’s experience. A 2018 study found that when therapist self-disclosure was unsuccessful, it was usually preceded by a countertransference reaction (Pinto-Coelho, K. G., et al., *Journal of Counseling Psychology*, Vol. 65, No. 4, 2018).

Countertransference can also manifest as positive feelings toward a patient, such as a maternal or protective instinct. While not problematic, these feelings are equally important to recognize so that they do not compromise objectivity.



MASKOTS/GETTY IMAGES

Lind Seal's advice: When in doubt, sit quietly.

"If you're very activated, it's probably a good general rule not to do anything right in the moment," McWilliams said.

When and how to respond

The art of managing countertransference lies in knowing whether, when, and how to address it with a patient. The choice between expressing or containing, Slochower said, requires drawing on your clinical judgment. Is this person capable of hearing how you see them? What are the chances they might shut down, leave, or otherwise suffer?

"Sometimes, you really have to name the elephant in the room," Slochower said. "Other times, you just have to make space for the patient and wait for another moment to name what you see."

Small self-disclosures can move therapy along for some patients, said McWilliams, such as a therapist who says: "I find myself to be really sad as you talk, and yet you don't seem to be processing any sadness."

A more direct challenge, in the case of Lind Seal's patient who skipped multiple social opportunities despite his loneliness, might sound something like this: "I'm feeling like you've got a lot of excuses here, and I wonder if other people might feel the same. What do you think?"

Offering a forewarning can help soften the blow of a hard-to-hear statement. Slochower sometimes starts by noting, "I'm going to say something you're not going to like."

Using language that emphasizes therapy as a two-person process is another way to make such statements more palatable. For example: "It feels like we're in a place where there's temporarily a loss of hope" or "It feels like

there's a lot of irritation between us right now."

"Sometimes when you talk about countertransference in a two-person way, it's easier for the patient to sign on to," McWilliams said.

With a patient who was repeatedly angry and devaluing, Fisher found herself thinking, "No matter how hard I try, I can never please her." The thought brought to mind her relationship with her mother—and helped her snap out of a countertransference reaction: She had been walking on eggshells.

"I realized: I'm the little kid trying to please my mother, and there's no therapist in the therapy room," Fisher said.

It took a few tries to find an approach that worked. One day,

when Fisher did not respond to an angry remark, the patient demanded, "What's wrong with you?" Fisher closed her eyes and noticed her internal experience—she felt shaky and worried about saying the wrong thing. She then opened her eyes and shared that with the patient, who seemed surprised and apologized for causing anxiety. Processing the countertransference together ultimately deepened their relationship, Fisher said.

In certain situations, therapists should pause and consider seeking consultation before addressing a countertransference, such as if they feel a temporary hatred or futility toward a patient or if they are feeling very activated emotionally, McWilliams said. Disclosing sexual attraction or

In moments of uncertainty, it is often best to remain still. Pausing can allow for clarity and time to examine feelings and investigate reactions before responding.



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Clinical psychologist in Wellesley, Massachusetts

fantasies about a patient may need to be addressed in a general way, such as: “Do you feel like there’s a sexualization of the atmosphere between us?”

Caution is also warranted when patients have a history of trauma, Fisher said. Classic psychodynamic approaches to transference and countertransference may not work with these patients, who can interpret a pointed observation as a rejection or be triggered by the high degree of intimacy.

“Transference and countertransference work is very intimate,” Fisher said. “That’s complicated with trauma survivors, who were often abused by the people they were closest to. The closeness, although they yearn for it, can be triggering.”

New perspectives

Countertransference is not something therapists study once and master. Reviewing new clinical research and seeking support from colleagues can help midcareer psychologists sharpen their skills and deepen their impact.

Research by Hayes suggests that reflective practice, a system for exploring and improving one’s actions, offers a helpful framework for approaching countertransference. It involves therapists reflecting on their own thoughts, feelings, sensations, and behaviors during and after a session; forming and testing hypotheses about their underlying causes; and testing and evaluating potential solutions with patients. A preliminary test with trainees in Australia and New Zealand found that

engaging in reflective practice helped trainees think more critically about the causes and consequences of their countertransference reactions, as well as how to manage them (*Australian Psychologist*, Vol. 56, No. 2, 2021). Hayes is now conducting a follow-up study at Penn State that includes data on patient outcomes.

Feldman, who works with families and couples, has also studied new ways of looking at countertransference. A therapist’s attitudes toward “important others” in the patient’s life—anger at an insensitive spouse, for example—can also interfere with the therapeutic process (*Psychoanalytic Psychology*, Vol. 41, No. 2, 2024).

“When a therapist finds themselves feeling a particular way about a person in the patient’s life, we should think about that as countertransference, too,” Feldman said.

At any career stage, seeking support is key in dealing with countertransference. Join a peer supervision group, go for supervisory consults, or talk with a friend in the field, Slochower suggests.

“The challenge never goes away,” McWilliams said. “You always need people you can reach out to, preferably somebody who knows you very well and knows what soft parts of you have been activated.”

Self-care in whatever form works for you, be it socializing with friends, spending time in nature, or listening to music, should not be neglected. Hayes suggests reading *Leaving It at the Office*, a guide to self-care for therapists that covers sleep, diet, exercise,

leisure, managing a difficult case-load, and more.

“A lot of experienced therapists say they know this—but how often are we actually doing it? It’s a question we need to be honest about,” said Hayes. Forgoing sleep and downtime may feel like a necessary sacrifice for patients in need. But that sacrifice can undermine a therapist’s ability to stay emotionally regulated, making countertransference harder to manage.

“We need to remember that we are role models for our patients in terms of mental health,” Hayes said. “It’s hard to take care of other people if we’re not taking care of ourselves.” ■

RESOURCES

APA psychotherapy video series: Countertransference
Hayes, J. A.
APA, 2023

Countertransference: A foundation of psychotherapy
Corpuel, J. H.
In O’Donohue, W., & Graybar, S. R. (Eds.), *Handbook of contemporary psychotherapy*
Sage Publications, 2009

Countertransference and the therapist’s inner experience: Perils and possibilities
Gelso, C. J., & Hayes, J. A.
Lawrence Erlbaum Associates Publishers, 2007

An introduction to countertransference
Cartwright, C.
Sage Publications, 2022

The analyst’s vulnerability: Impact on theory and practice
Maroda, K. J.
Routledge, 2022

Navigating thorny topics in therapy
Abrams, Z.
Monitor on Psychology,
March 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.

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