

CE

CONTINUING EDUCATION TREATING CHALLENGING COUPLES CASES

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Forming and maintaining mutually satisfying relationships is challenging, and divorce rates show that humans are not that great at it. However, psychological science is helping to identify unreconcilable trouble spots as well as ways to heal relationship fractures.

CE credits: 1

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

1. Describe the best evidence-based treatments for addressing couple issues in therapy.
2. Identify common types of challenging couple cases and ways of treating them.
3. Discuss optimal training levels in couples therapy, how to receive such training, and gaps in the field.

For more information on earning CE credit for this article, go to www.apa.org/ed/ce/resources/ce-corner.

Evidence-based modalities are extremely effective in treating couples, according to psychologists who specialize in such treatment. In fact, 70% of couples report positive effects of counseling (Lebow, J. L., et al., *Journal of Marital and Family Therapy*, Vol. 38, No. 1, 2012), though those rates vary depending on the type of couples therapy provided, how often research is conducted on the modality, and whether the therapy is delivered by a specialist or a generalist, for example (Lebow, J., & Snyder, D. K., *Family Process*, Vol. 61, No. 4, 2022).

But good outcomes depend on good training, and there aren't enough well-trained providers to go around, said Terence Patterson, EdD, ABPP, a couple and family psychologist in San Francisco and coauthor of *Real-World Couple Counseling and Therapy: An Introductory Guide* (Cognella, 2020). At best, most psychology graduate programs give only cursory attention to family, couple, and systems therapy, and even marriage and family therapists may not get adequately trained in couple work, he and others said.

To become competent in the area, it is important to seek out specialized training for evidence-based modalities such as behavioral couples therapy, cognitive behavioral couples therapy, emotionally focused therapy, and integrative behavioral couples therapy (Doss, B. D., et al., *Journal of Marital and Family Therapy*, Vol. 48, No. 1, 2022). Few or no programs currently offer full, sequential training in couples therapy, but psychologists can access relevant trainings by contacting APA Div. 43 (Society

for Couple & Family Psychology), through relevant APA CE presentations, and through institutions that feature these trainings (see Training Resources for more). The most comprehensive credential in the area is board certification in couple and family psychology, which offers both standard and senior levels of certification; to qualify, psychologists must meet certain training and supervision criteria and pass an exam, Patterson explained.

TREATMENT BASICS

Many couple psychologists use a particular theoretical orientation in their couple work—say, cognitive behavioral therapy or existential therapy—but are trained in various couple methodologies and are flexible in their approach. Good couple therapists use approaches that best fit the patient rather than the other way around, Patterson said.

To this end, he and others cite several universal strategies that can help with most couple issues that you might find yourself working with, including the most challenging cases:

- **Assess first.** Patterson always begins with a comprehensive initial assessment, which takes place in the first two to three sessions. After asking about the couple's stated goals for treatment, providers can use standardized measures or interview the couple to learn about the systemic context and "ecology" of the relationship—for example, how partners solve problems together, whether they communicate clearly, whether they share joint responsibilities, and the degree to

which they accept their partner as they are. The aim, Patterson said, is to improve on these areas as treatment progresses.

It is also important at the beginning to develop a clear idea of what you see as the main treatment issues and how you plan to address them, said Corinne Datchi, PhD, ABPP, a couple psychologist, professor of psychology at William Paterson University in Wayne, New Jersey, and coauthor of *Integrative Couple and Family Therapies: Treatment Models for Complex Clinical Issues* (APA, 2019). “It’s really important to be clear about what principles and concepts inform your understanding of what is happening in a couple relationship,” she said.

■ **Use a relational lens.** It may be self-evident, but couple work is primarily about helping couples effectively manage the challenges of everyday life rather than addressing each person’s well-being—though that is often a side benefit.

“I look at each individual, but also at the connection between them,” said Jerrold Lee Shapiro, PhD, a psychology professor at Santa Clara University and coauthor with Patterson of *Real-World Couple Counseling and Therapy*. “And I know that the best changes will occur if I can work with the couple as a unit as opposed to the two individuals.” To this end, he helps couples think and behave as a team; he is also guided by an existential framework that focuses on what gives

meaning to the couple, what helps them develop greater intimacy, and how they can balance the tension between the need for safety and security and the need for freedom, individuation, and adventure.

■ **Look beneath communication problems.** Communication is often considered the factor that couples need to work on the most. But poor communication often masks other major issues such as unsolvable problems, unresolved resentments, age-old baggage, money problems, competition, trauma, or opposing values or views. Therefore, besides helping couples develop better joint communication, it is important to probe what lies beneath murky communication patterns, Shapiro said. For example, when people carry a long-standing resentment of their partner, it may actually be a way to avoid becoming too intimate—a common issue for couples.

■ **Be self-aware.** Be honest with yourself about your biases and how they may impede good treatment, as well as about areas where you need better education, including in cultural competence, these experts noted. At the same time, remember that all people are unique: Just because someone is lesbian, Native American, cisgender, or other does not mean that they fully represent that particular group, Datchi

noted. “When we put people in categories, we fail to understand them,” she said. “Their experience of being gay, Black, or other may be very different from another person who may be part of the same category.

“The most important thing is to be curious, humble, and ask questions,” Datchi added. “Assume that you don’t know anything about their unique experiences, formulate hypotheses that you can share with the couple, and invite them to verify that these hypotheses are good representations of their unique experiences.”

■ **Learn the best intervention techniques.** There is a wide range of techniques that are useful in couples therapy situations, including tailored versions of tools psychologists use in individual therapy. Among these are **psychoeducation**—for example, teaching partners about negative communication styles and how to shift them when they arise; **training in skills** such as listening, emotion regulation, and taking time outs to manage conflict; and **therapeutic amazement**—expressing seemingly innocent confusion over a partner’s contradictory messages on a given topic. Let’s say one person claims to want to be closer to their partner but is not taking



steps to do that. “The therapist might say something like ‘I am confused—help me understand. Earlier you said you wanted more intimate connection, and now you say you prefer reading to sharing a meal or a bedtime. Can you help me put those together?’” Shapiro explained.

Other techniques include helping couples create firm but flexible boundaries to protect the relationship, avoiding triangulation with third parties, such as in-laws, by prioritizing communication within the couple first and guiding couples to understand each other’s vulnerabilities so they have a better sense of what might set their partner off.

“If someone pokes at their partner’s vulnerability without realizing it, it’s going to produce some kind of negative reaction,” said Jay L. Lebow, PhD, ABPP, a clinical psychology professor at Northwestern University and coeditor of *Clinical Handbook of Couple Therapy*, 6th edition (Guilford, 2023). “Therapists can guide couples to understand possible triggers and then help partners take a step back and notice when they’ve engaged their partner’s vulnerabilities.”

■ Consider follow-up sessions.

It is always the couple’s decision whether to continue therapy, and often therapists do not know what happens once a couple leaves their office. But if a couple requests follow-up sessions, go for it, said Shapiro. One couple that managed to elude divorce now checks in regularly with him “for an oil and lube change,” as they put it to Shapiro—something they have been doing for 35 years.

COMPLEX CASES

All of these suggestions pertain to any couple, but added interventions are sometimes needed with couples who have more specialized, complex, or serious issues. Here are examples of such cases and some ways of treating them:

■ **High-problem pairings.** Some couples enter therapy with extremely serious issues such as domestic violence, addiction, or severe psychopathology. In such cases, Patterson takes time during the initial assessment to get an idea of how intractable the problem is, which may entail seeing each partner individually for two or three sessions.

If he determines that the issue is serious enough—for example, that a home is unsafe for one of the partners or that a person’s addiction or manipulative

KEY POINTS

1

Challenging couple cases include those with (a) partners of diverse cultural, ethnic, or religious backgrounds; (b) high-conflict couples; (c) couples with an abusing partner; and (d) so-called mixed-agenda couples, where one couple is committed to the relationship but the other is ambivalent.

2

While couple cases are as individual as couples themselves, there are common modalities that can help most couples improve or make clearer decisions about their relationship.

3

Helpful interventions include behavioral couples therapy, cognitive behavioral couples therapy, emotionally focused therapy, and integrative behavioral couples therapy.

behavior prevents them from being able to meaningfully communicate with their partner or with him—he refers them to individual treatment for those issues. He also tells couples they are free to return to him if the partner has received enough treatment to curb their tendency to abuse their partner or has entered Alcoholics Anonymous and undergone rehab, for example.

The bottom line? “If the problem seems like it will prevent successful couples therapy, it doesn’t make sense for me to take on those cases,” Patterson explained. “The only way that couples therapy can work is if both partners can take responsibility for their own beliefs and behaviors and offer their partner trust that they will do their part.”

■ **High-conflict couples.** Other challenging cases that sometimes overlap with high-problem cases are couples who are locked in extremely negative relational patterns, including those who argue incessantly or who have entered a long-term cold war.

Many of these couples fall into communication patterns that University of Washington professor emeritus and couple researcher John Gottman, PhD, has found predict divorce: defensiveness, stonewalling, withdrawal, and

criticism—what he calls “the four horsemen [of the relationship apocalypse].”

When Datchi sees couples whose main communication style is arguing, “I have to be very present and very active so I don’t let them reenact their usual patterns in the room,” she said. When they enter a fight, she acknowledges their frustration, anger, and hurt, then firmly puts a halt to the problematic behaviors, saying something such as, “You are putting your gloves on as if you are about to go into the boxing ring and start punching each other. Let’s try something different.” Once they calm down, she works with them on ways to communicate their differences with greater respect and attentiveness.

Another helpful tool is teaching these couples de-escalation techniques that can help them pause in the middle of an argument and become aware of their emotions and bodily sensations before they lose control. Psychoeducation, too, can be extremely helpful in helping people understand and identify their negative communication patterns, Datchi said.

Again, if such patterns are entrenched, it may be time to refer each partner for individual therapy in relevant areas such as anger management or meditation techniques, Patterson added.

He also underscored that some of these couples may be past the point of no return. “Characterologically, some people have never developed the ability to listen carefully to someone without being defensive or arguing or stonewalling,” he said. In such cases, he acknowledges that there is little that he can do to





FURTHER READING

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Gordon, K. C.
Family Process, 2023

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Smoliak, O., et al.
Family Process, 2023

A qualitative meta- analysis exploring client-reported outcomes of couple therapy

O'Malley, R., et al.
Psychotherapy, 2023

Specialty competencies in couple and family psychology

Stanton, M., &
Welsh, R.
Oxford, 2011

help and offers them assistance in deciding whether to stay together or to separate.

■ **Couples with cultural, ethnic, or religious differences.** More couples are entering therapy who have significant cultural, religious, ethnic, or racial differences or are at varying levels of acculturation. In Shapiro's experience, such couples often have opposing life ideals: The more acculturated person may be focused on individuation—on personal growth, independence, and external success, for example—and the other on nurturing and maintaining family harmony.

Shapiro uses his existential framework to help such couples achieve a better balance between security and adventure, family harmony and individual growth. An example is a heterosexual couple he treated: an East Indian man and a Jewish American woman. They were happily married except for one feature: When the man's parents visited from India, they stayed for several months, which drove the woman crazy.

In therapy discussions, they emerged with a solution that honored the man's need for family harmony and the woman's need for more space. On some weekends, the couple would leave for a couples-only trip, and the grandparents stayed home to enjoy a weekend with their grandkids. "What's needed sometimes is not major life changes, but a push to experiment with small, new freedoms," as Shapiro put it.

Religious differences can also pose therapeutic challenges, especially if the couple's value systems are at odds. Shapiro and

Patterson consulted together in a case where both partners belonged to the same fundamentalist religious group, but the woman was questioning some of its tenets, including a strong prohibition against sex before marriage.

The issue came to a head when the couple was sharing intimate physical time, some of which was tacitly allowed by the group. As they grew physically closer, though, the woman wanted to continue, but the man pulled back.

In therapy, the woman said the man's actions made her feel unattractive and rejected. While the man said he loved and was attracted to her, he thought it was more important to follow the religion's rules. Shapiro and Patterson then used a technique that helps people think more clearly about big-picture issues by projecting given scenarios into the future. Asking how they would feel about their children attending a religious school, for example, the man said it was mandatory, and the woman said she would be open to a different approach.

This querying helped the couple become clear that they were on different paths, and they decided to separate. While disappointing, "it was probably exactly what they needed to do," Patterson said (Shapiro and Patterson discuss this case at greater length in an APA webinar).

■ **Financially troubled couples.** Financial issues are not a big

TRAINING RESOURCES

■ **APA Div. 43 (Society for Couple & Family Psychology)**
www.apadivisions.org/division-43

■ **APA CE programs on families and couples**
www.apa.org/education-career/ce/topic?query=cetopic:Families+and+Couples

■ **American Academy of Couple and Family Psychology**
<https://americanacademyofcoupleandfamilypsychology.org/>

■ **Emotionally focused therapy**
<https://iceeft.com/therapist-training/>

■ **Integrative behavioral couples therapy**
<https://ibct.psych.ucla.edu>

■ **Cognitive-behavioral couples therapy**
100-hour video training with Arthur Freeman, EdD
www.apa.org/pubs/videos/4310765#:~:text=Description,Dr.

■ **Behavioral couples therapy**
www.recoveryanswers.org/resource/behavioral-couples-therapy/

emphasis in couples therapy training, but they probably should be: They are a common and often thorny source of couple problems, couple practitioners noted.

Ashley Quamme, LMFT, a couple therapist and certified financial therapist-practitioner in Evans, Georgia, has been trained to understand the psychological patterns that underlie financial difficulties and conflicts. She uses her understanding to help couples address their money conflicts and refer them for financial guidance as needed.

Tom and Helen (real names withheld to protect privacy) are a case in point. The couple was having difficulty moving from one house to a new one: Their current home was Tom's from a previous marriage, and Helen wanted a fresh start. But every time they neared action, Tom stalled, suggesting that he and Helen create a new budget and timeline for the house-seeking process. That did not please Helen, who responded by criticizing Tom and withdrawing from him emotionally and sexually. As Quamme talked with the

couple, it became clear that Tom's behavior stemmed from deep financial insecurity, the result of growing up with a single mom and never having enough. In turn, Helen's reactions stemmed from an earlier marriage to a man who had been unfaithful and untrustworthy. Quamme helped them identify and discuss those patterns, which eventually helped them catch themselves in real time as those cycles occurred. "They were able to really learn and name those positions and understand when each of them would cue or trigger the other," she said.

The couple worked on these issues for about a year, and on Quamme's suggestion, eventually visited a financial planner. The planner helped to allay Tom's fears about their finances, confirming that they could afford the move and even benefit from it financially. Meanwhile, the therapy helped Helen to better understand and empathize with Tom, which helped improve their relationship. The result was a new home, though "there were a lot of arguments around how big the house should be," said Quamme with a chuckle.

■ **"Mixed-agenda" couples.** The so-called mixed-agenda couple, where one person is committed to maintaining the relationship and the other has one foot out the door, is another challenging—and common—couple case.

Traditional couple counseling does not seem to help these pairs, largely because the "leaning out" partner is ambivalent about staying in the relationship and hence may sabotage counseling efforts, said William J. Doherty, PhD, a professor in the couple and family therapy specialization at the University of Minnesota in St. Paul and author of *Helping Couples on the Brink of Divorce: Discernment Counseling for Troubled Relationships* (APA, 2017), cowritten with Steven M. Harris, PhD.

Seeing these problems, Doherty has developed a short-term mode of assessment called "discernment counseling" designed to help these couples make a clear decision on the direction of their relationship.

The assessment lasts for a maximum of five sessions, with couples deciding at the end of each session whether to attend the next one or stop. Each session follows the same template: The partners first meet together with the therapist then break off to meet with the therapist individually while the other one waits. At the end of the session, they come together again to summarize what they have discussed in the individual meetings. Besides helping the "leaning out" person clarify negative feelings about the relationship, the work helps both partners examine how they may have contributed to

problems in the relationship, which helps them develop a more nuanced, realistic, and compassionate look at one another, Doherty said.

At the end of the work, couples choose one of three directions: maintaining the status quo (not getting divorced and not continuing therapy), separating or divorcing, or committing to at least 6 months of couples therapy. If they choose therapy, they create a clear agenda of what they are going to work on in themselves. During that time, they are asked to agree that divorce is off the table, which helps to relieve the pressure of a decision, Doherty noted. The methodology has proven highly effective and is now being taught in workshops around the country.

Patterson, who uses the discernment approach in his work, as well, added that good couples therapy is not about saving couples per se but about helping some couples to improve their relationship, and others to clarify their need to separate or divorce. And if those who decide to part have children, it is also about guiding them on how to successfully coparent for the rest of their lives, he said.

"Besides improving the couple relationship, I'd say a main goal is to improve each person's mental health, now and in the future—to help them proceed in their lives with what they've learned." ■



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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