

BEHAVIORAL PSYCHOLOGY EDUCATION & TRAINING GUIDELINES

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The Behavioral Psychology Specialty Council

Members of the Council:

**The American Board of Cognitive and Behavioral Psychology
The American Academy of Cognitive and Behavioral Psychology
The Association for Cognitive and Behavioral Therapies
Division 25 of The American Psychological Association
Association for Behavior Analysis
Behavior Analyst Certifying Board**

1. Introduction:

Behavioral psychology is an experimental-clinical approach that provides a framework for understanding and changing human behavior through modification of cognitive behaviors as well as observable behaviors. Behavioral Psychology has its origins in applications of classical and operant conditioning, social learning theory, multiple causality theory, and theories regarding constructs (e.g., schemas) that mediate behavior, including cognitive behavioral modification and cognitive therapy methods. It is empirically-based in principles of human learning and cognitive development, focusing its delivery of professional services on present problems or issues. The clinical work is active in nature and relies heavily on the natural environment as the setting for many of its clinical applications. The practice of behavioral psychology is broad in nature, including overt actions that are observable, internal cognitive phenomena (e.g., cognitions, beliefs, attitudes, and schema), and subjective and physiologic manifestations of affect.

Behavioral Psychology is a specialty that is formally recognized by the American Psychological Association. The specialty includes several distinct areas:

- Assessment of behavior through behavioral interviewing, direct observation, self-report, rating scales, functional (analog) behavioral analysis, applied behavior analysis, task analysis, role playing, skills assessment, self-monitoring of behaviors and cognitions, and informant reports and ratings.
 - Formal instruments can be used in the assessment of behavior, including instruments such as the Adaptive Behavior Scale, the Vineland Adaptive Behavior Scale, the State-Trait Anxiety Inventory, the Fear Schedule, the Behavioral Analysis History Questionnaire, the Multimodal Life History Questionnaire, the Beck Depression Inventory, the Beck Anxiety Inventory, the Integrated Functional Behavior Assessment Protocol, the Reinforcement Survey Schedule, the Childhood Autism Rating Scale, the Child Behavior Checklist and affiliated Achenbach rating scales, and the Connor's Rating scales. Additionally, Behavioral Psychologists often use personality inventories to determine indications of behavioral or cognitive problems in major clinical syndromes, such as the MMPI-2, the Personality Assessment Inventory, and the Adolescent Psychopathology Scale.
 - Behavioral observations are conducted using standardized procedures that include Antecedent-Behavior-Consequence observations, time-sampling procedures, applied behavior analysis, task analysis, and functional (analog) behavior analysis.
 - Assessment of cognitive behaviors are conducted through self-report procedures, direct observations of client utterances, or interviewing. Self-report procedures can include completions of activity reports, dysfunctional thought records, belief inventories, and schema diaries. Direct observations of client utterances typically occur in treatment sessions when techniques such as the Downward Arrow, role playing or other Socratic methods are

applied. Interviewing techniques rely on structured questioning such as the Motivational Interview methods, Beck's model for interviewing within the cognitive triad, or Ellis' method of Activating Events—Beliefs—Consequences.

- Assessment has as an outcome the case conceptualization. Case conceptualizations identify stimuli that trigger a behavior or cognitive behavior, behaviors including their frequency and duration, cognitive distortions related to maladaptive behaviors and emotional problems, rewards and punishers that shape the behaviors, the functions of behaviors, and methods for modifying behaviors or cognitions.
- Interventions used by Behavioral Psychologists have distinct components, including specific behavioral therapy techniques, applied behavior analysis techniques, and cognitive therapy techniques. , behavior therapy, cognitive-behavior therapy, and rational emotive behavior therapy.
 - Behavioral therapy techniques include anxiety induction to cause habituation (often referred to as exposure therapy), thought flooding response prevention, habit reversal, counter-conditioning, graduated exposure therapy, stress inoculation, relaxation therapy and behavior marital therapy.
 - Applied behavior analysis techniques include environmental modifications, stimulus control, differential reinforcement protocols, generalization techniques, manipulation of rewards and punishers, prompting and prompt fading, skills development, and reinforcement thinning.
 - Cognitive therapy techniques include psycho-education on the role of cognitive distortions, activity scheduling, classification of cognitive distortions, paradoxical acceptance, correction of cognitive distortions, self-control techniques, problem solving, pros-cons analysis, guided imaging, modification of beliefs, personal narrative modification and cognitive therapy of couples.
 - Cognitive-behavioral techniques include combinations of several of the techniques already mentioned, including interventions such as Mastery of Anxiety

and Worry, Mastery of Panic, Dialectic Behavior Therapy, and Exposure Response Prevention therapy.

- Rational emotive behavior therapy techniques include use of A-B-C forms, disputation of ideas, and confrontation of irrational beliefs.
- An additional component, evaluative feedback, is included in the interventions of Behavioral Psychology in order to empirically base the services. Typically, sessions or intervention periods will include assessment of the effects of the previous interventions. Methods for conducting these on-going assessments include multiple-baseline designs, withdrawal designs, weekly mood ratings, use of Subjective Units of Distress Scale ratings (SUDS), or daily ratings of treatment goals and outcomes (e.g., daily ratings of anxiety during an exposure and response prevention technique for OCD). Failures to progress typically result in modification of the case conceptualization, the treatment strategies, or both.
- Consultations in behavioral psychology employ the principles and techniques already identified, often delivered to schools, community agencies, hospitals, and business organizations. Families also are identified for consultations, particularly when child behaviors are the target of intervention; and methods for families include psychoeducational and skills training for parents. Schools and community agencies often received behavioral consultations to foster the development of behavioral modification programs or skills development with students who are developmentally disabled.
- Supervision of staff or trainees is directed toward specific skills development and management of one's own schema activations. Using the supervisor as a modeling role, the supervision both identifies problematic behaviors or cognitions in the supervisee as well as provides goal-based skills development instruction. Identification of training goals is done through task-analytic techniques using comparisons to existing treatment models, and supervision trains through modeling, reinforcement, and performance-based outcome measures.

- Research and Inquiry is a hallmark of Behavioral Psychology. Validated interventions are considered the standard treatment protocols whenever available. Assessment and case conceptualization are informed by validated instruments, standardized strategies, and epidemiological research. Interventions rely both on group research as well as single case studies and ethnographic studies.
- Consumer Protection is accomplished through two mechanisms. First, Behavioral Psychology relies as much as possible on validated or empirically based interventions, leading to interventions that are guided by well-informed decision making. Second, Behavioral Psychology emphasizes constant evaluation of the efficacy of interventions within each case—promoting accountability in the delivery of services.
- Professional Development is a required component of those specializing in Behavioral Psychology. CE workshops are made available through the APA, AABT, ABA, and other organizations that target specific behavioral assessment strategies, behavioral interventions, and refinements of theory. In addition, Practice Guidelines are under development to augment ethics codes and jurisdictional regulations so that Behavioral Psychologists will be best informed on the use of their skills.

2. Training Goals:

The goals for training in Behavioral Psychology are captured under the general goal of developing specialized competencies in the application of Behavioral Psychological principles to behavioral and emotional disorders in humans.

The specific goals are:

- Development of competency in theories underpinning behavioral interventions, cognitive interventions, cognitive-behavioral interventions, rational emotive behavioral interventions, and applied behavior analysis.

- Development of competencies in the application of one or more of the areas within Behavioral Psychology to the assessment of presenting problems from patients, clients, or organizations.
- Development of competencies in the application of one or more of the area within Behavioral Psychology to the conceptualization of cases and planning of interventions.
- Development of competencies in the application of one or more of the area within Behavioral Psychology to the delivery of interventions that are based on empirical evidence.
- Development of competencies in the application of one or more of the area within Behavioral Psychology to the evaluation of the effects of interventions and the factors promoting or detracting from effectiveness.

3. Assumptions

The assumptions upon which the post-doctoral education and training in Behavioral Psychology are:

- Intervention into the problems of humans, couples, systems, and organizations can be effective if delivered in an active and direct manner using the principles of learning and behavior.
- The most readily available targets for intervention are those that are in the present and most readily observable.
- Modification of behaviors and cognitive behaviors can be done through techniques that rely on 1) direct intervention, 2) collaboration with the client or patient, and 3) psycho-educational and capacity building strategies.
- Assessment and intervention should be carried out within empirically-based or validated strategies.
- Interventions should follow a prescribed plan that was derived from assessment data and resulting case conceptualizations.
- Interventions should be regularly assessed for effectiveness throughout their delivery.

4. Entrance Criteria:

There are two criteria for entrance to post-doctoral residency programs in Behavioral Psychology:

1. Completion of all requirements for a doctoral degree in professional psychology from a program accredited by an accrediting body recognized by the Council on Post-Secondary Accreditation (APA Committee on Accreditation), or in Canada, accredited by the CPA Accreditation Committee. While not required, preference should be given to those degrees from institutions offering pre-doctoral programs with a behavioral or cognitive emphasis.
2. Completion of an internship in professional psychology accredited by an accrediting body recognized by the Council on Post-Secondary Accreditation (APA Committee on Accreditation), or in Canada, accredited by the CPA Accreditation Committee, or an equivalent experience accepted by a state or provincial board of psychology as meeting the criteria for at least one year of supervised internship-level training in professional psychology. The internship should evidence specific experiences in one or more of the areas of applied behavior analysis, behavioral therapy, cognitive therapy, cognitive-behavioral therapy, or rational emotive behavior therapy.

5. Length of Training:

The minimum length of post-doctoral training is one year. Training periods of two or three years are encouraged, particularly in settings where research is emphasized.

6. Overall Curriculum Model:

A. Clinical

For residents who will have a clinical component to their training, the overall curriculum is based on three types of teaching methods: supervised clinical work, seminars and course work. As is the case

with most clinical post-doctoral residencies, the majority of training will be through supervised clinical experience. The specific content of clinical work, seminars, and coursework may vary with specific programs since variations in the resources of training centers preclude a standardized list of what can be made available to students. However, the minimal expectations for training in each of these areas are outlined in this document. In addition, inherent in the clinical training model is that training is the purpose of the residency and should not be compromised by either excessive service or research demands.

The use of existing standards for assessment, treatment and consultation should be used to create the clinical training. For example, the use of standardized and objective assessment methods should be required as well as the development of case conceptualizations based on those assessment results. Treatments should have a grounding in existing empirically validated or well researched methods, so that the curriculum teaches these intervention methods and how to apply them in real-world clinical settings. Consultations should be delivered within existing consultation models, and the curriculum should use these models as the basis for instruction and training.

B. Academic

For psychologists who will not be training for a potential clinical position in behavioral psychology, the supervised clinical work component of the program will be omitted. Although, such trainees will likely be involved primarily in a scholarly pursuit to the field of behavioral psychology, the seminars and coursework to be described will also be relevant to their training.

7. Practica and Clinical Work:

A. Supervision

The post-doctoral residency setting has a designated Behavioral Psychologist who is clearly responsible for the integrity and quality of the training program, who has administrative authority commensurate with those responsibilities, and who is licensed as a psychologist in the jurisdiction where the program exists. This

director has expertise in behavioral psychology as reflected by credentials of excellence such as the American Board of Professional Psychology diploma, status as a fellow in APA or CPA, certification through the Behavior Analyst Certification Board®, certification through the Academy of Cognitive Therapy, an extensive record of active research productivity, or other clear evidence of professional competence and leadership.

The program has sufficient staff with demonstrated competence in the area(s) of training in Behavioral Psychology provided to meet the goals of the program, including two or more psychologists, both of whom are licensed in the jurisdiction of the program and have demonstrated expertise in Behavioral Psychology. The program strives to provide diversity in its professional role models.

The post-doctoral program includes a minimum of two hours per week of regularly scheduled, face-to-face individual supervision by licensed psychologist(s) with the specific intent of dealing with Behavioral Psychological services rendered directly by the resident. There are also at least two additional hours of supervision per week in professional learning activities such as: supervised case conferences including cases in which the resident is activity involved; seminars dealing with professional issues; co-therapy with a staff person, including discussion; group supervision; additional individual supervision; and mentorship.

Primary supervision is provided on-site by licensed psychologists who have expertise Behavioral Psychology and who have professional responsibility for the psychological services given by the resident. Supervision includes attention to the diversity of the populations served. Each resident has a minimum of two supervisors per residency year. Supervisors are available, or make appropriate provision, for emergency consultation and intervention.

Supervisors facilitate the growth of their residents' professional responsibility. Along with residents, supervisors have ethical and regulatory responsibility for the psychological services their residents provide.

To enrich and expand the post-doctoral training experience, post-doctoral residency programs are encouraged to include

professionals from the practice and scientific community as an integral part of the program. Whenever warranted, these professionals are accorded appropriate status and responsibilities.

The nature and structure of the supervision are discussed by the supervisee and supervisor early in the program. Opportunities are made available for further discussion of the supervisory arrangement in accordance with the professional maturation of the resident.

B. Client Populations

Behavioral Psychology emphasizes work with persons with mental disorders, behavioral disorders, or developmental disorders. The training should target one or more distinct types of clients: children, adolescents, adults, or couples. Trainees are expected to engage in clinical work with a client groups that represent a variety of clinical problems such as those indicated below.

Generalized Anxiety Disorder

Panic Disorder

Obsessive-Compulsive Disorder

Phobias, both specific and social

Depression

Dysthymia

Behavioral Disorders including ADHD and Oppositional
Defiant Disorder

Childhood Disorders (e.g., enuresis, academic disfunction)

Autism or Autism Spectrum Disorders

Mental Retardation and Developmental Disabilities

Personality Disorders

Impulse Control Disorders, including Habit Disorders

Substance Abuse

Pain Disorders

Impairment of sensor modality(s)

Severe psychiatric disability or emotional disturbance

Sleep Disorders

Psycho-physiologic Disorders

Marital Dysfunction

Weight Control

Eating Disorders

Stress Management
Supervisory Behaviors
Employment Problems
Workplace Issues (e.g., safety, conservation, staff training)

C. Seminars:

The focus of the Seminars is to provide specialized training in one or more of the areas that comprise Behavioral Psychology: Applied Behavior Analysis, Behavioral Therapy, Cognitive Therapy, Cognitive-Behavioral Therapy, or Rational Emotive Behavior Therapy. Seminars have a small student to teacher ration of no greater than 8:1. They involve didactic teaching and favor interaction between instructor and student. Post-doctoral residents are expected to participate in at least bi-weekly seminars for the duration of their post-doctoral training. In dealing with topics that may be too narrow for coursework, seminars can accommodate many of the training needs of residents. Topics should rotate each quarter or semester throughout the 12 months of the residency. It is understood that content areas covered at one institution through a seminar might be addressed at another thorough coursework.

D. Coursework:

Coursework in addition to seminars should develop foundational knowledge across the specialized areas in Behavioral Psychology, and include coverage of theory, assessment, diagnosis, and intervention. The following illustrates the minimum content for such courses:

Use of Cognitive and Behavioral Assessment and Case Conceptualization Methods in the Diagnosis of Disorders and the Planning of Interventions

- Use of interviewing and observational techniques to identify cognitive and behavioral features to presenting problems
- Use of standardized instruments to assess cognitive and behavioral components to presenting problems (e.g., STAI, BDI, BAI, PAI, CBCL, YSF, TRF)
- Use of theories such as Wolpe, Beck, Hayes, or Ellis to conceptualize assessment results for treatment planning.

- Use of case conceptualization to make diagnoses using standard nosologies with special notations of cognitive and behavioral factors uniquely present in the diagnosis
- Use of standard goal-based treatment plans that integrate cognitive and behavioral intervention methods into the case conceptualization.

Use of Cognitive and Behavioral Techniques in the Treatment of Mental and Emotional Disorders

- Use of standard cognitive methods in the treatment of specific diagnoses
 - Beckian methods for the treatment of depression
 - Ellis' techniques for management of anger and maladaptive life-patterns
- Use of treatment manuals and how to obtain them
- Barlow's methods for the treatment of anxiety disorders
- Foa's methods for treatment of Obsessive Compulsive Disorder
- Exposure methods for treatment of Post-Traumatic Stress Disorder
- Relaxation therapy and counter-conditioning for management of stress
- Problem solving, skills development and self-determination strategies in the treatment of severe mental illness
- Dialectic Behavior Therapy methods for treatment of complex patients with affective dysregulation
- Use of Habit Reversal strategies for treatment of habit disorders
- Use of exposure therapy and counter-conditioning for treatment of phobias
- Use of self-control methods for children and adolescents with hyperactivity and other behavioral disorders
- Use of schema-focused methods in treatment of complex or personality disordered cases.
- Assessment of treatment progress and modification of treatment protocol

Use of Applied Behavior Analysis in the Development, Increase, Replacement, or Cessation of Behaviors

- Methods for direct observations and interviews to identify and operationalize target behaviors
- Use of specific assessment methods in conducting behavioral analysis, including A-B-C analysis, time sampling, ratio data, duration data, frequency counts, visual displays, inter-rater reliability and agreement, and functional (analog) behavior analysis.
- Use of behavior analytic methods to modify behaviors including modeling, prompting, schedules of reinforcement and punishments, associational learning paradigms, satiation, habituation, stimulus discrimination training, precision teaching, chaining, shaping, differential reinforcement, and baseline/multiple baseline designs.

E. Scope and Sequence of Training:

The scope of the training should follow a prescribed logical progression, building on existing competencies from doctoral training and internship experiences. The scope should include theory, assessment, case conceptualization, treatment, and evaluation of effects.

The sequence of the post-doctoral training in Behavioral Psychology should feature concurrent use of all three training methods: supervised cases, seminars, and courses. The post-doctoral resident should complete the first course in the fall, the second in the spring, and the third in the summer.

The seminars should be designed to follow a sequence of theory, assessment, case conceptualization, treatment, and evaluation of effects within a narrowly defined area in Behavioral Psychology. Such areas include, but are not limited to

- Use of Applied Behavior Analysis in the treatment of Childhood Autism and Autism Spectrum Disorders
- Use of Applied Behavior Analysis in the treatment of self-injurious behaviors in adults with mental retardation
- Use of Self-Control methods with children who have ADHD
- Use of Relaxation and Graduated Exposure in the treatment of specific phobias

- Use of Dialectic Behavior Therapy in the treatment of Borderline Personality Disorder
- Use of Cognitive Therapy techniques in the treatment of reactive depression
- Use of Schema-Focused Therapy in the treatment of personality disorders
- Use of REBT in the treatment of anger problems

The seminars should be structured so that coverage provides in-depth education and training in one topic area per semester or quarter, through the twelve months of the Post-Doctoral Training Program.

The didactic training through case supervision should follow a sequence that introduces the use of techniques in Behavioral Psychology for each case in the sequence of assessment, case conceptualization, treatment planning, intervention, and evaluation of effects. The cases initially assigned should be as least complex as possible, with cases of greater degrees of complexity provided for training to a resident only when competency with less complex cases is documented.

8. Content Areas and Issues for Behavioral Psychologists:

By the time a resident has completed post-doctoral training, he or she should have engaged in systematic study through seminars and course work or a broad range of content areas and issues related to Behavioral Psychology. Thus the learning needs of a given resident at the time of entry into the post-doctoral residency will vary as a function of previous educational and training opportunities. It is understood that specific post-doctoral offerings will depend on the orientation and resources of the training setting. The following topics are listed to convey the expected breadth and depth of knowledge and understanding to which a well-trained Behavioral Psychologist should have been exposed. It is the responsibility of the training facility to provide access to instruction (e.g. seminars, coursework, colloquia, preceptor training, relevant readings) to meet each resident's professional development and training needs.

- Behavioral Disorders in Children and Adults
- Emotional Disorders in Children and Adults

- Psycho-physiologic Bases of Psychopathology
- Assessment of Behavior and Cognitive Behavior
- Applied Behavior Analysis and Functional (Analog) Behavior Analysis
- Methods of Behavior Therapy
- Methods of Cognitive Therapy
- Methods of Cognitive-Behavior Therapy
- Methods of Rational Emotive Behavior Therapy
- Contemporary Theories of Learning and Behavior
- Social Learning Theory
- Psycho-bio-social Model of Psychological Functioning
- Cognitive and Affective Components of Behavior
- Role of Human Development in Delivery of Assessment, Treatment, and Consultation Services
- Systems Theory and its Role in Consultation

9. Sensitivity Training and Ethics:

All psychologists working in Behavioral Psychology, whether or not they have been trained in clinical, counseling or school psychology, need to understand the nature of negative bias involving disability and illness to which they themselves are prey so that they can consciously invoke counterchecks against such flawed human perception. Such counterchecks are needed in both the research and clinical domains.

One of the best means to ensure that the effects of negative bias are minimized is to provide sensitivity training throughout the course of the training program. Training in the multi-cultural guidelines of APA, as well as other methods of sensitivity training should be build into the supervision, seminars and coursework.

Diversity is not simply the study or awareness of individual and group differences, but rather the awareness of the similarities and difference both between and within groups. Within behavioral psychology it cannot be an individual study or course, but rather an integral part of every module and area of study and concern within the curriculum. Every syllabus will include the study of individual differences that are socioculturally based

Training in ethics should focus on the discussion of ethical issues in seminars and case supervision whenever appropriate. The training should identify ethical problems first through the instructor or supervisor, but by the second half of the residency, residents should be able to identify ethical problems on their own for discussion. Ethical problems should be addressed through application of the APA Ethical Guidelines, the jurisdiction's regulations, the Behavioral Psychology Specialty Guidelines, and other specialty guidelines or ethical principles that might apply.

10. Required Post-Doctoral Program Characteristics

Post-Doctoral residencies occur in a variety of settings, including consortia. A program is a least one calendar year full-time (minimum 1800 hours in 12 months) or two part-time years. The resident must commit to the training at a sufficiently high level so as to foster focus on the training and delimit distractions from coursework and training activities.

Post-Doctoral Programs in Behavioral Psychology ensure appropriate financial support and the provision of other necessary resources, and provide for employee-status employment. Behavioral Psychology trainees should be funded either through stipends, fee-generation through clinical work, or a combination of both. The stipend is consistent with the afforded comparable doctoral level professionals in training, and fee-based support is in keeping with prohibitions against mistreatment of trainees in sources such as the APA Ethical Guidelines or jurisdictional regulations. Additionally, through employment status, provision for health insurance and other benefits, including liability insurance, is made by the program. Facilities and resources, such as office space, clerical support, computer access, recording equipment, library resources, and populations are adequate to meet the education and training goals of residency program.

Post-Doctoral Behavioral Psychology residency programs ensure that socialization into the profession occurs through interaction with faculty/staff and/or other residents. The program affords opportunities for peer interaction and consultation. Post-Doctoral residency programs encourage the resident to participate in state

and provincial, regional, national, and international scientific and professional organizations.

11. Evaluation Mechanisms: Systematic Evaluation of Residents in Behavioral Psychology

Exit criteria are established through written objectives reflective of the program's implementation of the models and emphases in these Education and Training Guidelines. Use of existing competency criteria should be incorporated, including the standards from the Behavior Analyst Certification Board, the Academy of Cognitive Therapy, the Institute for Rational Emotive Behavior Therapy, and the American Board of Cognitive and Behavioral Psychology. Additional criteria from manualized or empirically-validated treatments should also be reflected in the exit criteria (e.g., training standards for Acceptance and Commitment Therapy, Dialectic Behavior Therapy, or Behavior Marital Therapy).

At least two formal written evaluations of residents' performance in the post-doctoral residency precede the assessment of their satisfactory completion of the full program. The initial evaluation is provided early in the program so that the resident has feedback to serve as the basis for self-correction. The second evaluation occurs sufficiently early in the year to provide time for continued development. Each evaluation is conducted face-to-face with appropriate faculty/staff of the program. A written report of the evaluation is read and signed by both the resident and supervisor. It is conceivable that a resident will fail the residency, and adherence to written objectives should occur to minimize ambiguity about the competency, or lack of competency, represented by any individual resident.