PETITION FOR THE RECOGNITION OF A SPECIALTY IN PROFESSIONAL PSYCHOLOGY

THIS PETITION gives guidance to the types and amounts of information necessary for a formal decision to be reached. Petitioning organizations may use additional pages where necessary. The petitioning organization is free to provide any additional material deemed relevant.

NOTE: Complete responses to all questions posed in each of the criteria are required. Appendix materials should not be considered as substitutes for the completion of responses to questions in the criteria.

AMERICAN PSYCHOLOGICAL ASSOCIATION
750 First Street, NE
Washington, D.C. 20002-4242
(202) 336-5500

PETITION PACKAGE
Knowledge and practice skills in psychology have expanded and become increasingly differentiated over the past 50 years. Historically, the American Psychological Association (APA) acknowledged four professional specialties in psychology: clinical, counseling, school, and industrial/organizational psychology. It is important to note that these specialties first gained de facto recognition through a process of historical evolution. The APA accreditation guidelines also reference clinical, counseling, and school psychology as specialties.

A shared core of scientific and professional knowledge, skills, and attitudes is common to professional specialties. This shared core has been recognized in several conference reports on the future of professional psychology including the reports of groups and conferences of the National Council of Schools and Programs of Professional Psychology, the Joint Council on Professional Education in Psychology, and the National Conference on Scientist-Practitioner Education and Training for the Professional Practice of Psychology. Nothing in this document precludes a provider of psychological services from using the methods or dealing with the populations of any specialty, except insofar as they do so “within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience” (APA Ethical Principles of Psychologists and Code of Conduct, 2002).

The public will continue to need the services of general practice specialists, such as those offered by clinical, counseling, school and industrial/organizational psychologists. However, the emergence of new specialties to provide needed psychological services must also be recognized and validated. There must be a mechanism within the field to provide for the recognition of specialties.

Recent decades have produced what amounts to an explosion in professional knowledge and areas of application. As a result, new areas of application of psychology's scientific and applied knowledge have been organized around particular emphases in professional practice. The training to acquire this knowledge and skill may occur at the doctoral and/or postdoctoral levels. Such a proliferation of knowledge and an expansion of practice domains has resulted in a need to establish a process for recognizing specialties in professional practice that are differentiated from core scientific and applied professional foundations in psychology. At various times in past years, groups within and outside APA have worked to articulate such an identification and recognition process. Acknowledgement is given to the work of APA's Task Force on Specialty Criteria, the Board of Professional Affairs Subcommittee on Specialization, and the Board of Educational Affairs Task Force on Scope and Criteria of Accreditation, as well as the American Board of Professional Psychology for important contributions to this process. Their efforts have been a part of the continuing evolution of a process to identify specialties in psychology. It is now time for APA to exercise leadership in the design and implementation of a de jure process for the recognition of specialties in psychology.

For purposes of this endeavor the following definition of a specialty is adopted:

A specialty is a defined area of professional psychology practice characterized by a distinctive configuration of competent services for specified problems and populations. Practice in a specialty requires advanced knowledge and skills acquired through an organized sequence of education and training in addition to the broad and general education and core scientific and professional foundations acquired through an APA or CPA accredited doctoral program. *Specialty training may be acquired either at the doctoral or postdoctoral level as defined by the specialty.

*Except where APA or CPA program accreditation does not exist for that area of professional psychology
Although the specific dimensions of specialty programs may vary in their emphases and in available resources, every defined specialty in professional psychology will contain: (a) core scientific foundations in psychology; (b) a basic professional foundation; (c) advanced scientific and theoretical knowledge germane to the specialty; and (d) advanced professional applications of this knowledge to selected problems and populations in particular settings, through use of procedures and techniques validated on the same.

The relationship between a body of knowledge and a set of skills in reference to each of the parameters of practice specified in Criterion VI below represents the most critical aspect of the basic definition of a specialty.

A specialty is distinguished from a proficiency, which is a circumscribed activity in the general practice of professional psychology or one or more of its specialties that is represented by a distinct procedure, technique, or applied skill set used in psychological assessment, treatment and/or intervention within which one develops competence.

The American Psychological Association and its Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP) will consider petitions for formal recognition of specialties. Petitions that are received by CRSPPP will be reviewed and acted upon by the APA Council of Representatives. CRSPPP will review the status of each specialty at least every seven years and recommend whether the specialty should continue to be recognized.
Name of Proposed Specialty: Behavioral and Cognitive Psychology

Please check one:

☐ Petition for Initial Recognition
☐ XX Petition for Renewal of Recognition
Criterion I. Administrative Organizations. The proposed specialty is represented by a specialty council or one or more organizations that provide systems and structures sufficient to assure the organized development of the specialty. **Commentary:** The evolution of a specialty generally proceeds from networks of psychologists interested in the area to the eventual establishment of organized administrative bodies which carry out specific responsibilities for the specialty and its practitioners. These responsibilities include governance structures which meet regularly to review and further describe the specialty and appropriate policies for education and training in the specialty.

1. Please provide the following information for the organization or specialty council submitting the petition:

   Name of organization or specialty council: Behavioral and Cognitive Psychology Specialty Council

   Address: c/o 4624 Sawmill Rd

   City/State/Zip: Columbus, OH 43220

   Phone: 614-832-5141       FAX: 614-457-3656

   E-mail address: kda1757@gmail.com


2. Please provide the following information for the President, Chair, or representative of the organization or specialty council submitting the petition:

   Name: Kevin D. Arnold, Ph.D., ABPP       APA membership status: Member

   Address: 4624 Sawmill Rd
3. Please provide the following information for the organization or specialty council submitting the petition:

Year founded? 1992
Incorporated? Yes _____ No XX
State incorporated ____

Describe the purpose and objectives of the administrative organization or specialty council submitting the petition.

The Behavioral and Cognitive Psychology Specialty Council consists of the following six organizations: The Association for Behavioral and Cognitive Therapies (ABCT), Division 25 of APA, the Behavior Analyst Certification Board (BACB), the Association for Behavior Analysis International (ABAI), the American Board of Behavioral & Cognitive Psychology (ABBCP), and the Association of Professional Behavior Analysts (APBA). In line with several other national and international organizations and boards in the specialty, the name was changed in 2006 from the Behavioral Psychology Specialty Council to the Behavioral and Cognitive Psychology Specialty Council.

The Behavioral and Cognitive Psychology Specialty Council has created, and had accepted by COA, both a set of Postdoctoral Education and Training Guidelines as well as Doctoral Education and Training guidelines that create a formalized process of developing a) post-doctoral training residency in the specialty area and b) a Major Area of Study in the specialty within clinical, counseling or school programs. To ensure that site reviewers for these post-doctoral residencies will be competent, the Specialty Council organized, with the Association for Behavioral and Cognitive Therapies, a training of COA site reviewers at the 2007 Convention of the ABCT. By establishing a set of E&T Guidelines and by developing site reviewers with expertise in the specialties, the Specialty Council has provided a system for training and created an adjunctive strategy for accrediting post-doctoral training programs through the COA.

The Specialty Council also collaborated throughout several years, recently, to negotiate the role of professional applied behavior analysis within and outside of professional psychology. The efforts produced, among other things, an understanding among organizations that professional psychologists, who evidence competencies in applied behavior analysis, should not have their scope of practice restricted to deliver ABA. The collaboration also produced a landmark decision allowing the BACB to permit those certified by the ABBCP, who were examined for ABA competencies, to supervise those seeking BACB
certification, as long as the certified specialist in B&CP also completed the BACB's supervision training requirements. Additionally, the Specialty Council participated with the Association of State and Provincial Psychology Boards to publish an informational flyer for parents on what ABA is and who can perform it. The ABBCP is a member of the Specialty Council and is the specialty's corresponding certifying board under the American Board of Professional Psychology. The Specialty Council is a member of the Council of Specialties in Professional Psychology (CoS), and has had its representatives serve in leadership roles in CoS.

Please append the bylaws for the petitioning organization or specialty council if bylaws are not provided on the website.

Outline the structure and functions of the administrative organization or specialty council (frequency of meetings, number of meetings per year, membership size, functions performed, how decisions are made, types of committees, dues structure, publications, etc.) using the table below. Provide samples of newsletters, journals, and other publications, etc.

<table>
<thead>
<tr>
<th>Name of Organization</th>
<th>Behavioral and Cognitive Psychology Specialty Council</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of Meetings</td>
<td>Annual, special meetings when needed</td>
</tr>
<tr>
<td>Number of Meetings per year</td>
<td>One</td>
</tr>
<tr>
<td>Membership size</td>
<td>6 organizations</td>
</tr>
<tr>
<td>Functions Performed</td>
<td>1. Write Education and Training Guidelines, 2. Complete &quot;Taxonomy cells&quot; to define coverage within specialty at each of four stages of education and training, 3. Respond to controversies within the specialty at the national level, 4. Facilitate education and training program development, 5. Promote the specialty through publications, 6. Consult to organizations on issues related to the specialty.</td>
</tr>
<tr>
<td>How are decisions made</td>
<td>Consensus of all members</td>
</tr>
<tr>
<td>Types of committees</td>
<td>None, Task Forces appointed when needed</td>
</tr>
<tr>
<td>Dues Structure</td>
<td>$300 per organization</td>
</tr>
<tr>
<td>Names of Publications</td>
<td>Weblinks to publications which reflect participation or authorship by the Specialty Council. (<a href="https://example.com/article1">Professional Psychology: Research and Practice Article on the Specialty of Behavioral and Cognitive Psychology</a>, <a href="https://example.com/guideline1">Guidelines for Doctoral Psychology Programs Incorporating Cognitive and Behavioral Education and Training</a>, <a href="https://example.com/guideline2">Behavior Therapy Published Guidelines for Cognitive</a>)</td>
</tr>
</tbody>
</table>

Present a rationale that describes how your organization or specialty council provides systems and structures which make a significant contribution to the organized development of the specialty.

As mentioned above, The Behavioral and Cognitive Psychology Specialty Council consists of six organizations: The Association for Behavioral and Cognitive Therapies (ABCT), Division 25 of APA, the Behavior Analyst Certification Board (BACB), the Association for Behavior Analysis International (ABAI), and the American Board of Behavioral & Cognitive Psychology (ABBCP). In line with several other national and international organizations and boards in the specialty, the name was changed in 2006 from the Behavioral Psychology Specialty Council to the Behavioral and Cognitive Psychology Specialty Council. The Council publishes a fact sheet through the COS website (see appended).

The Behavioral and Cognitive Psychology Specialty Council has created and had accepted by COA a set of Education and Training Guidelines that creates a formalized process of developing a post-doctoral training residency in the specialty area. To ensure that site reviewers for these post-doctoral residencies will be competent, the Specialty Council organized with the Association for Behavioral and Cognitive Therapies a training of COA site reviewers at the 2007 Convention of the Association for Behavioral and Cognitive Therapies. By establishing a set of E&T Guidelines and by developing site reviewers with expertise in the specialties, the Specialty Council has provided a system for training and created an adjunctive strategy for accrediting post-doctoral training programs through the COA.

The Editor of Professional Psychology: Research and Practice invited for review a series of articles describing specialties in professional psychology several years ago. Behavioral and Cognitive Psychology submitted an articles which was accepted and published (Dowd, Clen & Arnold, 2010).

The Behavioral and Cognitive Psychology Specialty Council is a member of the Council of Specialties in Professional Psychology (CoS). The council is a non-profit joint venture, initially sponsored by the American Psychological Association (APA) and the American Board of Professional Psychology (ABPP), to represent and support the development and functioning of recognized specialties in Professional Psychology. The Cos currently consists of 14 specialties and liaisons with ABPP and CoA.


4. Signatures of official representing the organization or specialty council submitting the petition:

<table>
<thead>
<tr>
<th>name</th>
<th>title</th>
<th>date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark B. Sobell, PhD ABPP</td>
<td></td>
<td>December 31, 2018</td>
</tr>
<tr>
<td><strong>On behalf of the Application Writing Team, Mark B. Sobell, PhD, ABPP, Chair.</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Criterion II. Public Need for Specialty Practice. The services of the specialty are responsive to identifiable public needs

Commentary: Specialties may evolve from the professions’ recognition that there is a particular public need for applications of psychology. Specialties may also develop from advances in scientific psychology from which applications to serve the public may be derived.

1. Describe the public needs that this specialty fulfills with relevant references. Under each need specify the populations served and relevant references.

We will describe each area of major concentration in turn, including behavior analytic, behavioral, behavioral-cognitive, and cognitive psychological interventions. Identifiable public needs for behavior analytic psychology services span the primary service sectors in society, with particular emphasis on those sectors that primarily address the needs of children and adults with chronic mental and developmental disabilities, including early childhood services, educational services, adult developmental disabilities and mental health services, and behavioral aspects of health services. Needs for services have been growing with advances in health care, enabling survival of infants and children who previously died young and now live into adulthood, in combination with growing societal recognition of populations (e.g., survivors of head injury) to which service initiatives were not previously directed and better identification of disability effects during childhood. This general trend is associated with differential survival improvement for many subgroups that evidence behavioral or psychological treatment needs in addition to environmental accommodations and supports and heightened requirements for both tertiary and preventative health care.

The utility of behavior-analytic treatment for a variety of conditions has been recognized by the National Institutes of Health in the development of consensus statements, primarily on the Treatment of Destructive Behavior in 1989, and the Treatment of ADHD in 1998, as well as secondarily (i.e., limited evidence, at the time, as noted in the draft report) in the Rehabilitation in Traumatic Head Injury in 1998. Primary service populations for behavior analytic psychology include children with autism, children and adults with developmental, intellectual disabilities and emotional and behavioral disorders, and behavior management of older adults with dementia. Several studies have indicated that within these populations, available practitioner services tend to be directed to addressing the needs of children and adults with the most severe behavioral disturbances co-occurring with mental disorders, and that access to behavior analytic psychological services is inadequate, or at least highly uncertain, for children and adults with moderate but clinically and socially significant levels of behavior disorders, regardless of whether these co-occur with mental disorders.


Behavioral, behavioral-cognitive, and cognitive psychological interventions are especially well-equipped to meet the national need for evidence-based and cost-effective outpatient interventions. These approaches have demonstrated efficacy and effectiveness in many clinical and research studies over the years. These interventions have been shown to be effective with child, adult, and older adult populations.

They have been shown to be effective for a wide variety of psychological disorders, including anxiety disorders, depression, personality disorders, substance abuse and disorders of habit, anger disorders, bipolar disorder, PTSD and schizophrenia. The literature on empirically supported treatments, as documented below, has been dominated by behavioral and cognitive approaches, both treatment efficacy and treatment effectiveness.


Recent iterations of behavioral-cognitive approaches, such as Dialectical Behavior Therapy, Acceptance and Commitment Therapy, Mindfulness-Based Cognitive Therapy, Cognitive Processing Therapy, Problem-Solving therapy and Cognitive Hypnotherapy have integrated research and techniques from other theoretical orientations and approaches (e.g., emotional theories, evolitional theories, mindfulness practices, motivational and humanistic approaches). Such intervention systems, often referred to as “Third Wave,” have shown considerable effectiveness in recent years in ameliorating recalcitrant psychological disorders in previously hard-to-treat individuals and thus enhancing the quality of life.


2. Describe what procedures this petitioning organization and/or other associations associated with this specialty utilize to assess changes public needs.

Behavioral and Cognitive Psychology is constantly examining and refining its assessment and intervention techniques in the light of emergent needs and special populations. For example, as far back as 1994, Behavior Therapy began publishing periodic State of the Art Reviews (SOARs) on a variety of topics. Special series thus far include “Research contributions to Clinical Assessment,” “Body dissatisfaction, binge eating, and dieting as interlocking issues in eating disorders research,” “Experimental pain as a model for the study of clinical pain,” “Mechanisms, populations, and treatment innovations in anxiety disorders,” “Child abuse,” “Mental health in the elderly,” and “Cost effectiveness.” There are few public needs that surpass the discovery and implementation for the treatment of Veterans and returning Active Military personnel. Current trends in the treatment of veterans and active military include behavioral and cognitive strategies in the forefront. For example, the majority of treatments recognized by the Department of Veterans Affairs regarding the treatment of PTSD and the management of TBI or chronic pain, and suicide prevention, are behavioral and cognitive treatments.

Behavioral and cognitive psychology is continually informed by recent and emerging research, resulting in expanded and improved treatments. For example, several interventions now incorporate the latest neuroscientific research regarding emotional regulation. In addition, contemporary problem solving therapy has introduced new techniques as art of its intervention largely informed by LeDoux and other brain scientists.


3. Describe how the specialty attends to public need

Behavioral and cognitive psychologists conduct research specific to answering questions in response to contemporary public needs. For example, they have made significant contributions to the scientific literature regarding treatment solutions for major societal problems such as autism, TBI, military readjustment, trauma treatment, substance abuse, obesity, and other health behaviors.

Behavioral and Cognitive Psychology has specialty credentials that determine the actual competencies of psychologists who are trained to provide the assessment and interventions that address the public need. All individuals who provide professional services within the specialty of behavioral and cognitive psychology, must have completed doctoral level training in psychology that provides eligibility for licensure in their jurisdiction. To be board certified in behavioral and cognitive psychology by the American Board of Behavioral and Cognitive Psychology (ABBCP), psychologists must provide evidence of their experience in this specialty area. Psychologists with training in behavior analysis might also seek an additional credential as a board certified behavior analyst by Behavior Analyst Certification Board (BACB).

**Criterion III. Diversity. The specialty demonstrates recognition of the importance of cultural and individual differences and diversity.**

*Commentary:* The specialty provides trainees with relevant knowledge and experiences about the role of cultural and individual differences and diversity in psychological phenomena as it relates to the science and practice of the specialty in each of the following areas: i) development of specialty-specific scientific and theoretical knowledge; ii) preparation for practice; iii) education and training; iv) continuing education and professional development; and v) evaluation of effectiveness.

1. Describe the specialty-specific scientific and theoretical knowledge required for culturally competent practice in the specialty, how it is acquired and what processes are in place for assessment and continued development of such knowledge.

Behavioral and cognitive psychology considers culture, in its broadest sense, to provide the context in which learning occurs. As such, one cannot practice in the specialty without a profound respect for the role of culture and multiculturalism in all aspects of human learning. Additionally, the specialty requires behavioral and cognitive psychologists to be aware of how their own individual characteristics and individual learning history may impact assessment and treatment. It includes being able to independently monitor and apply knowledge of one’s self as a cultural being in assessment, treatment, and consultation. There is not one group of individuals that represents the “norm” for human behavior. There can be an
implicit notion that one from a dominant culture does not have an ethnicity – or that sexual orientation or gender issues only pertain to others. This misconception can inevitably render one blind to one’s own biases, culture bound beliefs, and need to understand others from the diverse cultures and backgrounds from which we all come. It also may result in professionals from a dominant culture expecting that others from ethnic or cultural minority groups will take the responsibility to deal with cultural concerns; teach the dominant group “what they need to know,” and in essence be “the face of diversity” rather than recognizing that culturally relative and diverse perspectives include the dominant cultural perspective as just one diverse form.

With regard to behavioral and cognitive psychologists’ recognition of how one’s cultural background influences various aspects of practice, choice of specialty and, as A. Nezu (2010) suggests how one’s cultural background may have shaped their “clinical decision-making road map,” is pertinent to all aspects of their work. The psychologist’s own background and learning history, recognition of how one brings one’s culture to bear upon therapy can take many forms.

Behavioral and cognitive psychologists must recognize that they themselves may evoke or elicit specific responses from their patients. Patients will react to therapists according to their individual histories with similar people. All aspects of diversity come into play here. For example, a young, physically fit, attractive, female therapist working with an older, obese, female patient may be experienced by that patient as incapable of understanding her difficulties, or the patient may be reticent to discuss her struggles out of fear of being judged. This knowledge is initially acquired in doctoral training programs through courses and experiences in culturally aware Behavioral and Cognitive Psychology practice. It is enhanced by the presence of diverse faculty and students. Further training is provided in post-doctoral training programs and by on-going workshops and CE offerings. For example, ABCT presents regular convention workshops on diversity in Behavioral and Cognitive Psychology. It is assessed by examinations such as those conducted by the ABBCP, which has a diversity examination component. It is further enhanced by clinical experience with a diverse range on clients and consultation with peers. It is a life-long learning process.

2. Describe how the specialty prepares psychologists for practice with people from diverse cultural and individual backgrounds (e.g., through coursework, supervised practice, continued professional development, etc.) and how competence is demonstrated.
The specialty of Behavioral and Cognitive Psychology provides trainees with relevant knowledge and experiences about the role of cultural and individual differences and diversity in psychological phenomena as they are related to the science and theoretical knowledge, preparation for practice, education and training, continuing education and professional development, and evaluation of effectiveness. This occurs through coursework, supervised practice, and professional development at the doctoral and post-doctoral level as well as ongoing CE activities in professional organizations such as the Association for Behavioral and Cognitive Therapies. For example, psychologists are trained in behavioral and cognitive therapy to work with a wide diversity of populations including LGBTQ individuals, various ethnic, religious, racial, cultural, and socioeconomic backgrounds.


Fuchs, C., Lee, J. K., Roemer, L., & Orsillo, S. M. (2013). Using mindfulness-and acceptance-based treatments with clients from nondominant cultural and/or marginalized backgrounds: Clinical considerations, meta-analysis findings, and introduction to the special series: Clinical considerations in using acceptance-and mindfulness-based treatments with diverse populations.


3. Describe how the specialty is monitoring developments and has moved to meet identified emergent needs and changing demographics in training, research, and practice (e.g., through research, needs assessment, or market surveys).
Cognitive and behavioral specialists are increasingly aware of the rapidly growing body of research on applying behavioral and cognitive therapies with culturally and ethnically diverse populations. Although the available research on adaptations and applications of such interventions with ethnically and culturally diverse populations was sparse until the last decade, (Nezu & Greenberg, 2012), there has been a growing number of research studies to address this issue. In a review of research on behavioral and cognitive therapies with ethnic minorities, Nezu and Greenberg found a limited number of studies that had been conducted and reviewed selected examples of the studies, particularly randomized clinical trials, which represent the most highly regarded research to provide empirical support for the use of a particular treatment with a particular population or for a specific disorder. Fortunately, in the last several years, a greater number of studies (as cited above) have been published. This provides an evidential foundation for programmatic training and continuing education activities.

Some studies to understand the effectiveness of behavioral and cognitive interventions with recent immigrants to the U.S. A. have been conducted which shed some light on the application of such approaches with people from ethnic minority groups. Hinton and Otto (2006) studied an adaptation of exposure-based cognitive behavioral therapy for Cambodian refugees experiencing posttraumatic stress disorder (PTSD). The authors identified challenges and culturally appropriate adaptations that can be made. The challenges included limited English, illiteracy, limited resources, cultural barriers, somatic presentations of symptoms, and culture-specific interpretations. Modifications to the treatment including providing the intervention in a group format that did not mimic a classroom-like setting resembling experiences of living under a dictatorship, slowing the pacing of the treatment, and allowing for open discussion. Santiago-Rivera, Kanter, Benson, Derose, Illes, and Reyes (2008) considered similar challenges of language, education and fewer financial resources in a pilot adapting behavioral activation (BA) for depression in a Latino/Latina Health Center with clients who were primarily recent immigrants from Mexico and Puerto Rico. Adaptations to Behavioral Activation (BA) included using culturally sensitive activation targets in the context of Latino-specific values and beliefs, and focusing on stress and avoidance. The BA protocol also was flexible enough to include addressing issues of unemployment and helping the participants to use job searches and addressing the understandable anxiety and avoidance that accompanies the many tasks that can be overwhelming for someone who is not fluent in English, or may be intimidated by bureaucratic institutions. Other adaptations included using proverbs rather than acronyms to express concepts that are useful to teach in a course of BA. For example, the authors suggest that “Pasos de acción” or “action steps” minimize the stigma associated with depression and seeking mental health treatment. In a study by Beshai, Clark, & Dobson, (2013) some of the philosophical and theoretical tenets of both Islam and CBT are first discussed. Secondly, and as to heighten clinical awareness, several points of concordance and dissonance between these systems were discussed and highlighted through an illustrative case study. Finally, the authors concluded by offering a number of suggestions for future research. The primary aim of an article co-authored by Austin & Craig, (2015) was to introduce a transgender-affirming adaptation of a cognitive behavior therapy intervention (TA-CBT) for use with transgender individuals suffering from depression, anxiety, and/or suicidality. Clinical considerations such as the historical context of transgender issues in mental health care, the minority stress framework, current mental health disparities, and resilience were explained. Additionally, transgender-affirming practice applications focused on psychoeducation, modifying problematic thinking styles, enhancing social support, and preventing suicidality were provided.
As the reader can glean from these few examples, the specialty is continuing to make significant strides in the application of behavioral and cognitive interventions to diverse populations.

4. Describe how the education and training and practice guidelines for the specialty reflect the specialty’s recognition of the importance of cultural and individual differences and diversity.

The importance of multiculturalism is underscored as a foundation of the specialty that informs and affects all aspects of functional training, such as assessment, intervention, consultation, teaching and supervision. Additionally, the specialty recognizes the importance of cultural and individual differences with regard to research training. For example, in their literature review of RCTs evaluating the efficacy of cognitive behavioral therapy with ethnic minority populations, Nezu and Greenberg (2012) conclude that both behavioral and cognitive researchers and clinicians should take into account dimensions that may affect work with ethnic minority populations. First, concerns about poverty and lower socioeconomic status must be taken into account. The disenfranchisement of ethnic minority and cultural minority groups from the dominant culture can lead to serious economic disadvantage for many members of these groups. Treatment providers must take into account the enormous cost, financially but also in terms of getting child care, missing time at work, and so forth that may be associated with any therapy, including behavioral and cognitive therapy. Researchers need to strictly adhere to guidelines for the protection of human subjects when it comes to providing financial incentives to lower SES participants that may be coercive. Immigration status must also be considered, as this is directly relevant to many aspects of clients seeking therapy or participating in research. New immigrants may not be fluent in English, and may not have adapted culturally. For immigrants who have not yet obtained legal status, participating in research or seeking treatment from a behavioral health provider may be a threatening endeavor and trigger fears of having illegal immigration status discovered resulting in negative consequences. Seeking professional help for emotional problems may be stigmatized in some cultures and this stigma is another dimension to consider. Behavioral and cognitive specialists must take into account cultural values, the importance of family, and the importance of religion and spirituality and use metaphors, analogies, and images that are culturally relevant. Many participants from ethnic minority groups have experienced discrimination in other settings and may expect the same from research institutions or clinicians. These are some considerations that are expressly interwoven into the education and training guidelines for the specialty.

With regard to training in case formulation, it is important that trainees recognize the vulnerability of their biases and interpretations that are classically conditioned emotional responses toward other people. They may be unaware that they have been conditioned in these ways. They are also subject to making explicit assumptions and having explicit biases. Culturally competent behavioral and cognitive practitioners are trained not to evade facing their own biases, and are provided methods for case formulation that specifically aim at reducing these biases.


Specific Behavioral and Cognitive Psychology documents pertaining to education and training can be found at: [http://www.cospp.org/behavioral-and-cognitive-psychology](http://www.cospp.org/behavioral-and-cognitive-psychology)
Criterion IV. Distinctiveness. A specialty differs from other recognized specialties in its body of specialized scientific knowledge and professional application.

Commentary: While it is recognized that there will be overlap in the knowledge and skill among various specialties in psychology, the petitioning organizations must describe the specialty in detail to demonstrate that it is distinct from other recognized specialties in the knowledge and skills required or the need or population served, problems addressed and procedures and techniques used.

1. Identify how the following parameters differentiate and where they might overlap with other specialties. Describe how these parameters define professional practice in the specialty.

a. populations

A full range of therapies in behavioral and cognitive psychology have been used with a wide variety of populations, including individual and group work with children, adolescents, adults, and older adults. There is a strong evidence base for their successful application with psychiatric inpatients, medically hospitalized individuals, individuals with developmental, intellectual, and physical disabilities individuals with autism, individuals with a wide variety of health behavior problems, as well as the full range of mood, anxiety, substance abuse and interpersonal problems present in outpatient populations. They have also been implemented with couples and families, as well as applied to schools, brain injured populations, and in organizational settings. Due to the significant research evidence, many of the behavioral and cognitive assessment and intervention strategies have been widely adopted across many specialties. Except for populations such as autism and individuals with severe intellectual disabilities, there is substantial overlap in populations served by this specialty and others. The applied behavior analysis area of focus of Behavioral and Cognitive Psychology tends to be especially prominent in treating autism and developmental disabilities and this tends to differentiate the specialty from most others. The reliance on empirically supported treatments tends to differentiate the specialty.

b. problems (psychological, biological, and/or social that are specific to this specialty)

Behavioral and cognitive psychology conceptualize and addresses problems under several different domains. These include those that are overt behavioral in nature, cognitive in nature, emotional in nature, and problems that represent a combination of these problem areas. We have listed examples of some of the specific problems that are uniquely addressed under each category.

Overt behavior Domain

Behavioral and cognitive psychologists have focused on two domains of overt behavior. One area is focused building new skills and intentionally practicing/learning those skills. The second is on reducing behaviors that create difficulties for the individual’s functioning. Examples of skills building behaviors include academic performance, assertiveness, social skills. Examples of problem behaviors to decrease include hyperactivity, conduct disorders, eating disorders, anger disorders, and self-injurious behavior.

Cognitive Domain

Behavioral and cognitive psychologists target behaviors in this domain, by focusing on problems such as cognitive distortions, suicidal ideation, ruminative worry, obsessional thinking, and self-deprecation thoughts.
Emotional Domain

Examples of problems that behavioral and cognitive psychologists focus on in this domain include emotion dysregulation, pain disorders, and learned fear reactions.

Combination of Domains

Examples of problems that represent a blending of these domains includes substance abuse problems, mood disorders, stress disorders, eating disorders, relationship problems, and trauma disorders.

c. procedures and techniques

The primary procedures and techniques that characterize the practice of behavioral and cognitive psychology directly address the functional relations between behavior and the environment, including the relations between and among behavior, cognition, and emotions. Behavioral and cognitive psychologists engage in assessment, case conceptualization, intervention, consultation, supervision, and research strategies that have been developed from a broad empirical behavioral – cognitive – emotion model, as described above.

The Behavioral and Cognitive Psychology specialty is defined by its unique set of interventions, case conceptualizations, assessments, procedures and protocols. Therefore, the procedures and protocols that define our specialty differentiates us from other specialties.

**Case Formulation:** Behavioral and cognitive case formulation links the philosophical roots of behavioral and cognitive approaches together. In all cases, assessment is linked to treatment. Additionally, behavior and cognitive case formulation approaches all embrace the following concepts.

- Assume a multiple causal hypotheses perspective
- Place an emphasis on functional analysis
- Include positive treatment goals as part of a constructional approach
- Underscore the importance of using strategies to reduce biases in clinical judgment

a. procedures and techniques

Examples of case formulation unique to the specialty of behavior and cognitive psychology include those described below under the specialty problem domain listed above.

Overt behavior

One example of formulation for self-injurious behavior would consist of understanding the behavior as controlled by its immediate antecedents and consequences, conducting a functional assessment through direct observation and experimental manipulations, utilizing the information form the functional assessment to change the reinforcement contingencies and writing those into specific protocols that can be implemented by parents, teachers, and staff.

Cognition
One example of formulation for this domain is that Persons CBT case formulation model which would identify problematic schemas, beliefs, and assumptions from both a historic learning and current situations that have been learned and contextual factors and consequences that serve to maintain these cognitions. Assessment would occur through structured clinical interviews, questionnaires, self-monitoring, and thought records. Prescriptive interventions would target the cognitive factors most functional related to symptoms of distress. Emotion

One example of case formulation for this domain is the formulation of conditioned phobias. This approach would identify, the level of emotional arousal present when an individual is confronted with specific stimuli to which arousal has been linked through classical conditioning. Assessment would occur through observation of emotional arousal in the presence of the feared stimuli, self-report of subjective fear level; and often presented in a situational hierarchy. Assessment informs interventions designed to result in habituation or learned extinction to the phobic stimuli, as identified in the hierarchy. Treatment would involve an individual exposure to the feared stimulus, based upon the results of the assessment.

Combination of Domains

One example of case formulation for a combination of domains is the case formulation involved in post-traumatic stress disorder. This approach assumes a combination of previous learning, classical conditioning, emotional arousal, Cognitive processing, and operant escape and avoidance behavior, and post event learning as important contributing factors. The gold standard assessment of this disorder is the clinical structured interview for PTSD which assess all of these relevant domain areas. Interventions are prescriptively focused on the most pertinent domains for the individual patient.

Part of the training for behavioral and cognitive case formulation with a complex problem is to consider all domain areas and combinations of domain areas and in conceptualizing each individual case. Moreover once the domains are identified, the behavioral and cognitive psychologist develops a treatment plan that prioritizes the relevant domains.

A list of references that provide some foundational information about the behavioral and cognitive case formulation approach.


2. In addition to the professional practice domains described above, describe the theoretical and scientific knowledge required for the specialty and provide references for each domain as described below. For each of the following core professional practice domains, provide a brief description of the specialized knowledge that is required and provide the most current available published references in each area (e.g., books, chapters, articles in refereed journals, etc.) While reliance on some classic references is acceptable, the majority of references provided should be from last five years and should provide scientific evidence for the theoretical and psychological knowledge required for the specialty.

A comprehensive statement of the foundational knowledge that is required for background in behavioral and cognitive psychology has been delineated by Klepac, et al., (2012), entitled Guidelines for Cognitive Behavioral Training Within Doctoral Psychology Programs in the United States of America: Report of the Interorganizational Task Force on Cognitive and Behavioral Psychology in Doctoral Education. An additional resources for the foundational knowledge required for the specialty can be found in Nezu, Nezu & Martell (2014), entitled Specialty Competencies in Cognitive and Behavioral Psychology.

a. assessment:

Behavioral and cognitive psychologists use assessment procedures relevant to each of the problem domains as outlined above, and the factors that contribute to these domains.
Overt Behavioral Domain
The knowledge required in understanding of overt behavior and factors and the factors that influence it. Therefore, it is important for behavioral and cognitive psychologists to understand behavior and the antecedent and consequence factors contributing to it. Behavioral and cognitive psychologists use a number of assessment methods to understand overt behavior including behavioral checklists, behavioral interviewing (to identify target behaviors and controlling/maintaining variables); behavioral checklists, observation and recording of the frequency, duration, intensity, or magnitude of target behaviors and behavioral activity logs functional analysis, among others.

Cognitive Domain
The knowledge required to understand cognitive behavior includes cognitive processing theory, understanding relationships between thoughts, emotions, and behavior, factors that evoke specific thoughts. Behavioral and cognitive psychologists use a number of assessment methods for this domain including structured interviews, core cognitive schema assessment, self-statement assessment, thought listing, and identification of thought errors or cognitive distortions.

Emotional Domain
The knowledge required to understand behavior in the emotional domain includes understanding the factors contributing to emotions, relationship between emotions, thoughts, and behavior, the physiology of emotion and methods to assess the physiology of emotions. Behavioral and cognitive psychologists use a number of assessment methods in the emotional domain including structured interviews, emotional diaries, emotional and subjective distress scales, and the use of instrumentation to measure physiological functioning (e.g., measurement of GSR, sphygmomanometer, electromyographic electroencephalographic, and temperature devices).

Combination of Domains
The knowledge required to understand the combination of domains derives from knowledge of each separate domain and how the domains may interact. Therefore, behavior and cognitive psychologists use assessments of all three domains to determine the domains that characterize the problems presented by clients to construct the case formulation that guides treatment decisions.


b. Interventions:

The types of interventions used will follow from case formulations and be based on the assessments described above. In most cases there will be contributions from all domains as many problems consist of overt behavior, cognition, and emotion components.

Most interventions address behavioral, cognitive, and emotional domains and are often derived from learning paradigms.

Interventions focused on the overt behavioral domain include for example, contingency management, function-based interventions, token economy, behavioral skills training including instructions, modeling, rehearsal and feedback (for example, assertiveness training, social skills training, anger management training).

Interventions focused on the cognitive domain include for example Beck’s cognitive therapy for depression, Ellis rational emotive therapy, relapse prevention approaches based on managing beliefs and self-efficacy, problem solving therapy, mindfulness therapy, and acceptance and commitment therapy. Interventions focused on the emotional domain include for example, systematic desensitization, exposure based therapies, progressive muscle relaxation, autogenic training, biofeedback.

Interventions focused on a combination of domains utilize many of the interventions listed above as these interventions often affect more than one domain and are used in combination to address different domains. For example, behavioral activation therapy focuses on the behavioral domain to get individuals engaged in more reinforcing activities. In addition to addressing the behavioral domain, after more reinforcing behavior starts to occur there are corresponding changes in the cognitive domain (for example, less depressotypic thoughts, less distorted thinking, more positive self-evaluation) and the emotional domain (for example, less negative affect and more positive affect).


c. Consultation:

Because of the historic focus that behavioral and cognitive psychologists have placed on measured changes in overt behavior as well as the empirical support that has accumulated with regard to cognitive
behavioral interventions, they are frequently consulted with regard to changing problematic behavior in many different contexts. This specialty often overlaps with other specialties with regard to the clinical evidence base that has been developed with specific populations. For example, a behavioral and cognitive psychologist may be consulted on a hospital inpatient unit to help develop strategies to improve management of challenging patient behaviors. These may range from treatment non-adherence behaviors for outpatient settings as well as disruptive, withdrawn, or non-participatory behavior during stays on a medical or psychiatric inpatient unit. These consultations extend to many different psychiatric, medical, and behavioral-health settings such as rehabilitation hospitals, nursing homes, drug and alcohol treatment programs, and hospice environments. In such cases, there is often integration or overlap with other ABPP specialties such as clinical, clinical health, clinical neuropsychology, and rehabilitation.

When behavioral and cognitive psychologists are consulted with regard to assessment or treatment of non-adherence with medical requirements, mood disorders or coping challenges concerning chronic illness populations such as individuals who struggle with cancer, heart disease, diabetes management, or other problems, they frequently overlap with specialties of clinical, clinical health, couples and family, and clinical neuropsychology. As such, they may be consulted as part of an integrated care team.

The unique contributions of the behavioral and cognitive psychologists in these circumstances may involve adapting effective interventions for pain and stress management, depression and anxiety that is associated with an illness experience. As one example, distressed patients with cancer were shown to experience reduced depression associated with cancer-related problems following a problem-solving therapy (PST) intervention and to sustain the improvement over time (Nezu, Nezu, Felgoise, McClure, & Houts, 2003). When treatments such as these are delivered in a group format, there is also overlap with the specialty of group psychology. It is possible in these situations that the group format itself may be an effective component of the intervention in addition to the content of the intervention itself. Additionally, cognitive and behavioral interventions may be combined with other “mind/body” approaches. For example, stress management and interventions based upon mindful meditation and yoga have been very helpful to patients with various cardiac-related conditions (Ditto, Eclache, & Goldman, 2006; Jayasinghe, 2004).

The incorporation of cognitive and behavioral interventions has become ubiquitous with regard to their integration into health care settings and are often viewed as adjunctive to traditional western medical treatments because they can improve life quality and mood, and help people to cope with, or adapt to physical problems. Examples of such interventions include anger management, biofeedback, cognitive therapy, cognitive-behavior therapy, guided imagery, lifestyle modification, mindfulness meditation, problem solving therapy, relaxation training, stress management, and psycho-education, as well as other psychological interventions such as emotional disclosure, hypnosis, and supportive group counseling (Astin, Beckner, Soeken, Hochberg, & Berman 2002; Astin, Shapiro, Eisenberg, & Forys, 2003; Kabat-Zinn, 1982).

When such interventions are employed to reduce psychological distress (e.g., anxiety and depression), to manage stressful situations, or to treat a range of other behavioral and interpersonal disorders, physicians seeking the consultation of behavioral and cognitive psychologists with the recognition that these treatments have been well-tested and thus considered as best practices (Epp & Dobson, 2010). However, when the focus of such therapies is on the reduction of actual medical symptoms and disease, their use is often viewed by physicians as alternative or complementary mind/body interventions, because they have not been traditionally prescribed or employed in the culture of western medicine. For example, in a review (Astin et al.; 2002) the authors claim that despite
significant emerging evidence during the past several decades of the direct influence of psychosocial factors on both physiologic function and health outcomes, the western medical culture has yet to fully embrace a biopsychosocial model of health and illness. These authors review the literature and conclude that there is considerable evidence on which to base a realistic optimism concerning the effectiveness of therapies that fall under the cognitive and behavioral umbrella within the context of an integrative care model. In a similar manner the potential effectiveness of cognitive behavioral treatments regarding many medically unexplained symptoms has also been suggested (A. M. Nezu, Nezu, & Lombardo, 2001). This is particularly relevant with regard to the large percentage of individuals who seek medical care each year from their primary care physicians, in cases where there exists no known biomedical explanation for symptoms.

School settings represent environments where consultation is frequently sought for ways to improve attention, reduce behavioral or disruptive behavior, and create more effective learning environments. It is not uncommon for psychologists trained in the specialty of school psychology to also have a strong background in a subset of behavioral and cognitive specialty areas, such as applied behavioral analysis or functional family therapy approaches. Where school psychologists are not trained in behavioral and cognitive procedures, they may seek collaborative consultation with a behavioral and cognitive psychologist to augment their work. This represents another intersection of behavioral and cognitive psychology with other specialties.

Correctional facilities and other forensic rehabilitative settings frequently seek consultation with a behavioral specialist. Behavioral interventions based upon applied behavioral analysis have been employed in such settings in the form of token economies, other reinforcement-based contingency management programs, and cognitive-behavioral therapies have been applied to various criminogenic behavioral targets. In addition to contingency-based behavioral interventions, cognitive behavioral interventions have been shown to be effective in such settings (Andrews, Zinger, Hoge, Bonta, Gendreau, & Cullen, 1990). Additionally, behavioral and cognitive psychologists have also worked with forensic psychologists in consultation regarding their behavioral expertise related to victims, perpetrators, and jurors. Two interventions that have a very strong evidence-based regarding emergence of post-traumatic stress disorder (PTSD) in individuals who have been victimized by crime, include strategies developed within the specialty, such cognitive processing therapy (CPT) and prolonged exposure (PE) (National Center for Posttraumatic Stress Disorder, 2012). For more information on these interventions, the reader is directed to the chapter in this volume regarding cognitive and behavioral interventions.

Because of the powerful and evidence-based observational technologies developed by behavioral and cognitive psychologists, their expertise in learning and behavior change has also been sought by the military, police and public safety, as well as ways to help law enforcement officers cope with critical incidents and anger management (Novaco, 1977). Behavioral and cognitive psychologists have developed assessment and treatment techniques that are effective for stress-related disorders that are often associated with the life experience of first responders. As such the specialty also may intersect with the specialty of police and public safety psychology.

Behavioral and cognitive psychologists have been consulted in many private sectors areas such as advertising, political campaigns, with regard to conditioning theories and associative learning (Gorn, 1982). Even the leisure industry has consulted with behavioral and cognitive psychologists with regard to how best to train animals, control crowds, maintain attention, or sell souvenirs.
Behavioral and cognitive psychologists supervise a variety of mental health professionals. They teach in educational and other settings, particularly regarding the application of behavioral and cognitive principles and techniques. Their supervision tends to be more empirically-based (more operational, more use of explicit feedback) with reliance on modeling, shaping, successive approximations, self-statement identification, and role playing. In other words, there is a greater reliance on the use of behavioral principles as a means of achieving identified goals of supervision. Behavioral and cognitive psychology supervisors also assist supervisees in assessing and modifying their own implicit assumptions, emotional reactions, automatic thoughts and beliefs that may be interfering with providing the most objective, confident care of which they are capable. Behavioral and cognitive supervisory emphasis involves implementation of procedures and methods that are comparable to those used in consultation and in organizational interventions with respect to specificity and clarity of criteria and performance, and establishment of practice or organizational systems that support appropriate and effective personnel performance.
Behavioral and cognitive psychologists employ similar approaches and interventions with supervisees as they do with clients. There is an emphasis on task analysis, specification of target goals and objectives, modeling and reinforcement, performance-based outcomes, and changing cognitive distortions related to role as therapist-in-training. Consistent with a cognitive-behavioral approach, behavioral and cognitive psychologist supervisors serve as role models for appropriate behavior for supervisees. They may also use cognitive-behavioral technology supervisory aids. Behavioral and cognitive psychology supervisors teach their trainees to engage their clients in collaborative empiricism, and model the maintenance of hope in spite of difficult clinical problems. The behavioral and cognitive psychologist working with behavior analysis practitioners must have the knowledge and skills generally required to supervise professionals and paraprofessionals in human service and health care contexts, as well as to demonstrate, model, and systematically monitor and improve the practices of graduate and post-graduate trainees and other professional supervisees.


e. Research and inquiry:

The use of sound research methodology and an empirical approach is the hallmark of behavioral and cognitive psychology. Behavior and cognitive psychologists are well versed in traditional research methods (e.g., group designs, randomized controls, statistical analyses), but have also
been instrumental in developing and using single case research design. Behavioral and cognitive psychology makes use of additional research strategies ethnographical, epidemiological, qualitative, and observational methods. The behavior and cognitive psychologist must have the knowledge and skills generally required to function effectively as a scientist-practitioner, and in particular, to conduct naturalistic experiments in the course of assessment and treatment. Reliance upon behavioral and cognitive theory and empirically derived practice provides the cohesion that organizes the knowledge areas into a single pattern that defines the specialty.


Public Interest

The emphasis of behavioral and cognitive psychology on outcome assessment, empirical validation and accountability is especially relevant to consumer protection and therefore the public interest. A major purpose of board certification, as communicated by placing “ABPP” after one’s name is to inform consumers that the practitioner has been assessed by experts and determined to be competent in designated areas of expertise. Behavioral and cognitive psychologists constantly evaluate the efficacy of their interventions in both empirical research and with each individual case and have historically stressed a time-effective therapy model. Moreover, there has been a strong focus in both the basic and applied behavior analytic literature on discerning the parameters of effects and side effects of reinforcement and punishment procedures, on rules and guidelines for behavior analysis practice, on competencies, and on controversial issues on which there has been persisting interest. Knowledge of parameters of effect and the dimensions and character of controversies, as well as applicable regulatory requirements and related competencies are essential to effective professional practice. Behavioral and cognitive psychology is particularly suited to meet the public need for effective, efficient, and accountable health and mental health services. In addition, behavioral and cognitive psychologists have been at the forefront in developing treatment manuals so that therapists are maximally accountable for their work, and therapies can be effectively disseminated. For example, in the list of empirically supported treatment approaches spearheaded by APA’s Division 12, the vast majority are behavioral and cognitive in nature. Another example is the Cognitive Therapy Adherence and Competence Scale which has been developed in order to rate therapists’ thoroughness and mastery in following the cognitive therapy treatment protocol. Like all other psychologists, behavioral and cognitive psychologists are taught to follow relevant ethical and legal codes.

Finally, behavioral and cognitive psychologists have developed a set of procedures that provide, from a variety of sources, indication of the reliability of its observations and social validation of its techniques, as discussed in this section. In this way, the field continually evaluates itself and protects the public.


g. Continued professional development

Behavioral and cognitive psychologists, like any licensed psychologists, must get the number of CEUs in psychology required by the jurisdiction where they are licensed. It is incumbent on the behavioral and cognitive psychologist to choose CEU offerings in the specialty to maintain competence in the specialty. Fortunately, there are numerous opportunities for CEUs in the specialty. Behavioral and Cognitive Psychologists are active in choosing continuing education offerings in the specialty, as evidenced by the large number of well-attended workshops, institutes, and fundamentals courses at the annual conventions of the American Psychological Association, Association for Behavior and Cognitive Therapies and the Association for Behavior Analysis International. They are also active in offering continuing education activities at the annual ABPP conference and workshops. Similarly, behavioral and cognitive psychologists engage in CE workshops sponsored by a wide variety of organizations, (e.g., The Beck Institute for Cognitive Therapy and Research). For those behavioral and cognitive psychologists who are also board certified behavior analysts, the BACB requires CEUs for continuing professional development. Most recently, the ABBCP, in line with the standards and policies of the ABPP, is developing procedures to document maintenance of specialty competencies through documentation of continued professional development. This is known as the Maintenance of Certification (MOC) and a board member of the ABBCP has been charged with the task of directing this effort. Finally, evidence of continuing professional development in the specialty is required for initial board certification in the specialty.


3. Identify professional practice activities associated with the specialty in each of the following domains and how they differentiate and where they might overlap with other specialties.

a. assessment:

What distinguishes behavioral and cognitive psychologists is their “her and now” approach to understanding the variables influencing problems. This here and now approach is what constitutes the case formulation approach based on functional analysis of variables currently occurring that influence problems. Because we are interested in current environmental determinants of problems consisting of behavioral, cognitive and emotional responses, our assessments focus on identifying and understanding the role these variable play in maintaining or reducing presenting problems. Assessments used by behavioral and cognitive psychologists focus on the current events in the environment and in the behavior of clients. Examples of such assessments are behavioral interviews, direct observations of antecedent, behavior consequence relations, functional analyses, identification of effective reinforcers, ecological momentary assessment of events as they naturally occur to influence problems, self-monitoring and monitoring by others. Although assessments used by behavioral and cognitive psychologists may overlap with those used by other specialties, ours are differentiated by the use of the assessments to inform case formulations focused on understand current the relations between overt behavior, cognition, and emotion and behavior-environment relations.

b. intervention:

Given the behavioral and cognitive psychology approach to case formulation based on understanding current environmental events and their relation to the triad of behavior, cognition, and emotion, interventions are focused on altering the current behavior environment relations to ameliorate problems. These interventions focus on changing environmental contingencies, changing client’s cognitions, and on altering clients’ responses to environmental events. Some examples of interventions focused on these goals are contingency management, behavioral skills training, function based interventions, emotional regulation techniques cognitive therapy and cognitive restructuring, mindfulness, and exposure based interventions. Although interventions used by behavioral and cognitive psychologists may overlap somewhat with those used by other specialties, ours are differentiated by the use of the assessments to inform intervention selection focused on altering current the relations between overt behavior, cognition, and emotion and behavior-environment relations.
c. Consultation:

Consultation in behavioral and cognitive psychology is based on the same model as assessment and intervention used in the specialty. In consultation, behavioral and cognitive psychologists identify behavior-environment relations and develop interventions to address these relations. We then teach consultees (parents, teachers, agencies, staff, employers, other health professionals) to implement the interventions. The goal of consultation is to help consultees understand the rationale for specific interventions to generalize this knowledge to new cases they might encounter.

d. Supervision:

The process of supervision in behavioral and cognitive psychology is similar to supervision in other specialties. However, the content of the supervision is on accessing and changing specific behaviors, emotional regulatory process and cognitions in the supervisee as well as the client. The goal of supervision is to help supervisees understand the model that underlies the behavioral and cognitive psychology specialty and to correctly implement assessment and intervention procedures consistent with the model.

e. Research and Inquiry:

Behavioral and cognitive psychologists have developed innovative research strategies focusing on single case designs based on repeated measures of behavior over time. Although behavioral and cognitive psychologists use group designs and correlational designs similar to other specialties, single subject designs (e.g., multiple baseline designs, reversal designs) are unique to the specialty.

f. Public Interest:

Behavioral and cognitive psychologists use assessment and interventions procedures that are strongly supported with clinical research. Furthermore, behavioral and cognitive psychology has guidelines for clinical practice and many interventions are manualized. Therefore, behavioral and cognitive psychology is well-positioned to provide for consumer protection, and therefore the public interest. Furthermore, we educate the public about empirically supported interventions (e.g., ABCT fact sheets), and provide information on psychologists trained in behavioral and cognitive psychology e.g., (ABCT Association of Behavioral and Cognitive Therapies, ABBPB, Academy of Cognitive Therapy).

g. Continuing Professional Development:

Although all licensed psychologists must get CEUs as required by the jurisdiction where they are licensed, behavior and cognitive psychologists are expected to participate in continuing professional education in areas specific to the specialty. Furthermore, behavioral and cognitive psychologists provide CEU opportunities specific to the specialty. Numerous examples of CEU opportunities in the specialty are available at ABCT and APA annual conferences and through other institutes such as the Beck Institute for Cognitive Behavior Therapy and through numerous webinars offered by behavioral and cognitive psychologists.

h.1. Teaching:

Behavioral and cognitive psychologists use behavioral and cognitive principles in delivering relevant education materials and apply learning-based principles of
change in increasing competence of trainees

h.2. Management and Administration

Behavioral and cognitive psychologists use learning based procedures such as cuing, prompting, shaping, chaining, feedback, and reinforcement to promote effective management.

h.3. Advocacy

Behavioral and cognitive psychologist apply principles of associative and instrumental change to advocate for the people that behavioral and cognitive psychologists serve, as well as promotion of the specialty to peers.
h.4. teaching
   Behavioral and cognitive psychologists use behavioral and cognitive principles in delivering relevant education materials and apply learning-based principles of change in increasing competence of trainees

h.5. Management and Administration
   Behavioral and cognitive psychologists use learning based procedures such as cuing, prompting, shaping, chaining, feedback, and reinforcement to promote effective management

h.6. Advocacy
   Behavioral and cognitive psychologists apply principles of associative and instrumental change to advocate for the people that behavioral and cognitive psychologists serve, as well as promotion of the specialty to peers

Criterion V. Advanced Scientific and Theoretical Preparation. In addition to a shared core of knowledge, skills and attitudes required of all practitioners, a specialty requires advanced, specialty-specific scientific knowledge.
   Commentary: Petitions demonstrate how advanced scientific and theoretical knowledge is acquired and how the basic preparation is extended.
1. Specialty education and training may occur at the doctoral (including internship), postdoctoral or post-licensure levels. State the level of training of the proposed specialty.
Specialty education and training occurs at the doctoral and post-doctoral levels.

2. Training at the doctoral level is assumed to be primarily broad and general. If specialty training occurs in whole or in part at the doctoral level, describe that training. If there is specialty specific scientific knowledge that is typically integrated with aspects of the broad and general psych curriculum (e.g., biological bases of behavior, cognitive-affective bases of behavior, individual bases of behavior, ethics (science and practice) rather than taught as a freestanding course or clinical experience, specify how this integration occurs.

For a number of decades, applied psychology in America has been heavily influenced by behavioral and cognitive psychology. Many doctoral programs in clinical psychology, counseling, school, and health psychology, have provided significant instruction in behavioral and cognitive approaches to understanding human development, psychopathology and approaches to psychological change. Behaviorally and cognitively-based professional psychology programs typically include a significant amount of instruction in traditional behavioral and cognitive core courses as well as professional practicum courses. Because of the range of problems and population applications in behavioral and cognitive psychology, specific programs may require advanced scientific and theoretical preparation that varies somewhat from program to program. Programs also differ in which components of a broad learning based model are given more emphasis (e.g., behavior analytic, respondent and instrumental conditioning, social learning, information processing, cognitive and affective theories). Behaviorally and cognitively oriented psychology programs, as opposed to any one singular area of focus, underscore the importance of viewing the following domains as interacting in a complex and integrated way. Therefore, one significant and unique area of advanced scientific knowledge lies in the models of integration that are required for trainees to have a functional understanding of psychological and behavioral disorders.

a. biological bases of behavior:
Individuals trained as behavioral and cognitive psychologists are expected to have an understanding of the biological bases of human behavior and psychopathology as they relate to development, assessment, diagnosis, and intervention. This understanding should extend to more advanced knowledge that is general to behavioral and cognitive psychology, as well as specific to populations or problems that are the foci of the individual training program. Examples of advanced scientific knowledge regarding behavioral and cognitive psychology in general include: biological theories of psychological or behavior disorders; psychopharmacology; neuroanatomy; neurophysiology; neuroscience substrates, affective neuroscience, autonomic nervous system functioning, and psychoneuroimmunology. However, the relative emphasis of these areas is dependent upon the specific populations or problems with which the psychologist is engaged. Specialty specific scientific knowledge regarding biological bases of behavior for behavior analytic psychologists primarily involves relationships of specific, syndromic, and traumatic neurological impairments to learning and performance, treatment priorities and sequences, biases in learning pace, sequence, and ability associated with or induced by neurological factors, biological factors associated with sudden or gradual changes in performance, response acquisition, or rate or severity of maladaptive behavior or features of psychopathology. Trends in the field of behavior analytic psychology have emphasized extensive diagnostic processes (e.g., behavioral diagnostics) which involve systematically assessing and identifying biological factors (acute, chronic, inborn, genetic, or environmentally triggered) contributing directly or indirectly to referral problems.

b. cognitive-affective bases of behavior:
Behavioral and cognitive psychologists should have knowledge of cognitive-affective bases of behavior as they relate to individual, group, and systems behavior, and to assessment (including the functional analysis of behavior), diagnosis, prevention, and treatment. In programs that emphasize cognitive approaches to behavioral treatment, this area is of special importance regarding advanced training. Examples of areas of advanced scientific knowledge include information processing, cognitive-developmental theories, decision-making theory, cognitive mediational processes, constructivist metatheory, emotional arousal and regulation, and cognitive-affective interaction. A robust literature also now exists on the analysis of cognition, behavior, emotions, and other private events from a behavior analytic perspective, including stimulus equivalence, other derived stimulus relations, verbal behavior, rule-governance, problem-solving, self-rules and self-talk and relational frames. Thus, the cognitive and affective aspects of behavior are given emphasis by most adherents to a broad learning-based model. In behavior analytic psychology, specialty specific scientific knowledge regarding cognitive-affective bases of behavior primarily involves the relationships of developmental and social behavioral history, and communication performance, to impairments of learning and performance, treatment priorities and sequences, and biases in learning pace, sequence, and ability associated with cognitive developmental or social-contextual factors (e.g., abuse, neglect). Additional knowledge requirements include relationships of cognitive and affective history and functioning to sudden or gradual changes in performance, response acquisition, or rate or severity of maladaptive behavior or features of psychopathology, as well as to issues of performance enhancement (e.g., organizational applications).

c. social bases of behavior:

Behavioral and cognitive psychology views behavior as occurring within a social context. The social context both influences and is influenced by individual behavior (both adaptive and maladaptive) in complex ways. Therefore, in general, advanced knowledge of social learning theory, social information processing theory, social contingencies, cultural differences and practices, meta-contingencies, attributional biases, stereotyping, and prejudice are required advanced knowledge cores. Knowledge of environmental variables is essential to the methodology of a functional analysis of behavior, and many of these variables are social. For behavior analytic psychologists, specialty specific scientific knowledge regarding social bases of behavior primarily involves the relationships of developmental and social behavioral history to present functioning, for example, with regard to early childhood experiences, parenting, educational experience, situational or environmental constraints, situational or interpersonal norms of behavior, and cultural, sub-cultural, or ethnic and social class norms of behavior. Specialty scientific knowledge must also be integrated in regard to the effects of cohabitant or social group participation, social and community integration, limiting or facilitating features of social organizational (i.e., service agency) performance, and impacts of the organization of various educational, human, and health services systems (as well as corporate contexts) and associated rules and regulations upon practitioners and consumers.

d. individual bases of behavior:

An understanding of life span development, gender, ethnicity, race, spiritual and religious background, and culture are all essential to conducting individualized or ideographic assessment of an individual. For behavioral and cognitive psychology, advanced scientific nomothetic information from all of these areas, as well as the previously described domains, all contribute to this understanding. Functional analysis provides a means of understanding and a method of formulation regarding the unique, inter-individual, and intra-individual differences across settings. As well, specialty specific scientific knowledge for behavior analytic psychology must be integrated with knowledge related to individual factors that impair or facilitate growth and development in the individual case. Specific consideration is given to simultaneous
impacts of multiple disabilities, health, or biobehavioral factors that in turn affect feasibility and selection of treatment procedures and potential benefits of a range of possible treatment practices.

e. ethics (science and practice):

Sound ethical knowledge and decision-making in both research and practice are central to all psychological specialties, including behavioral and cognitive psychology. All training programs include training in ethics as an official part of the curriculum. This includes ethical decision-making within different cultural contexts.

f. research design, methodology, statistics:

All training programs in professional psychology provide instruction in research design, methodology, and statistics, although the number and sophistication of these courses will vary according to the nature of the program. Behavioral and cognitive psychology employs the full range of research and statistical strategies—group designs, multivariate, regression, structural equation modeling, and program outcomes evaluation. In addition, it has pioneered the use of a scientifically based single case design approach, with appropriate statistical analysis, such as time series analysis.

g. history and systems:

All professional psychology programs are required by accreditation standards to provide instruction in history and systems. Behavioral and cognitive psychology programs include and emphasize the major learning theorists that have contributed to the specialty.

h. measurement:

All professional psychology training programs provide instruction in assessment and measurement. In addition, behavioral and cognitive psychology training programs emphasize more behaviorally and cognitively oriented aspects of measurement, such as direct observation of behavior, role-plays, and clinician administered instruments.

i. practicum:

Practicum training is as extensive as in other specialties and tends to occur in settings and with populations for whom behavioral and cognitive interventions are prescribed.

j. supervision:

Supervision provided by behavioral and cognitive psychology supervisors is similar to that provided by supervisors in other specialties. However, there is a significant emphasis on applying evidence-based learning theories and interventions, and setting measurable goals. These activities are required for clients and supervisees. Training and supervision concerning all procedures and techniques provides a role model for a behavioral and cognitive approach. Specific therapist behaviors should be operationalized and monitored during the clinical training process. Specific feedback is clearly and concretely provided to trainees.

k. case formulation
Coursework and training in behavioral and cognitive case formulation applies a functional framework and heuristic for trainees to integrate all of the extensive areas of training required for the specialty regarding assessment and treatment.

3. If specialty training occurs in full or in part during a formal postdoctoral program describe the required education and training and other experiences during the postdoctoral residency. Are there any doctoral level prerequisites beyond an APA-accredited degree in professional psychology required for postdoctoral training?

Currently there are no post-doctoral accredited programs in Behavioral and Cognitive Psychology although there are many accredited clinical psychology postdoctoral programs that are functionally behavioral and cognitive in orientation. For example, these programs provide advanced training in behavioral and cognitive assessment and interventions such as prolonged exposure, contingency management, social skills training, relapse prevention, cognitive processing therapy, problem-solving therapy, CBT for insomnia, ACT and DBT. The behavioral and cognitively oriented postdoctoral candidate would be expected to have successfully completed all requirements of an APA accredited program. Although not required, it is suggested that most postdoctoral candidates should have completed basic graduate-level coursework in learning-based theory, assessment and interventions and have completed related practicum experiences in the specialty.

4. If specialty training occurs in full or in part post-licensure, describe the required education and training during this training. Are there any doctoral level prerequisites beyond an APA-accredited degree in professional psychology required for post-licensure training?

Professional ethics requires that behavioral and cognitive specialists continue their education and development in the specialty. Additionally, in order to become board-certified in Behavioral and Cognitive Psychology through the ABPP, an applicant must demonstrate a specialty-competent knowledge base and experience in order to qualify for the examination by peers. This includes detailed knowledge in the candidate's major area of practice along with a competent understanding of information in the broader specialty. Post ABPP board certification, behavioral and cognitive psychologists will be formally required to provide evidence of competency maintenance as provided for Maintenance of Certification (MOC) requirements that are under development.

Although some organizations (e.g., BACB, ACT) provide credentials for non-doctoral trained clinicians or practitioners in other disciplines such as psychiatry, the competencies required for certification are in restricted applications of behavioral methods and cognitive interventions and do not require the range of competencies or broad academic background such as is required by accredited doctoral psychology training programs and internships. In other words, programs that offer such certification to non-doctoral level clinicians or practitioners from other disciplines are providing certification in what might be viewed as a specific proficiency that can be considered under the rubric behavioral and cognitive psychology. These programs, however, do not meet APA, APIC, CRSPPP, jurisdictional psychology licensure, or ABPP standards.

Criterion VI. Advanced Preparation in the Parameters of Practice. A specialty requires the advanced didactic and experiential preparation that provides the basis for services with respect to the essential parameters of practice. The parameters to be considered include: a) populations, b) psychological, biological, and/or social problems, and c) procedures and techniques. These parameters should be described in the context of the range of settings or organizational
arrangements in which practice occurs. If the specialty training occurs at more than one level (e.g., doctoral, postdoctoral, post-licensure) please list the levels of preparation separately.

Commentary:

A) Populations. This parameter focuses on the populations served by the specialty, encompassing both individuals and groups. Examples include but are not limited to the following: children, youth and families; older adults; workforce participants and those who seek employment; men and women; racial, ethnic, and language minorities; gay, lesbian, bisexual and transgender individuals; persons of various socioeconomic status groups; religion; and those with physical and/or mental disabilities.

B) Psychological, Biological, and/or Social Problems. This parameter focuses on symptoms, problem behaviors, rehabilitation, prevention, health promotion and enhancement of psychological well-being addressed by the specialty. It also includes attention to physical and mental health, organizational, educational, vocational, and developmental problems.

C) Procedures and Techniques. This parameter consists of the procedures and techniques utilized in the specialty. This includes assessment techniques, intervention strategies, consultative methods, diagnostic procedures, ecological strategies, and applications from the psychological laboratory to serve a public need for psychological assistance.

1. Describe the advanced didactic and experiential preparation for specialty practice in each of the following parameters of practice:

   a. populations (target groups, other specifications):

Behavioral psychology was once described as having “a long past but a short history” (O’Leary & Wilson, 1987, p.1), in that many of its procedures, strategies, and methods have been used throughout human history, but the systematized field has had only a short history dating back about 70 or so years. Since the 1950s however, behavior therapy, applied behavior analysis, cognitive therapy, and cognitive-behavior therapy have emerged into center stage in the field of psychology and mental health. The populations relevant to the specialty of behavioral and behavioral psychology, include populations at the individual level (children, adolescents, adults, geriatric populations), as well as larger systems (couples, families, groups, organizations, and communities). Research has also demonstrated the effectiveness of behavioral treatments especially for psychiatric and medical inpatients and outpatients, individuals with physical, mental, and developmental disabilities.

Because of the enormous variety of individuals for whom behavioral and cognitive treatment is scientifically appropriate, different programs may have an emphasis on various aspects of these areas, but there should be significant and adequate didactics and clinical practicum opportunities that are outlined in training programs. These practicum experiences are under the supervision of behaviorally and cognitively-oriented therapists. Training and supervision should be provided within the context of a behavioral and cognitive approach toward skill competency. Specific goals and therapist competencies should be operationalized and documented as a requisite of completion of advanced training. Advanced training will help people to develop the competencies required for research and program development.

The populations addressed include people of all ages seen in a broad range of settings. These include early intervention programs; preschool services, schools, colleges, and vocational rehabilitation contexts (e.g., work preparation, workshops, supported work); academic health science centers, community and teaching hospitals; brain injury rehabilitation settings; developmental and intellectual disabilities; day, residential, and clinic programs; private pediatric and primary medical care practices; tertiary mental health care programs and community centers; corporations, large businesses, Active Military and Veterans are services, and not-for-profit organizations. Specific populations served include, but are not limited to:
1. children, adolescents, adults and older adults with autism and pervasive developmental disorder
2. children, adolescents, adults and older adults with mental retardation and related developmental conditions
3. children, adolescent, adults and older adults with cerebral palsy (and other paralytic disorders)
4. children, adolescents, adults and older adults who have sustained brain injury (e.g., CHI, TBI)
5. children, adolescents, adults and older adults with chronic medical conditions
6. children, adolescents, adults and older adults with eating disorders (e.g., including obesity)
7. children, adolescents, adults and older adults with epilepsy (i.e., seizure disorders)
8. children, adolescents, adults and older adults with severe psychological conditions (e.g., persistent or recurrent anxiety, phobic, affective, and psychotic or schizophrenic disorders)
9. children, adolescents, adults, and older adults with severe emotional disturbance
10. young children at risk of developmental disability, disorder, or severe emotional disturbance
11. older adults with impairments of aging
12. children, adolescents, adults and older adults with learning disabilities
13. children, adolescents, adults and older adults with specific health care needs who are medically noncompliant
14. children, adolescents, adults and older adults with chronic diseases requiring self-care, self-directed regimens, or special self-care skills
15. children, adolescents, adults and older adults with trauma-related disorders
16. children or adolescents who are pre-delinquents or delinquents
17. children or adolescents who are in youth or correctional services, and who have been adjudicated
18. children, adolescents, adults or older adults who are severely aggressive or self-injurious
19. adolescents, adults or older adults with sexual dysfunction
20. parents and siblings of children with disabilities, chronic health conditions, or persistent mental disorders.
21. families who are affected by, or engaged in, child abuse.
22. families seeking child rearing or parent training
23. adults seeking social skills, or couples’ skills enhancement
24. students and teachers in classrooms (e.g., improving classroom management practices and instructional methods)
25. workers and managers seeking improvement in supervisory skills, organization, management, productivity, or career development.
26. Clients of all ages with significant depression, anxiety, and anger problems.
27. Clients of all ages with impoverished lives.
b. problems (psychological, biological, and/or social (including symptoms, problems behaviors, prevention, etc.)):

c. Behavioral and cognitive psychology has been applied to diverse psychological, biological, and social problems. It is important to underscore the notion that behavioral and cognitive psychology methods are not limited to the alleviation of psychological, emotional, or behavioral distress. The specialty has also contributed to public policies in health and safety issues, health care reform, and many different industries. It also affects the field of bio-behavioral medicine regarding a comprehensive understanding of health and wellness, disease and illness.

Training programs may vary in their focus. However, specific advanced didactic and clinical practicum experience in any of these areas should be provided in order to adequately prepare more experienced trainees for functioning within the specialty. Advanced training in specific problem areas should include knowledge of empirical research relevant to this area as well as the limitations and gaps in empirical research in this area. As examples, problems treated by behavior and cognitive psychologists include, but are not limited to:

1. Self-injurious behavior
3. Social skills deficits and diagnostic-criterion behaviors in various populations.
4. Pragmatic skills deficits in children and adults with various conditions and disorders.
6. Deficits in social performance, social skills, and self-directive skills. Deficits in functional skills performance associated with changes in physical, sensory, or neurological capabilities.
7. Behavioral health-related conditions, such as eating disorders, obesity, medical and pharmacological non-compliance, compensatory and instrumental skills compensation for paralytic disorders, seizure disorders, parental care for childhood chronic medical conditions, sexual dysfunction, and substance abuse.
8. Relationship problems, including couples, family and parent skills deficits.
9. Communication skills development.
11. Primary and secondary prevention of disability, disorder, and disease.
12. Addictive disorders
13. Behavioral issues related to public and individual safety and environmental issues, as well as public health concerns.
14. Problems with depression, anxiety, and anger.
15. Stress-related and medically unexplained symptoms in primary care
16. Chronic pain
17. Sleep disorders
d. procedures and techniques (for assessment, diagnosis, intervention, prevention, etc.):

The advanced procedures and techniques of behavioral and cognitive psychology that make it a unique specialty are the foci of training. Assessment and intervention strategies subsumed under this umbrella have been developed from (a) experimental psychology, such as learning theory, (b) cognitive psychology, such as informational processing and tacit knowledge structural models, and (c) social psychology, such as social learning theory. These varying areas of emphasis result in both shared strength as well as unique contributions to behavioral procedures and techniques unique in each subspecialty area.

Assessment: Advanced training in behavioral and cognitive assessment methods includes the integration and extension of the full range of methods referred to in descriptions of basic training and previous criteria. This integrative assessment includes traditional behavioral and cognitive-behavioral methods, as well as standardized assessment instruments.

Case Formulation. Behavioral and cognitive case formulation is the process that links the results of a therapist’s assessment to treatment planning. Nezu, Martell and Nezu (2013), Tarrier and Johnson (2015), and Persons and Lisa (2015) describe models of case formulation and clinical decision making that are based on a systematic problem-solving approach. According to these models, the process of designing an intervention and selecting actual treatment strategies is characterized as involving the integration of all the functional relationships among important biopsychosocial variables. Hypotheses concerning the various direct and indirect clinical paths are derived from the scientific literature, but applied ideographically. This comprehensive functional analysis is a meta-judgment and a synthesis of several judgments about client problems and goals, their effects, related causal and mediating variables. Cognitive case formulation involves looking at causal links between early maladaptive beliefs and current, faulty information processing and decision-making that perpetuate problems in moods and living.

Although behavior analytic psychologists, as do other psychologists, may employ psychometric measures in diagnosis or classification, or rating scales and screening checklists as appropriate to referral questions or circumstances, there are a number of assessment procedures that are specific to this specialty, and which are applied on an episodic or continuous basis in linking assessment and treatment. Behavior analytic assessment procedures are commonly used to obtain an ongoing determination of treatment effects and as a basis for modifying treatment methods accordingly in a timely and responsive manner. Thus most of the assessment procedures to be mastered entail ascertainment of present processes of learning and behavior change in the individual case through direct observation and measurement, as well as corresponding status measures of impact or effect. Specific didactic and experiential training focuses on:
1. Operational definition and direct observation and measurement of behavior, antecedents, and consequences in order to identify environmental events or contexts that may cause behavior.

2. Systematic manipulations of environmental variables while measuring related changes in behavior (demonstrating functional relations) and for determining the reliability and generality of functional relations (functional analysis).

3. Within-subject assessment designs (withdrawal reversal, alternating treatments, changing criterion, multiple baseline), component analysis, and parametric analysis methodologies to demonstrate functional relations between environmental events and behavior, and to determine the reliability and generality of functional relations through direct and systematic replication of treatment effects.

4. Continuous measures of behavior of frequency, rate, duration, latency, per trial or opportunity, inter-response time, and other observable dimensions of behavior.

5. Estimates of dimensions of behavior through sampling methods such as partial-interval recording, whole-interval recording, and momentary time sampling.

6. Systematic manipulations of environmental (e.g., learning or performance tasks) variables in order to ascertain learning or performance status and identify skill or performance deficits.

7. Self- or other-report of direct observation and self- or other-monitoring of operational measurement of behavior, antecedents, and consequences supplemented by direct practitioner observation and in order to identify environmental events or contexts that may cause behavior.

8. Sequential recording of operationally defined and directly observed multiple behavioral and situational events to identify complex or multiple stimulus-behavior contingencies, e.g., ecological behavioral recording in natural contexts.

9. Estimates of dimensions of behavior through sampling methods and systematic manipulations of environmental variables in order to ascertain effects of changes in prescribed medications on changes in behavior (i.e., in particular, therapeutic effects).

Interventions: Advanced training in behavioral and cognitive interventions involves the knowledge to apply effectively the interventions previously listed throughout this document in a prescriptively applied manner. Specifically, the advanced specialists make their determination of what strategies to employ based upon their advanced knowledge of learning theory and a sophisticated functional analytic thought process. In others words, although basic training involves the therapist obtaining a level of skill competency to implement clinical interventions, advanced specialty training involves discovery, development and integration of these interventions. For example, in the area of behavior analysis, this requires skills with respect to:

1. Selection, development, and use of discrete trial and incidental teaching techniques.

2. Consequence-based interventions entailing use or withdrawal of reinforcers (based on functional assessment results).

3. Consequence-based interventions, including use of punishers.

4. Stimulus control strategies and strategies based on motivating operations.

5. Shaping procedures, chaining procedures, and behavioral skills training procedures.

6. Comprehensive systems for skill building that incorporate multiple behavioral principles and
techniques (e.g., Direct Instruction, precision teaching, Personalized System of Instruction [PSI]).

7. Reinforcement systems, including token reinforcement systems and behavioral contracts.

8. Molar (stage or levels) systems of intervention.


With regard to other behavioral and cognitive areas, decision-making skills consistent with the case formulation approach described above, as well as skills in the competent delivery of interventions relevant to one’s practice are required.

Criterion VII. Structures and Models of Education and Training in the Specialty. The specialty has structures and models to implement the education and training sequence of the specialty. The structures are stable, sufficient in number, and geographically distributed. Specialty education and training may occur at the doctoral, postdoctoral, or both.

Commentary:

A) Sequence of Training. A petition describes a typical sequence of training, including curriculum, research, and supervision.

B) History and Geographic Distribution. A specialty has at least four identifiable psychology programs providing education and training in the specialty in more than one region of the country that are geographically distributed and which have produced an identifiable body of graduates over a period of years.

C) Psychology Faculty. Specialty programs have an identifiable psychology faculty responsible for the education and training of students and their socialization into the specialty. The faculty has expertise relevant to the education and training offered. Faculty may include individuals from other disciplines as appropriate. Specialty programs also have a designated psychologist who is clearly responsible for the integrity and quality of the program and who has administrative authority commensurate with those responsibilities. This psychologist has credentials of excellence (e.g., the diplomate from one of the specialty boards affiliated with the American Board of Professional Psychology, or status as a fellow of the American Psychological Association or the Canadian Psychological Association, or other evidence of equivalent professional recognition) and a record of scholarly productivity as well as other clear evidence of professional competence and leadership.

D) Procedures for Evaluation. Specialty programs regularly monitor the progress of trainees to ensure the relevance and adequacy of the curriculum and integration of the various training components. Attention focuses on the continuing development of the trainee’s knowledge, skills, attitudes, and values. Formal performance based feedback is provided to trainees in the program.

E) Admission to the Program. Program descriptions specify the nature and content of the program and whether they are designed to satisfy current licensing and certification requirements for psychologists as well as whether or not graduates can satisfy the education and training requirements for advanced recognition in the specialty. Postdoctoral programs have procedures that take into account the trainees’ prior academic and professional record. These programs design an education and training experience that builds upon the doctoral program and internship and the professional experiences of the postdoctoral residents as they prepare for meeting the guidelines of preparation for the specialty.

1. How are education and training programs in the specialty recognized? How many programs exist in the specialty?
Educational and training programs in the specialty are generally identified through descriptions provided on their website, through perusal of their curriculum, or through perusal of faculty research areas. For example, many clinical psychology doctoral programs are functionally behavioral and cognitive but are not specifically accredited as such officially by that name because of current CoA accreditation requirements. The APPIC currently lists 90 programs that are self-identified as providing behavioral and cognitive training.

It is difficult to provide an accurate and precise number because the programs are self-identified. Although the training programs that provide training in the behavioral and cognitive specialty are well known among the academic and clinical training community in this specialty, there is no publicly available listing of these programs. We see this issue as a limitation in identifying programs providing training in the specialty. There is a serious need for professional organizations representing behavioral and cognitive psychology to compile a directory of program that provide training in the specialty. In response to this need, ABBCP plans to ask major behavioral and cognitive organizations to survey their membership in order to develop an accurate directory of behavioral and cognitive psychology programs that takes into account the specific curriculum and training opportunities provided in each program.

2. Describe the qualifications necessary for faculty who teach in these programs. Describe the qualifications required for the director of such programs.

Like other doctoral programs in professional psychology (clinical, counseling, school), behavioral and cognitive psychology programs are staffed by doctoral-level psychologists with extensive experience in teaching, research and service as well as possessing professional credentials. Program directors may possess board certification in Behavioral and Cognitive Psychology and/or APA fellowship status. For a program to be identified as behavioral and cognitive, faculty qualifications for individuals responsible for training in the specialty would be expected to demonstrate documented expertise in the specialty. Examples of these credentials may include publications in behavioral and cognitive therapy, research in behavioral and cognitive therapy and peer evaluated competency in professional service from a behavioral and cognitive orientation (e.g. ABPP)

3. If programs are doctoral level, what are the requirements for admission? Provide sample evaluation forms.

Students admitted to these programs typically possess a bachelor’s or master’s degree in psychology, often with research experiences with faculty mentors who are themselves behaviorally and cognitively oriented psychologists. In the more clinical scientist programs, they may be co-authors of publications and professional presentations behavioral and cognitive psychology.

Most evaluation forms are specific to the professional school or university relevant to the doctoral program, but would typically include a review of academic credentials, letters of recommendation, standardized admission examinations, and evidence of research and/or clinical interest and achievements. Usually there are in-person interviews or telephone interviews with members of the faculty of the department to which they are applying and these interviews are rated by the faculty members. Pertinent to such interviews, program faculty are seeking students with a strong commitment to training in the behavioral and cognitive specialty.

The evaluation forms for doctoral programs lists rudimentary information such Student GPA, GRE scores, institutions attended, and contact information. Information about their suitability for behavioral and cognitive training can be found through perusal of their cv, review of recommendation letters, personal statements, and interview.
4. If programs are postdoctoral, what are the requirements for admission? Provide sample evaluation forms.

Graduation from an APA accredited program or equivalent in professional psychology is generally required. Expressed interest in behavior and cognitive psychology is required. Coursework in behavioral and cognitive psychology is preferred. Doctoral level internships with evidence of behavioral and cognitive psychology training is preferred.

The APPIC Universal psychology post-doctoral directory lists 45 postdoctoral programs that self-identify as behavioral and cognitive. [https://www.appic.org/Postdocs/Universal-Psychology-Postdoctoral-Directory-UPPD](https://www.appic.org/Postdocs/Universal-Psychology-Postdoctoral-Directory-UPPD)

Most evaluation forms are internal and specific to the program but would typically include documentation of accredited doctoral training and a written description of the applicant’s background relevant to behavioral and cognitive psychology as well as letters of recommendation. Often in-person or telephone interviews are conducted.

5. Include or attach education and training guidelines, for this specialty as appropriate for doctoral training, postdoctoral training, or both. (In this context, education and training guidelines may be found in documents or websites including, but not limited to, those bearing such a title or as described in a variety of published textbooks, chapters, and/or articles focused on such contents.)

Education and training guidelines for both doctoral and postdoctoral programs as well as Applied Behavior Analysis can be found here: [https://www.cospp.org/](https://www.cospp.org/)

The education and training guidelines in behavioral and cognitive psychology are as follows:

**Behavioral and Cognitive Psychology**

- [ABCBP Guidelines for Specialists with Competency in Applied Behavior Analysis](https://www.cospp.org/)
- [APBA Position on Psychologists and Applied Behavior Analysis](https://www.cospp.org/)
- [BACB Position on Psychologists and Applied Behavior Analysis](https://www.cospp.org/)
- [Behavior Therapy Published Guidelines for Cognitive Behavioral Training Within Doctoral Psychology Programs in the U.S.](https://www.cospp.org/)
- [Education and Training Guidelines for Behavioral and Cognitive Psychology at the Post-Doctoral Level](https://www.cospp.org/)
- [Guidelines for Doctoral Psychology Programs Incorporating Cognitive and Behavioral Education and Training](https://www.cospp.org/)
- [Professional Psychology: Research and Practice Article on the Specialty of Behavioral and Cognitive Psychology](https://www.cospp.org/)
- [Taxonomy for Behavioral and Cognitive Psychology](https://www.cospp.org/)
6. Provide sample curriculum expected of model programs.

A sample curriculum from the University of Nevada — Reno can be found with the following link: https://www.unr.edu/psychology/degrees/clinical-phd

7. Select four exemplary doctoral and/or postdoctoral level geographically distributed, and publicly identified programs in psychology in this specialty and provide the requested contact information. If no example programs that are APA accredited are available, please complete the appropriate Attachment (A or B) for the level of the program. If the specialty education and training occurs at both the doctoral and postdoctoral level provide examples of both and not from the same institution.

Program One

Doctoral

Postdoctoral

Both

Name of University, School, or Institution offering program: University of Nevada - Reno

Name of Program: PhD Clinical Psychology

Address: 1664 N. Virginia Street

City/State/Zip: Reno NV 89557

Contact: Michael Crognale, Interim Department Chair

Telephone No: 775-784-1126

E-mail address: mcrognale@unr.edu

Website: http://www.unr.edu/psychology

APA Accreditation: Full

Program Two

Doctoral

Postdoctoral

Both

Name of University, School, or Institution offering program: Drexel University

Name of Program: PhD Clinical Psychology

Address: Stratton Hall, 3201 Chestnut Street

City/State/Zip: Philadelphia, PA 19104

Contact Person: Ms. Roxanne Staley-Hope Telephone No.215-895-1895 E-mail address: ms25@drexel.edu
Website: Drexel.edu/psychology APA
Accreditation: Full

Program Three

Name of University, School, or Institution offering program: Stony Brook University
Name of Program: PhD Clinical Psychology
Address: Stony Brook University City/State/Zip: Stony Brook, NY 11794
Contact Person: Dr. Arthur Samuel, Department Chair Telephone No. (631) 632-7792
E-mail address: arthur.samuel@stonybrook.edu
Website: http://www.stonybrook.edu/commcms/psychology/index.html APA
Accreditation: Full

Program Four

Name of University, School, or Institution offering program: Kennedy Krieger Institute, Johns Hopkins University
Name of Program: Behavioral Psychology Postdoctoral Training Program
Address: 707 North Broadway
City/State/Zip: Baltimore, MD 21205
Contact Person: Training Director: Valerie Paasch, PhD, Director of PostDoctoral Training
Telephone No. 443-923-7980
E-mail address: psychology@kennedykrieger.org
Website: https://www.kennedykrieger.org/training/programs/psychology-training/behavioral psychology/postdoctoral-fellowship
APA Accreditation: Full

Criterion VIII. Continuing Professional Development and Continuing Education. A specialty provides its practitioners a broad range of regularly scheduled opportunities for continuing
professional development in the specialty practice and assesses the acquisition of knowledge and skills.

Commentary: With rapidly developing knowledge and professional applications in psychology, it is increasingly difficult for professionals to deliver high quality services unless they update themselves regularly throughout their professional lives through continuing education mechanisms. A variety of mechanisms may be used to achieve these goals.

1. Describe the opportunities for continuing professional development and education in the specialty practice. Provide detailed examples, such as CE offerings that are available.

Several professional organizations have a large number of research and clinical continuing education offerings as posters, papers, plenary presentations, workshops, and master training experiences in behavioral and cognitive psychology. These include the conferences of ABCT, APA, APBA, ABAI, WCBCT (World Congress of Behavioral and Cognitive Therapies) and the more recent ABPP workshops and conference. In addition, many behavioral and cognitive interventions have been nationally disseminated and required through the Department of Veterans Affairs. The state psychological associations also offer CE opportunities. There are also numerous free-standing behavioral and cognitive psychology offerings through various CE groups and organizations.

There is likewise a rich professional literature, providing many opportunities for professional development. These include but not limited to the specialty journals listed below:

Behavior Therapy
Cognitive and Behavioral Practice
The Behavior Therapist
The Behavior Analyst
The Analysis of Verbal Behavior
Behavior Analysis in Practice
Behavior Analysis: Research and Practice
Annals of Behavioral Medicine Behavioral Interventions
Behavior Modification
Behavioral Medicine
Behavioral Sleep Medicine
Behavioural and Cognitive Psychotherapy
Behaviour Research & Therapy
Child & Family Behavior Therapy
Journal of Behavior Therapy & Experimental Psychiatry
Journal of Behavioral Medicine
Journal of Behavioral Education
Journal of Cognitive and Behavioral Psychotherapies
Journal of Cognitive Psychotherapy
It is important to note that many additional general journals contain substantial content specific to behavior and cognitive psychology such as the *Journal of Consulting and Clinical Psychology* and the *Journal of Pediatric Psychology*.

2. Describe the formal requirements, if any, for continuing professional development and education to maintain competence in the specialty

At present, psychologists practicing behavioral and cognitive psychology do not have specific formal continuing professional requirements. The only requirements are set by state licensing laws. However, for those seeking board certification by the American Board of Behavioral and Cognitive Psychology are required to demonstrate maintenance of competency by reporting activities outlined in the ABPP Maintenance of Competency (MOC) guidelines.

An important part of this continuing professional development in behavioral and cognitive psychology is board certification in behavioral and cognitive psychology granted by the American Board of Behavioral and Cognitive Psychology, a member board of the American Board of Professional Psychology. All board certified behavioral and cognitive psychologists must now demonstrate continued competence through the process of Maintenance of Certification (MOC). The MOC protocol is standardized through the ABPP and must be completed every 10 years.

Licensed and board certified behavioral and cognitive specialists or certified behavior analytic psychologists are subject to all prevailing requirements for continuing education participation and documentation established in their respective state licensure or certification legislation.

3. Describe the minimum expectations, if any, for continuing professional development and education to maintain competence in the specialty.

The minimum expectations for continuing professional development and education to maintain
competence in the specialty includes the relevant jurisdictional requirements for licensure maintenance. In the case of board certification, all required Maintenance of Competence protocols pertaining to the individual board must be followed.

**Criterion IX. Effectiveness.** Petitions demonstrate the effectiveness of the services provided by its specialist practitioners with research evidence that is consistent with the APA 2005 Policy on Evidence-based Practice.

**Commentary:** A body of evidence is be presented that demonstrates the effectiveness of the specialty in serving specific populations, addressing certain types of psychological, biological and social behaviors, or in the types of settings where the specialty is practiced.

**PLEASE NOTE:** If the same article illustrates more than one of these items, it may be referenced under each applicable category. Evidence should include the most current available published references in each area (e.g., books, chapters, articles in refereed journals, etc.) While reliance on some on classic references is acceptable, the majority of references provided should be from last five years.

Here is a link to a list of Evidence-Based practices, most of which are behavioral and cognitive in orientation. [http://www.div12.org/psychological-treatments/treatments/](http://www.div12.org/psychological-treatments/treatments/)

Although this link provides the rich evidence base for behavioral and cognitive procedures, the behavior and cognitive specialty embraces the APA policy statement concerning evidence-based practice. Specifically, behavioral and cognitive psychology promotes the principle that EBPP involves the integration of the best available research (provided in link above) with clinical expertise and decision making in the context of patient characteristics, culture, preference and therapeutic relationship.

1. Provide at least five psychological manuscripts published in refereed journals (or equivalent) that demonstrate the efficacy of the specialty's services for dealing with the types of clients or populations (including groups with a diverse range of characteristics and human endeavors) usually served by this specialty. Summarize and discuss the relevance of the findings of the studies, specify populations, interventions, and outcomes in relation to the specialty practice.

Regarding persons with autism:


Regarding children with chronic illness:


Regarding adolescents:

Regarding adults with cancer:

Regarding people diagnosed with personality disorders:

2. Provide at least five psychological manuscripts published in refereed journals (or equivalent) that demonstrate the efficacy of the specialty’s services for dealing with the types of psychological, biological, and/or social problems usually confronted and addressed by this specialty. Summarize and discuss the relevance of the findings of these studies, particularly their measures and outcome results.

Regarding chronic pain:

Regarding PTSD:

Regarding Insomnia:

Regarding Depression:

Regarding Schizophrenia:

Regarding Anxiety:

3. Provide at least five psychological manuscripts published in refereed journals (or equivalent) that demonstrate the efficacy of the specialty's procedures and techniques when compared with services rendered by other specialties or practice modalities. Summarize and discuss the relevance of the findings of these studies, particularly their measures and outcome results and the comparisons to other specialties or modalities.


4. Provide at least five psychological manuscripts published in refereed journals (or equivalent) that demonstrate the efficacy of the specialty's services for dealing with the types of settings or organizational arrangements where this specialty is practiced. Summarize and discuss the relevance of the findings of these studies in relation to the specialty practice.


**Criterion X. Quality Improvement.** A specialty promotes ongoing investigations and procedures to develop further the quality and utility of its knowledge, skills, and services.  
**Commentary:** The public interest requires that a specialty provides the best services possible to consumers. A specialty, therefore, continues to seek ways to improve the quality and usefulness of its practitioners' services beyond its original determination of effectiveness. Such investigations may take many forms. Specialties promote and participate in the process of accreditation in order to enhance the quality of specialty education and training. Petitions describe how research and practice literatures are regularly reviewed for developments which are relevant to the specialty’s skills and services, and how this information is publicly disseminated.

1. Provide a description of the types of investigations that are designed to evaluate and increase the usefulness of the skills and services in this specialty. Estimate the number of researchers conducting these types of studies, the scope of their efforts, and how your organization and/or other organizations associated with the specialty will act to foster and communicate these developments to specialty providers. Provide evidence of current efforts in these areas including examples of needs assessed and changed that resulted.

An inherent principle of behavioral and cognitive psychology involves the evaluation of its assessment and treatment efficacy. The specialty’s contribution to the scientific literature and peer review process often serve as a model for other specialties in terms of methodology and outcomes measurement. There are numerous journals devoted specifically to the empirical evaluation of behavioral assessment and interventions. The vast majority of empirically supported treatments cited in the APA Division 12 report are cognitive-behavioral in nature. Furthermore, much of the research in more general clinical and health psychology journals focus on behavioral and cognitive procedures. Meta-analyses consistently support the efficacy of behavioral and cognitive psychology. These studies, along with the extensions of specific treatments to different populations and disorders, constitute a continually evolving data in support of behavioral and cognitive psychology.

The membership of Association for Behavior and Cognitive Therapies (ABCT) is more than 4,800 and over 90% of them are psychologists. The number of presentations at the ABCT conventions is
approximately 900 annually. ABCT also fosters the development of junior researchers through its awards and recognitions programs. The largest numbers of behavioral and cognitive psychologists who are members of APA are represented by membership in Division 12 (Society of Clinical Psychology, section 3). The Society of Clinical Psychology maintains a listing of research supported treatments. The majority of them are behavioral and cognitive approaches (at least 70%).

Because behavior analytic psychology utilizes a specific group of methodological approaches in applied research that mirror those used in the experimental analysis of behavior, and because practitioners are uniformly trained to use these methods to monitor the implementation and effects of treatment, it is common for practitioners to engage in publication of applied research findings. This has resulted in a rich professional literature, encompassed by more than a dozen journals.

There is no existing enumeration of behavior analytic psychologists, but about one-third of Division 33 members (N > 750), Division 25 members (N > 750), and at least one-third of ABA members (N > 3,500) are psychology practitioners engaged in behavior analytic psychology. Similarly, about one-half of the membership of the Psychology Division of the American Association on Intellectual and Developmental Disabilities (N > 1,700) consists of behavior analytic psychological practitioners.

The Association for Behavior Analysis International has systematically fostered basic and applied research, as well as professional and theoretical commentary, through its journal publications. Division 33, Division 25, and ABA have encouraged research actively through their newsletters; Division 25 and ABA recognize research and applied contributions through career and recognition awards that are given on an annual basis. During the past several years ABA International has a much broader international focus, with membership not only from Canada and Mexico, but also from Japan and the greater Asian continent, South America, Australia, and the United Kingdom and Europe.

2. Describe how the specialty seeks ways to improve the quality and usefulness of its practitioners' services beyond its original determinations of effectiveness.

A large part of the annual conferences is directed toward continuing education. There is a philosophical adherence to self-monitoring and a continual improvement process concerning our services. In addition to ABCT there are several other organizations that offer continuing education opportunities in behavior therapy for psychologists. ABCT has established a journal intended primarily for cognitive-behavioral practitioners, Cognitive and Behavioral Practice, and more recently has commenced a continuing education program that offers opportunities at sites around the country. Experts in the behavioral and cognitive specialty have historically participated in the ABPP annual continuing education conferences.

A primary strategy to ascertain the quality and usefulness of behavioral psychological services that transcends initial concerns of effectiveness involves the determination of the acceptability of behavioral treatments to the consumers, interested parties, and organizational members involved in the delivery of professional services. A rich literature has developed in this area.

3. Describe how the research and practice literature are regularly reviewed for developments which are relevant to the specialty's skills and services, and how this information is publicly disseminated. Give
examples of recent changes in specialty practice and/or training based upon this literature review.

There is a plethora of scientific and practice-oriented journals and books dedicated to the dissemination of behavioral and cognitive psychology basic and applied research. These include: *Behavior Therapy*, *Cognitive and Behavioral Practice*, *The Behavior Analyst*, *the Behavior Therapist*, *Cognitive Therapy and Research*, *Journal of Cognitive Psychotherapy*, *Journal of Applied Behavior Analysis*, *Behavior Research and Therapy*, *Journal of Behavior Therapy and Experimental Psychiatry*, *Advances in Behavior Research and Therapy*, *Annals of Behavioral Medicine*, *Annual Review of Behavior Therapy: Theory and Practice*, *Behavior Modification*, *Behavioral Medicine*, *Behavior and Philosophy*, *Biofeedback and Self Regulation*, *Journal of Behavioral Assessment*, *Journal of Behavioral Education*, *Analysis of Verbal Behavior*, *Journal of Behavioral Medicine*, *Journal of Psychopathology and Behavior Assessment*, *Journal of the Experimental Analysis of Behavior*. In addition, many of the most prominent journals in psychology publish articles that are behavioral and cognitive in nature, e.g., *Journal of Consulting and Clinical Psychology*, *Journal of Counseling Psychology*.

APA, ABCT, ABAI, and ABPP regularly disseminate information to practitioners and the general public through topical fact sheets, workshops and institutes, books, videos, audiotapes, and media appearances.

All areas of behavioral and cognitive specialization seek to improve practitioner skills and services through support for the types of publications noted above and through educational programs conducted through the annual programs of the various relevant divisions of the APA and other organizations such as ABPP.

Recent advances in the specialty of behavioral and cognitive psychology include infusion of the most current literature from affective neuroscience and eastern meditation philosophies. Examples of this includes emotional regulation, a focus on inner awareness of thoughts and feelings, and mindfulness-based techniques.

Recent advances have adapted many evidence-based behavioral and cognitive interventions to web-based programs and mobile phone applications. Examples include programs regarding treatment of PTSD, risk reduction through problem solving and parenting skills in veterans, and programs to assist in reduction of heavy alcohol consumption.

4. This criterion includes two components: one focusing on past activities around accreditation (X.4.a), and the other on future activities around accreditation (X.4.b).

For X.4.a, describe how the specialty has promoted and participated in the process of accreditation in order to enhance the quality of specialty education and training. Also, indicate how many programs in this specialty have been accredited at the doctoral and/or postdoctoral level.

Behavioral and cognitive psychology has a long tradition of a strong presence in APA-accredited clinical psychology programs and internships, and to a lesser extent in accredited counseling psychology and school psychology programs. The result is that more than half of the practitioners who are graduates of APA-accredited programs identify themselves as cognitive-behavioral. Many faculty of APA approved programs identify themselves as having a behavioral or cognitive. Additionally, there is an accreditation process of graduate programs by the ABAI, but it should be noted that the ABAI accredits programs at the doctoral, master’s, and bachelor’s level.

The American Board of Behavioral and Cognitive Psychology (ABBCP) is one of 15 member boards of the American Board of Professional Psychology (ABPP). ABBCP was formally represented on the
Interorganizational Council for Postdoctoral Accreditation in Professional Psychology (IOC), which established initial guidelines for the recognition of postdoctoral specialties, and is currently a member of the Behavioral and Cognitive Psychology Specialty Council and through BCPSC on the Council of Specialties (CoS). The CoS is designed to foster communication among existing and potential new specialties and to help set common standards for training programs. BCPSC is designed to foster a common mission and establish standards of training across the various groups comprising Behavioral and Cognitive Psychology.

Behavioral and Cognitive Psychology is already a recognized specialty in American Board of Professional Psychology and already credentials professionals in that specialty.

Many professionals who identify themselves as behavioral and cognitive psychologists additionally serve as Directors of Training, Department Chairs, and faculty members in APA-accredited programs, as well as APA-accreditation site visitors and members or former members of the Commission on Accreditation.

For X.4.b, describe how the specialty will promote and participate in the process of accreditation in the future in order to enhance the quality and sustainability of specialty education and training. Also, explain how the future accreditation support activities will be consistent with the Education and Training Guidelines: A Taxonomy for Education and Training in Professional Psychology Health Service Specialties (see: http://www.apa.org/ed/graduate/specialize/taxonomy.pdf) and will be sustained (e.g., training CoA site reviewers with specialty expertise, sponsoring CoA self-study workshops, fostering the development or ongoing operation of a specialty training council, administrative agreements and protections, financial support, etc.). Explain how these activities will result in an increase in the number of specialty programs that are accredited at the doctoral and/or postdoctoral level.

The specialty of Behavioral and Cognitive Psychology will promote and participate in the process of accreditation in the future in order to enhance the quality of our specialty education and training. The Behavioral and Cognitive Specialty Council will provide consultation and guidance regarding completion of the taxonomy for behavioral and cognitive psychology as its aspiration goal. A goal for the future will be to foster the development of post-doctoral accredited programs in behavioral and cognitive psychology, in conjunction with the Behavioral and Cognitive Psychology Specialty Council. An additional enhancement and improvement in specialty practice has recently been actualized for ABPP board certified specialists by the Maintenance of Certification process.

Criterion XI. Guidelines for Specialty Service Delivery. The specialty has developed and disseminated guidelines for practice in the specialty that expand on the profession’s general practice guidelines and ethical principles.

Commentary: Such guidelines are readily available to specialty practitioners and to members of the public and describe the characteristic ways in which specialty practitioners make decisions about specialty services and about how such services are delivered to the public

1. Describe the specialty-specific practice guidelines for this specialty. Please attach. How do such guidelines differ from general practice guidelines and ethics guidelines? (In this context, professional specialty guidelines refer to modes of conceptualization, identification and assessment of issues, and intervention planning and execution common to those trained and experienced in the practice of the specialty. Such professional guidelines may be found in documents or websites including, but not limited to, those bearing such a title or as described in a variety of published textbooks, chapters, and/or articles focused on such contents.)
The Behavioral and Cognitive Psychology specialty promotes and supports training for the specialty in the APA guidelines for Practitioners, including multicultural practice, guidelines regarding psychologists’ involvement in pharmacological issues, guidelines for assessment and treatment of gay, lesbian and bisexual clients, guidelines for practice in health care delivery systems, practice parameters regarding autism, guidelines for assessment and intervention with persons with disabilities, and any other published practice guidelines relevant to the area in which the behavioral and cognitive psychologist practices (for example, guidelines for practice of telepsychology. These published guidelines are considered invaluable tools to adapt to practice in the behavioral and cognitive specialty.

The specialty of Behavioral and Cognitive Psychology also possesses its own specialty-specific practice guidelines. They are called the “Guidelines for Doctoral Psychology Programs Incorporating Cognitive and Behavioral Education and Training: Report of The Inter-Organizational Task Force on Cognitive and Behavioral Psychology Doctoral Education” and was sponsored by the Association for Behavioral and Cognitive Therapies. The organizers were: Chair: Robert K. Klepac, Ph.D., ABPP and Co-chair: George F. Ronan, Ph.D. The complete document can be accessed at http://www.cospp.org/behavioral-and-cognitive-psychology The guidelines were later published:


2. How does the specialty encourage the continued development and review of practice guidelines?

The Behavioral and Cognitive Specialty Council supports the current task force work underway through APA to develop the various practice guidelines. Several prominent behavior and cognitive psychologists are member of the various task forces as well as the main practice guidelines committee. As such behavioral and cognitive psychologists are well represented in this ambitious endeavor. In addition, through periodic conferences and task forces such as the above-referenced Interorganizational Task Force and periodic meetings of the Behavioral and Cognitive Psychology Specialty Council the reviews and makes appropriate changes as necessary.

3. Describe how the specialty's practitioners assure effective and ongoing communication to members of the discipline and the public as to the specialty's practices, practice enhancements, and/or new applications.

Behavioral and Cognitive Psychology accomplishes these ends in a variety of ways. ABCT has been in existence for 50 years and its annual conferences contain much information and training in practice enhancements and new applications. An important part of each conference is the extensive fundamentals courses, workshops, and institutes. Behavioral and Cognitive Psychology also sponsors numerous continuing education offerings each year, focusing on new applications and skill-building. ABCT publishes brochures and fact sheets, designed to acquaint professionals with new applications and information. It also publishes two renowned journals, Behavior Therapy and Cognitive and Behavioral Practice as well as a timely newsletter, the Behavior Therapist. Other publications in the area include the Journal of Cognitive Psychotherapy: An International Quarterly, Cognitive Therapy and Research, Behavior Research and Therapy, International Journal of Cognitive Psychotherapy, and others.

ABCT serves as a centralized resource and network to its membership and the public for all facets of
behavior therapy and cognitive behavior therapy. It promotes these therapies through its journals, newsletters, annual conventions, web site, and other educational publications and programs. It also provides opportunities for professional growth and offers information and referral services to the general public, the media, third-party payers, and governmental and non-governmental agencies.

ABCT provides continuous and timely information to its members through its newsletter and serial publications in various ways. All members receive ten months of *the Behavior Therapist*, which contains the latest updates and thought-provoking debates. It features Clinical Dialogues, Behavior Assessment Reviews, Clinical Roundtables, and a Student Forum. It also includes book reviews, professional and legislative reports, training updates, employment listing, and association news. In contrast, *Behavior Therapy* is an international quarterly journal that focuses on original experimental and clinical research advancing the theory and practice of the behavioral therapies. Finally, *Cognitive and Behavioral Practice* integrates behavior therapy principles and research with clinical practice techniques. Its articles often address new populations and problems.

At ABCT’s annual convention, held every November, members worldwide have an opportunity to access our peer-reviewed program. The program features state-of-the-art research and clinical findings including symposia, workshops, panel discussions, poster sessions, clinical roundtables, addresses by distinguished speakers, master clinician programs with videos of well-known therapists in actual client sessions, and Advanced Methodology and Statistics Seminars (AMASS). Pre-convention programs are offered during the Annual Convention. They include Institutes featuring the latest clinical skills, Fundamentals Courses focusing on basic behavioral and cognitive principles and approaches in applied settings, and Professional Seminars that address the needs of administrators, clinicians, and researchers. The annual convention also features an Internship and Postdoctoral Training Site Overview for students, opportunities for networking. ABCT’s committees and Special Interest Groups are extended the opportunity to meet during the Annual Convention as well.

Continuing education credits are available to members who attend Workshops, Master Clinician’s programs, and AMASS seminars at the annual convention as well as Pre-convention Institutes, Fundamentals Courses, and Professional Seminars. ABCT is approved by the American Psychological Association to offer continuing education credits for psychologists although it maintains responsibility for the content of the program.

There are many opportunities for effective and ongoing communication that are additionally available through the APA Divisions 12, 33 and 25 and conventions as well as through the annual ABPP workshops and conference. These provide opportunities for demonstration of specialty interventions, new innovations, trainee development and networking opportunities.

APA Divisions 25 and 33 both publish newsletters three times yearly provide a mechanism for communication with practitioners and offer practitioners an opportunity to provide commentary. These Divisional newsletters also report on activities of the division with respect to collaboration with other divisions and work groups in APA. ABAI publishes a quarterly newsletter that serves similar functions for ABA members.

ABAI holds an annual national convention, which is attended by 2,000 or more practitioners and scientists. Presentation formats include papers, symposia, panels, posters, invited addresses, and discussion sessions on scientific issues and findings, applied research and demonstrations, and professional affairs. Advance notification of the convention content is available through special national mailings and information posted
Practitioners and the public may contact or access resources from all of these entities through the Internet, with access to a plethora of electronic resources.

Practitioners can access state-of-the-art information and research findings from several journals that are published by SEAB (the Society for the Experimental Analysis of Behavior) or that are closely coordinated with ABA activities and member research: *Journal of Applied Behavior Analysis*, and the *Journal for the Experimental Analysis of Behavior*. ABAI publishes *The Behavior Analyst*, *Behavior Analysis in Practice*, and *The Analysis of Verbal Behavior*.

4. How does the specialty communicate its identity and services to the public?

ABCT serves as a centralized resource and network to the public for all facets of behavioral and cognitive psychology and has an extensive organization webpage, linked to other relevant organizations. It also offers information and referral services to the general public, the media, third-party payers, and governmental and non-governmental agencies. ABCT also operates public service programs like the Referral Service, which helps the general public to locate therapists in their vicinity. People who call the Central Office for a referral receive a list with the names of ABCT members in their state that includes each therapist’s area of specialization, populations served, highest degree earned, address, and phone number. When callers indicate the problem for which they are seeking help, a Fact Sheet is included on that subject as well as the pamphlet entitled *Guidelines for Choosing a Behavior Therapist*. Fact sheets are designed to inform and educate the general public about emotional or behavioral disorders, giving the causes and characteristics, as well as an overview of behavioral and other interventions.

Another public service program is the ABCT web page that provides information on its publications, upcoming annual convention, careers in behavior and cognitive psychology, membership benefits, awards program, Special Interest Groups, a listing of the Board of Directors, Coordinators, Committee Chairs, and Committee members, and the Central Office staff. As the website is continuously developed, more information will be posted for the general public. The web site address is: www.abct.org.

Representatives of Divisions 12, 25 and 33 and ABAI, or members of executive councils of these Divisions and ABAI, participate in national policy-making through linkages of activities with organizations like the Psychology Division of the American Association for Mental Retardation, and communicate the results of these activities to the memberships through newsletter articles and informational releases. Representatives of the Divisions and ABA also participate in research priority setting in the National Institutes of Health and National Institute of Education in the area of behavioral science, particularly with regard to disability issues.

The American Board of Professional Psychology, of which the American Board of Behavioral and Cognitive Psychology is a member board, maintains a prominent section on its website “for the public.” Included are sections entitled, “Who is ABPP,” “ABPP Specialists,” and “Directory of Specialists.” This enables the public to learn what ABPP offers and how to find board certified specialists in their geographical area. The ABPP website also includes information about the nature and value of board certification as well as a link to the Directory of Board Certified Specialists in Behavioral and Cognitive Therapy.
Criterion XII. Provider Identification and Evaluation. A specialty recognizes the public benefits of developing sound methods for permitting individual practitioners to secure an evaluation of their knowledge and skill and to be identified as meeting the qualifications for competent practice in the specialty.

Commentary: Identifying psychologists who are competent to practice the specialty provides a significant service to the public. Assessing the knowledge and skill levels of these professionals helps increase the ability to improve the quality of the services provided. Initially practitioners competent to practice in the specialty may simply be identified by their successful completion of an organized sequence of education and training. As the specialty matures it is expected that the specialty will develop more formal structures for the recognition of competency in practitioners.

1. Describe the formal peer review-based examination process of board certification including its use of a review and verification of the individual’s training, licensure, ethical conduct status, and a peer assessment of specialty competence.

There are several ways the specialty assesses the actual knowledge and skills that define specialty-specific competencies. The first is by possession of board certification in Behavioral and Cognitive Psychology through ABPP, indicating the individual has passed a rigorous in vivo examination. For licensed psychologists who practice Cognitive Therapy, certification is available by the certification process granted by the Academy of Cognitive Therapy (ACT). For licensed psychologists who are also behavior analysts, certification by the BACB provides evidence of competence in the practice of behavior analysis, and a set of Guidelines, including the Stages of Education and Training by Levels of Educational Opportunity in Specialties: Behavioral and Cognitive Psychology (CBP)¹ can be found at http://media.wix.com/ugd/146c2d_36d3b810613646258a4f2728a4320cde.docx?dn=2014%20Approved%20ABCB%20Guidelines%20for%20ABA%20Competencies.docx. The board certifications listed above review applicants’ training, licensure, ethical conduct and all relevant practice related experience for eligibility.

2. Describe how the specialty educates the public and the profession concerning those who are identified as a practitioner of this specialty. How does the public identify practitioners of this specialty?

The American Board of Professional Psychology (ABPP) maintains a section of its website that provides a search engine that identifies and locates board certified behavioral and cognitive specialists around the country. Moreover, the ABPP website provides useful information regarding the importance of board certification and other information in a public access section. The Association for Behavioral and Cognitive Therapies maintains a website that has a “Find a Therapist” database and a section with Fact Sheets describing the types of therapies available, populations with whom these therapies they are used.

The BACB has a registry of individuals who are certified that can be searched by location.

The Academy of Cognitive Therapy has a “Find the Therapist” webpage that will locate certified cognitive therapists both internationally and nationally.

3. Estimate how many practitioners there are in this specialty (e.g., spend 25% or more of their time in services characteristic of this specialty and provide whatever demographic information is available) and how many are board certified through the process described in item 1.

¹ Attitudes, knowledge and skills in cognitive and behavioral psychology are described in Klepac, et al., 2012.
Currently there are about 5200 members of the Association for Behavioral and Cognitive Therapies, of which about 4400 are psychologists. Many other psychologists who have a behavioral and cognitive orientation have found professional homes in Division 12, Division 16, Division 17, division 19, Division 22, Division 25, Division 29, Division 38, Division 42, Division 50, Division 53, and Division 56 of APA. The Academy of Cognitive Therapy contains approximately 750 members. The membership of ABA is 6,000 of which 1500 are doctoral level psychologists. While the current number of ABPP Board Certified psychologists is about 180, this represents only about 5% of behavioral and cognitive psychologists that are eligible for board certification. Finally, many individuals who are board certified in specialties of clinical, clinical health, clinical child and adolescent, and school psychology define their practice orientation as behavioral or cognitive. This results in a conservative estimate of approximately 10,000-12,000 behavior and cognitive psychologists currently practicing.

Public Description:

An important component of the recognition process is to develop a public description of the specialty that can be used to inform the public about the specialty area. Please develop a brief description of the specialty by responding to the question below (total combined word limit for all five questions must not exceed 400 words). This provides the foundation for what will appear on the APA website upon recognition of the specialty and should be understandable to the general public (wording should not exceed an eighth-grade level). Descriptions will be edited for consistency to conform to the CRSPPP website standards.

1. Provide a brief (2-3 sentences) definition of the specialty.
   Behavioral and Cognitive Psychology uses principles of human learning and development as well as cognitive processing in overcoming problem behavior, emotional thinking and thinking. It uses these same principles in helping people live better lives. Behavioral and Cognitive Psychologists do research, training, education and clinical practice.

2. What specialized knowledge is key to the specialty?
   Behavioral and Cognitive Psychologists understand applied behavior analysis, behavior therapy, cognitive therapy and cognitive psychology, social learning theories, emotional processing theories and information processing theories. They know how to apply this knowledge to the human condition.

3. What problems does this specialty specifically address?
   Cognitive and Behavioral Psychology has been applied to a wide range of problems which include, but are not limited to, the following:
   (a) Anxiety disorders
   (b) Depressive disorders
   (c) Personality disorders
   (d) Substance abuse
   (e) Health-related problems
   (g) Autism Spectrum Disorders
   (h) Violence and aggressive behavior
   (i) Developmental and intellectual disabilities
   (j) Academic performance
   (k) Relationship problems
(l) Trauma
(m) Emotional regulation problems
(n) Stress management
(o) Problems in daily living

4. What populations does this specialty specifically serve?

Cognitive and Behavioral psychologists serve a wide variety of populations, including children, adolescents, adults, and older adults. Behavioral procedures have been successfully used with individuals, couples, groups, families, classrooms, and organizations, as well as in a variety of settings (homes, schools, clinics, hospitals, workplaces, correctional facilities, communities).

5. What populations does this specialty specifically serve?

Cognitive and Behavioral psychologists serve a wide variety of populations, including children, adolescents, adults, and older adults. Behavioral procedures have been successfully used with individuals, couples, groups, families, classrooms, and organizations, as well as in a variety of settings (homes, schools, clinics, hospitals, workplaces, correctional facilities, communities).

6. What are the essential skills and procedures associated with the specialty?

Behavioral and Cognitive psychologists measure behavior and cognitions. They create case conceptualizations based on learning principles and ways in which emotions and cognitions are processed. They use evidence-based treatments that are adapted to individual persons. They do ongoing assessment of the effectiveness of their interventions and modify their treatment as appropriate.

7. What populations does this specialty specifically serve?

Cognitive and Behavioral psychologists serve a wide variety of populations, including children, adolescents, adults, and older adults. Behavioral procedures have been successfully used with individuals, couples, groups, families, classrooms, and organizations, as well as in a variety of settings (homes, schools, clinics, hospitals, workplaces, correctional facilities, communities).

8. What are the essential skills and procedures associated with the specialty?

Behavioral and Cognitive psychologists measure behavior and cognitions. They create case conceptualizations based on learning principles and ways in which emotions and cognitions are processed. They use evidence-based treatments that are adapted to individual persons. They do ongoing assessment of the effectiveness of their interventions and modify their treatment as appropriate.
9. What populations does this specialty specifically serve?

Cognitive and Behavioral psychologists serve a wide variety of populations, including children, adolescents, adults, and older adults. Behavioral procedures have been successfully used with individuals, couples, groups, families, classrooms, and organizations, as well as in a variety of settings (homes, schools, clinics, hospitals, workplaces, correctional facilities, communities).

10. What are the essential skills and procedures associated with the specialty?

Behavioral and Cognitive psychologists measure behavior and cognitions. They create case conceptualizations based on learning principles and ways in which emotions and cognitions are processed. They use evidence-based treatments that are adapted to individual persons. They do ongoing assessment of the effectiveness of their interventions and modify their treatment as appropriate.
Attachment A

Structures and Models of Education and Training in (name of specialty) Psychology 
Doctoral Program

COMPLETE THE FOLLOWING FOR ANY EXAMPLE DOCTORAL PROGRAMS SUBMITTED IN CRITERION VII THAT ARE NOT APA ACCREDITED

Program One
Name of University, School, or institution offering program:

Name of Program:

Address:

City/State/Zip:

Contact Person: Telephone No.

E-mail address:

Website:

1. Provide evidence that your program, regardless of setting, (a) maintains a psychology faculty; (b) provides opportunities for scholarly inquiry and practice by the faculty; and (c) provides support for trainees to encourage and expand learning opportunities beyond course work.

2. Provide evidence from your program that published descriptions of the program specify whether or not graduates can satisfy the education and training requirements for advanced recognition in the specialty.

3. Indicate by document and page number where your program is clearly identified as a psychology program whose intent is to educate and train psychologists.

4. Enclose an organizational chart describing the administrative relationship of the program with other units within the organization (e.g., College/Division/Department/Program/Specialty). Indicate lines of authority for both academic decision making and resource allocation. Indicate names, titles, addresses, phone numbers, and authority.

5. Using examples of typical trainee schedules, show the sequence of courses recommended for each year level of trainees enrolled in the program.

6. Do you require at least three full-time years of graduate study (or the equivalent thereof) at your institution? (enclose documenting policy statement)

   Yes          No

7. Are two academic years of study at a single institution required for award of the degree? (enclose documenting policy statement):
Yes

8. Do you require at least one academic year of full-time residency (or the equivalent thereof) at the same institution for the award of the degree? (enclose documenting policy statement):

Yes

No

9. Using the following format, indicate the courses that your program requires. Please list didactic courses only here. Information about practicum experience will be requested elsewhere.

<table>
<thead>
<tr>
<th>Title</th>
<th>Number</th>
<th>Required of Elective</th>
<th>Catalog Page#</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Scientific &amp; Professional Ethics and Guidelines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Research Design &amp; Methodology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Statistics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Psychological Measurement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. History &amp; Systems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Biological Bases of Behavior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Affective Bases of Behavior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Social Bases of Behavior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Individual Behavior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Specialty course taught in department</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Specialty course taught in other departments</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. Using this format, show how laboratory, practicum, and internship requirements are met. NOTE: For practicum: names and agencies used, nature of agency, its mission, financial support, administrative structure, types of clients seen, services offered. For internship: name of agency, how they are selected, communication between psychology program and internship agency, name of chief psychologist and director of training, and nature of agency, its mission, financial support, administrative structure, types of clients seen, services offered.

Types of agency and experience:

<table>
<thead>
<tr>
<th>Types of agency and experience:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory, Practicum, Internship (please specify)</td>
</tr>
<tr>
<td>First Year</td>
</tr>
<tr>
<td>Second Year</td>
</tr>
<tr>
<td>Third Year</td>
</tr>
<tr>
<td>Fourth Year</td>
</tr>
</tbody>
</table>
11. Competencies in *(name of specialty)* psychology (please list all of the specific competencies which graduates of this program have mastered as a requirement for completion of the doctoral degree).

<table>
<thead>
<tr>
<th>Competency</th>
<th>Description of Competency</th>
<th>Description of how the Competency is Acquired</th>
<th>Criterion for Establishing Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Attachment B

Structures and Models of Education and Training in (name of specialty) Psychology Postdoctoral Program

COMPLETE THE FOLLOWING FOR ANY EXAMPLE POSTDOCTORAL PROGRAMS SUBMITTED IN CRITERION VII THAT ARE NOT APA ACCREDITED

Program One

Name of University, School, or institution offering program:

Name of Program:

Address:

City/State/Zip:

Contact Person: Telephone No.

E-mail address:

Website:

1. Provide evidence that your program, regardless of setting, (a) maintains a psychology faculty; (b) provides opportunities for scholarly inquiry and practice by the faculty; and (c) provides support for trainees to encourage and expand learning opportunities beyond course work.

2. Provide evidence from your program that published descriptions of the program's specify whether or not graduates can satisfy the education and training requirements for advanced recognition in the specialty.

3. Indicate by document and page number where your program is clearly identified as a specialty psychology program whose intent is to educate and train psychologists in the specialty.

4. Enclose an organizational chart describing the administrative relationship of the program with other units within the organization (e.g., College/Division/Department/Program/Specialty) Indicate lines of authority for both academic decision making and resource allocation. Indicate names, titles, addresses, phone numbers, and authority.

5. Using examples of typical trainee schedules, show the sequence of courses recommended for each year level of trainees enrolled in the program.

6. Do you require at least one year of full-time training (or the equivalent thereof) at your institution? (enclose documenting policy statement):

Yes No
7. Describe the education and training provided to the postdoctoral candidates in the program.
8. Competencies in (name of specialty) psychology (please list all of the specific competencies which graduates of this program have mastered as a requirement for completion of the postdoctoral program).

<table>
<thead>
<tr>
<th>Competency</th>
<th>Description of Competency</th>
<th>Description of how the Competency is Acquired</th>
<th>Criterion for Establishing Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

END OF PETITION FORM