Language: ASPPB offers a French form of the EPPP (the FEPPP) where a licensing authority legally requires one; the integrated EPPP is offered in French from Fall 2027, and the March and April 2027 beta is in English only. Canadian candidates may take the English form, and some licensing authorities do not accept scores from non-English versions. ASPPB has published the competency statements in French (Future EPPP Content Areas (Français)); our questions and cards are in English for now.

EPPP STUDY SHEET · DOMAIN 1

Scientific Orientation to Practice

Examination for Professional Practice in Psychology (EPPP)

15% of the exam · 11 competency statements · ASPPB integrated EPPP

This competency domain involves an orientation to the application of knowledge developed through the science of psychology. This competency domain includes knowledge and application of research design, statistical analysis, and psychometrics, and the ability to critically review published research studies, including methodology, interpretation, and generalizability. This competency also requires facility in sharing psychological knowledge in an unbiased manner with diverse groups within professional settings.

Every competency statement and its key concepts

1.A.1 Biological bases: genes, brain systems, drugs and imaging

Heritability: The share of variation in a trait, within a particular population and environment, that goes with genetic differences among its members. It is a population statistic: it does not say how much of one person's trait comes from genes, and a heritable trait can still change with the environment.

Stress hormones (HPA axis): The hypothalamus, pituitary and adrenal cortex form a hormonal chain that ends in cortisol, which feeds back to switch the response off. Brief activation is protective; prolonged or poorly regulated activation adds to the cumulative wear on the body that McEwen called allostatic load.

1.A.2 Learning, memory, emotion and motivation in everyday behavior

Classical conditioning and extinction: A neutral cue paired with an event that naturally triggers a response comes to trigger a similar response itself. Extinction, meeting the cue without the event, does not erase the original learning; it adds new learning that depends on context, so fear can return in a new setting.

Operant learning and avoidance: Behavior becomes more frequent when it adds something wanted (positive reinforcement) or removes something unpleasant (negative reinforcement). Avoidance that ends anxiety is negatively reinforced, so it persists and keeps the person from learning that the feared outcome rarely happens.

1.A.3 Social and cultural forces on behavior

Correspondence bias: The tendency to infer lasting traits from behavior that the situation could fully explain, also called the fundamental attribution error. Gilbert and Malone traced it to causes such as unawareness of situational constraints and incomplete correction of a first impression.

Stereotype threat: The risk of confirming a negative stereotype about one's group can itself lower performance. Black students underperformed relative to White students on a difficult verbal test framed as diagnostic of ability, but not when it was framed as nondiagnostic, and older adults show a similar effect on memory tests.

1.A.4 Development across the lifespan: risk, protection and timing

Developmental sequences: Many abilities emerge in a broadly consistent order. A meta-analysis of false-belief tasks found that preschoolers move from below-chance to above-chance understanding that others can hold mistaken beliefs, across countries and task versions, so a younger preschooler's errors are expected.

Cumulative risk: Adverse childhood experiences (ACEs), such as abuse or household dysfunction, show a graded relationship with adult health: the more categories of exposure, the higher the rates of depression, substance misuse, suicide attempts and several chronic diseases.

1.A.5 Models of psychopathology and their effect on functioning

Diathesis-stress: A vulnerability (diathesis), biological or psychological, raises risk, and stress helps determine whether and when a disorder appears. Zubin and Spring's vulnerability model of schizophrenia is an early, influential statement of this idea.

Equifinality and multifinality: Different pathways can lead to the same disorder (equifinality), and one risk factor can lead to many outcomes, including none (multifinality). Developmental psychopathology therefore treats risk factors as probabilities, not destinies.

1.B.1 Sampling, data collection and research designs

Sampling: In probability sampling every member of a defined population has a known chance of selection, which supports generalizing to that population. Convenience and purposive samples are easier to obtain and suit many questions, but conclusions reach only as far as the people studied.

Experimental and observational designs: In experimental studies the investigator assigns the exposure, ideally at random. Observational studies only observe: cohort studies follow people forward from exposure, case-control studies trace back from outcome, and cross-sectional studies measure both at one time.

1.B.2 Analyzing data and interpreting statistics

P value: The probability of a result at least as extreme as the one observed, computed assuming the null hypothesis and every other model assumption are true. It is not the probability that the null hypothesis is true, and it does not measure an effect's size or importance.

Effect size and confidence interval: An effect size, such as Cohen's d or a correlation, expresses how large a difference or association is, and a confidence interval shows a plausible range for it. Together they convey strength, direction and precision, whereas a p value addresses only chance.

1.C.1 Critically evaluating research findings

Risk of bias: Systematic error that pushes an estimate away from the truth. Cochrane's RoB 2 tool for randomized trials examines five domains: the randomization process, deviations from intended interventions, missing outcome data, measurement of the outcome and selection of the reported result.

Selective outcome reporting: Choosing which outcomes to report according to their results. Comparing protocols with publications, Chan and colleagues found that 62 percent of trials had at least one primary outcome changed, introduced or omitted, and that significant outcomes were more often fully reported.

1.C.2 Applying research to practice: does this evidence fit here?

Evidence-based practice in psychology: APA's policy defines it as integrating the best available research with clinical expertise in the context of patient characteristics, culture and preferences. Research is one of three elements; it informs judgment rather than replacing it.

External validity: Whether a trial's results can reasonably be applied to a definable group of patients in a particular setting. It depends on who was eligible or excluded, the setting, how the intervention was delivered and which outcomes were measured, details trial reports often describe poorly.

1.D.1 Reporting research accurately in professional settings

Honest reporting: Psychologists do not fabricate data, and when they find significant errors in their published data they take reasonable steps to correct them, such as a correction or retraction (APA Ethics Code 8.10). The CPA code's Principle III, Integrity in Relationships, likewise calls for accuracy and honesty.

Reporting standards: Checklists such as APA's Journal Article Reporting Standards (JARS) and the CONSORT 2025 statement for randomized trials set out what a report must include, such as a diagram of participant flow and, for each outcome, the effect estimate with its precision.

1.D.2 Explaining psychological knowledge so people can use it

Transparent numbers: People understand risk better through frequency statements, absolute risks and natural frequencies (for example, 8 of 26 people) than through single-event probabilities, relative risks or conditional probabilities. Nontransparent framing misleads patients, journalists and physicians alike.

Teach-back: Asking people to explain in their own words what they understood, then filling the gaps. Primary care physicians caring for diabetic patients with low health literacy rarely checked understanding, and checking it was associated with better glycemic control.

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