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 3

Intervention

Examination for Professional Practice in Psychology (EPPP)

20% of the exam · 15 competency statements · ASPPB integrated EPPP

This competency domain requires knowledge of treatment, intervention, and prevention, and application of this knowledge to plan, implement, and adapt psychological treatment, intervention, and prevention services to the public.

Every competency statement and its key concepts

3.A.1 Treatment models and how they produce change

Behavioral models: Problems are kept going by learning: avoidance, reinforcement and lost rewards. In the inhibitory learning account, exposure works by building new learning that competes with fear, strengthened by violating expectancies, removing safety signals and varying contexts (Craske and colleagues, 2014).

Cognitive models: Distress follows from how events are appraised. Cognitive therapy teaches clients to identify, test and revise unhelpful thoughts and beliefs, often through behavioral experiments that gather new evidence (Beck and colleagues, 1979).

3.A.2 Choosing a treatment: evidence, fit, readiness and cost

Matching to assessment: The diagnosis and formulation narrow the field to treatments tested for that problem; severity, risk, comorbidity and medical factors can change the order or call for combined care. Research, clinical expertise and patient characteristics all bear on the choice (APA Presidential Task Force, 2006).

Readiness to change: The transtheoretical model describes precontemplation, contemplation, preparation, action and maintenance (Prochaska and colleagues, 1992). Across 76 studies, the further along the stages clients were before treatment, the better their outcomes (Krebs and colleagues, 2018).

3.A.3 Telepsychology and digital treatments

Telepsychology guidelines (2024): Eleven guidelines: competence; informed consent; data security, management and transmission; data disposal; documentation; interjurisdictional practice; clinical best practices; testing and assessment; emergencies; supervision and training; and emerging technologies (Perle and colleagues, 2026).

Guided internet CBT: Therapist-supported internet cognitive behavior therapy produced effects similar to face-to-face CBT in a meta-analysis of 31 randomized trials covering sixteen conditions, with a pooled difference of g = 0.02 (Hedman-Lagerlöf and colleagues, 2023).

3.B.1 Choosing by evidence: efficacy, effectiveness and comparisons

Efficacy: How well a treatment works in controlled trials, usually randomized, with defined samples and trained therapists. Chambless and Hollon (1998) give efficacy trials the greatest weight and require independent replication before a treatment is called established.

Effectiveness: How well a treatment works in routine settings and with varied populations. Chambless and Hollon (1998) say efficacy trials should be followed by effectiveness research in clinical settings and by cost-effectiveness research.

3.B.2 Setting goals: from crisis to quality of life

Crisis stabilization: When safety is at risk, the first goal is to reduce immediate danger. The Safety Planning Intervention, a prioritized list of coping strategies and contacts, combined with follow-up calls, was associated with less suicidal behavior after emergency care (Stanley and colleagues, 2018).

Symptom reduction: Many plans target symptoms found in the assessment, such as depressed mood or panic frequency, measured with a standard scale before or during sessions so that change can guide treatment (Lewis and colleagues, 2019).

3.B.3 Building the plan with the client and others

Preferences: Across 53 studies, clients given a preferred treatment or condition dropped out less (odds ratio 1.79) and did somewhat better (d = 0.28); the effect did not vary with client age, gender, ethnicity or education (Swift and colleagues, 2018).

Readiness: Match the opening of treatment to the stage of change. When a client is ambivalent, motivational interviewing draws out the client's own reasons for change before planning action (Miller and Rollnick, 2013).

3.B.4 Explaining why: the rationale for a recommendation

Informed consent to therapy: Psychologists inform clients as early as feasible about the nature and anticipated course of therapy, fees, involvement of third parties and limits of confidentiality, with time for questions (APA Ethics Code, Standard 10.01a; CPA Code, Principle I).

Treatments still developing: When generally recognized techniques and procedures have not been established, clients are told of the treatment's developing nature, potential risks, available alternatives and the voluntary nature of participation (APA Ethics Code, Standard 10.01b).

3.C.1 Monitoring response session by session

Measurement-based care: The systematic evaluation of patient symptoms before or during an encounter to inform treatment (Lewis and colleagues, 2019). The scores are meant to guide decisions with the client, not simply to be filed.

Progress feedback: In a meta-analysis of 24 studies, routine outcome monitoring with feedback reduced deterioration and nearly doubled clinically significant or reliable change among clients predicted to have a poor outcome (Lambert and colleagues, 2018).

3.C.2 Adapting treatment to the person and the response

Flexibility within fidelity: Deliver a manual's core components faithfully while tailoring examples, pacing and emphasis to the client, so that adaptation does not drop what makes the treatment work (Kendall and colleagues, 2008).

Cultural adaptation: Changing language, concepts, goals and methods to fit clients' culture. Across 78 studies, culturally adapted interventions outperformed unadapted versions of the same intervention, g = .52 (Hall and colleagues, 2016).

3.C.3 Explaining a change of plan and deciding together

Consent as the course changes: Consent to therapy covers its nature and anticipated course (APA Ethics Code, Standard 10.01a), so a change of course is the moment to explain the new direction and seek the client's agreement to it.

Shared decision making: The three-talk model: team talk offers support and elicits goals, option talk compares alternatives using risk communication principles, and decision talk reaches a decision reflecting informed preferences (Elwyn and colleagues, 2017).

3.C.4 Evaluating outcomes: reliable, meaningful and lasting change

Reliable change: Jacobson and Truax (1991) proposed the reliable change index, which asks whether a client's change is larger than the instrument's measurement error would plausibly produce.

Clinical significance: Change that moves a client out of the range of the dysfunctional population or into the range of the functional population; combined with reliable change it forms a twofold criterion (Jacobson and Truax, 1991).

3.D.1 Planning prevention: tiers, risk and what works

Universal prevention: Offered to a whole population regardless of individual risk, such as every student in a grade or every new parent in a city, without screening anyone in or out (Mrazek and Haggerty, 1994).

Selective prevention: Offered to subgroups whose risk is higher than average because of a risk factor, such as a parent's illness or a known vulnerability, before symptoms appear (Mrazek and Haggerty, 1994).

3.D.3 Monitoring and improving a prevention program

Implementation matters: Across more than 500 studies, the level of implementation affected the outcomes of promotion and prevention programs, and at least 23 contextual factors influenced implementation (Durlak and DuPre, 2008).

RE-AIM: Reach, efficacy, adoption, implementation and maintenance, assessed at individual and organizational levels; failing to evaluate all five can waste resources and limit public health impact (Glasgow, Vogt and Boles, 1999).

3.D.4 Explaining changes to prevention with stakeholders

Community-based participatory research (CBPR): Community members, organizational representatives and researchers take part in all aspects of the work; partners contribute their expertise, and knowledge is joined with action that benefits the community (Israel and colleagues, 1998).

Power and mutual benefit: CBPR seeks to redress power imbalances, ensure mutual benefit for community and academic partners, and translate knowledge in both directions, bringing community theories into interventions (Wallerstein and Duran, 2010).

3.D.5 Evaluating prevention outcomes

Incidence versus risk factors: Reducing risk factors is not the same as preventing disorders: in one review, 51% of eating disorder prevention programs reduced risk factors but only 29% reduced current or future eating pathology (Stice, Shaw and Marti, 2007).

Credible comparison: Without a comparison group, a drop may reflect maturation or wider trends (Shadish and colleagues, 2002). Prevention science's standards of evidence set requirements for efficacy, effectiveness and scale-up claims (Gottfredson and colleagues, 2015).

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