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THE IMPACT OF MULTI-MODAL TRAINING IN REBT ON PERCEIVED AND OBSERVED CLINICIAN COMPETENCY

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ABSTRACT

THE IMPACT OF MULTI-MODAL TRAINING IN REBT ON PERCEIVED AND OBSERVED CLINICIAN COMPETENCY

Jessica L. Weiss

Rational Emotive Behavior Therapy (REBT) is a clinical psychotherapeutic intervention that falls under the broad umbrella of Cognitive Behavioral Therapy (CBT; Matweychuk et al., 2019). While CBT and the varied models have demonstrated efficacy, a more targeted analysis of clinical competence (Liness et al., 2019), the role of training in a specific model of CBT, such as REBT, and its impact on clinician competency is warranted. From a review of the extant literature in the area, overall, research on the areas of training in DBT, ACT, and CT, and associated clinician competency are to a larger extent greater than that of one of the originators of CBT: REBT. This research addressed this gap in scientific inquiry by looking at the impact of training in REBT on clinical competency. Four clinicians, two of which participated in a REBT three-day clinical practica training at a mental health facility, and two who did not undergo this training, served as participants in this research. All four clinicians were fourth year doctoral students and on their 4th year of clinical externship. This paper investigated the impact that training has on clinician competency, both perceived and rated by experts in REBT. Those who participated in the REBT training had significantly higher ratings of perceived competency than those who did not participate in the training. However, similar ratings of competency when rated by experts was seen across both groups. Additionally, outcomes were mixed in regard to consistency between expert and perceived ratings across participants. The limitations of the current investigation and directions for future

research are presented. Implications for the field of school psychology, graduate training programs, and formalized training programs are discussed.

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Chapter I

Introduction

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) is based on the premise that one's thoughts, feelings, and behaviors are all interrelated (Dozois & Dobson, 2019), with the types of thoughts one has (i.e., healthy or unhealthy) being linked to emotional and behavioral disturbance. Specific therapeutic approaches such as Rational Emotive Behavior Therapy (REBT), Cognitive Therapy (CT), Acceptance and Commitment Therapy (ACT), and Dialectical Behavior Therapy (DBT) all fall under the broad umbrella of Cognitive Behavioral Therapy (Matweychuk et al., 2019). Consistent with this treatment approach is the idea that one's maladaptive thoughts or cognitions influence one's emotional distress and/or behavioral difficulties (Hofmann et al., 2012). In other words, maladaptive cognitions (i.e., beliefs about the self, others, and the world) can result in emotional distress and behavioral difficulties. While the cognitive component of the CBT model focuses on negative thoughts and emotions that negatively impact functioning, the behavioral component seeks to change behaviors and indirectly modify thoughts through the use of behavioral techniques, as well as teaching and building skills (Dozois & Dobson, 2019). CBT is considered to be the "gold standard" of psychological treatment (David et al., 2018). In regard to its scientific support and efficacy, CBT was the first form of psychotherapy to be tested using randomized controlled trials (RCT) (David et al., 2018). CBT is practiced worldwide and is taught across professional training programs, workshops, and conventions (Dozois & Dobson, 2019).

CBT has been demonstrated to be effective across a variety of populations including clinical work with youth, adults, couples, in prevention programs, as well as in the treatment of comorbid and transdiagnostic populations (Hofmann et al., 2012). CBT consists of many different empirically supported treatments including CT, REBT, DBT, and ACT. The expansion of CBT treatments is split into waves in order to represent its developmental progression. The first wave includes behavioral therapies focused on classical conditioning, operant conditioning, and other behavioral learning principles (David & Hofmann, 2013). The second wave of CBT includes CT and REBT with their core clinical focus being on cognitive restructuring/changing unhealthy thoughts, while the third wave includes DBT and ACT (David & Hofmann, 2013) which had less emphasis on the restructuring component.

Additionally, CBT has shown to be effective across many disorders including mood disorders, anxiety disorders, obsessive-compulsive disorders, posttraumatic stress disorder, eating disorders, psychosis, borderline personality disorder, substance-related and addictive disorders, health anxieties, as well as sleep disorders (i.e., insomnia) (Dozois & Dobson, 2019; Hofmann et al., 2012). However, some disorders and difficulties have displayed superior efficacy with some forms of CBT when compared to others (Dozois & Dobson, 2019). For instance, with major depressive disorder (MDD), more focused forms of CBT, such as behavioral activation and problem-solving therapy, have been shown to have higher rates of efficacy (Dozois & Dobson, 2019). REBT has also shown to have significant effects in working with depressed and anxious individuals (Turner, 2016) who evidence irrational beliefs. In addition, exposure therapy has demonstrated significant benefits for specific phobia and has outperformed other

treatments (Dozois & Dobson, 2019). For posttraumatic stress disorder (PTSD), trauma-focused CBT (TF-CBT) has shown the greatest effect sizes and appears to be the most effective treatment when compared to non-trauma focused CBT, as well as other non-trauma focused treatments (Dozois & Dobson, 2019). Additionally, DBT was initially developed specifically for individuals who are diagnosed with borderline personality disorder (Matweychuk et al., 2019) and has shown to be effective at targeting suicidal behaviors and nonsuicidal self-injury (NSSI) behaviors with this population (Rizvi et al., 2013). While CBT and the varied models have demonstrated efficacy, a more targeted analysis of the role of training in a specific model of CBT is warranted. While exploring the third wave approaches are important in understanding CBT as a broad concept, REBT is foundational to CBT (Matweychuck et al., 2019) and as such, is the focus of the present paper.

Rational Emotive Behavior Therapy

REBT, developed by Albert Ellis, focuses on the idea that by reflecting on and disputing automatic thoughts and irrational beliefs, clients are better able to experience healthy and rational reactions to adverse events (Matweychuck et al., 2019). In REBT, similar to with CBT, the three main psychological aspects of functioning that are clinically targeted include thoughts, emotions, and behaviors (DiGiuseppe et al., 2013). The main ideas associated with REBT focus on the importance of cognition, with irrational beliefs being proposed to be the primary determinant of emotional distress. Irrational beliefs, or rigid and extreme beliefs, are thought to be inconsistent with reality whereas rational beliefs on the other hand, are consistent with reality and are both flexible and logical in process (Turner, 2016). Given this, the clinical approach of REBT

works to assist clients to better manage distress through changing the way one is thinking (i.e., changing irrational beliefs to more rational and adaptive ones) (David et al., 2018).

REBT proponents posit that we as humans typically waver between rational and irrational beliefs or in some cases, hold both rational and irrational beliefs at the same time. Related to this system of beliefs are the emotions that one experiences. REBT not only distinguishes between beliefs, but emotions as well. In other words, REBT differentiates between adaptive or healthy emotions and maladaptive or unhealthy emotions (DiGiuseppe et al., 2013). In REBT, there are three levels of cognitions known to be associated with emotional disturbance and arousal. The first level is referred to as inferential cognitions. This includes perceptions (i.e., "he didn't like my work"), automatic thoughts (i.e., "I fail at everything"), and negative attributions (i.e., "I am stupid") (DiGiuseppe et al., 2013). Next are second level cognitions that fall into one of three categories: awfulizing, frustration intolerance, and global evaluations of human worth. In other words, these beliefs take a deeper look at how bad the inference is (i.e., awfulizing), the individual's ability to cope with the situation (i.e., frustration intolerance), as well as the "worth" of the other individuals involved (i.e., global evaluations of human worth) (DiGiuseppe et al., 2013). At the very core of emotional disturbance, and from which these extreme beliefs are derived, is absolutistic beliefs (Matweychuck et al., 2019). Absolutistic beliefs, or the absolute "shoulds" or "musts", are proposed to lead to inflexible thinking, which then leads to the thought disturbances described above. The REBT clinician will examine and work with the client to change

the core irrational beliefs that may be contributing to their psychological and emotional disturbance.

In REBT, an important clinical consideration is that it is not the thoughts themselves that lead to disturbance, but rather it is to what degree does the client believe the thoughts are true that is proposed to affects one's feelings and behaviors (Dozois & Dobson, 2019). By holding such core irrational beliefs, it is likely the individual will experience maladaptive symptoms of anxiety, depression, anger, and so on. As such, REBT clinical work focuses on identifying such irrational beliefs, recognizing that they are illogical and interfering with functioning, and replace the beliefs with more adaptive ones (David et al., 2018). This is done by utilizing an ABC model in which the therapist will identify the activating event (A), identify one's beliefs about the event (B), as well as the resulting emotional and behavioral consequence (C) (DiGiuseppe et al., 2013; Matweychuck et al., 2019). The ABC model of REBT may be considered to be a strength in that it is easily communicated to clients and may assist in the training of clinicians. At the same time, there may be the risk that clinicians may believe that by understanding the ABCs of REBT that they are able to provide effective REBT clinical services, which may not be accurate. As such, it is important to consider the competency of clinicians in delivering REBT.

Clinician Competency

In assessing the skills of therapists, both the therapists adherence ("whether the therapist implemented the relevant procedures") and the therapists competence ("whether procedures were implemented in a competent manner") are relevant (Liness et al., 2019). Competence in clinical work includes individuals' ability to understand and

perform the tasks consistent with the training and qualifications of a psychologist (Falender & Shafranske, 2007). Competency is included in the American Psychological Association (APA)'s ethical standards set out for psychologists and is what informs clinicians in practice. Specifically, services provided by psychologists, whether that is therapy, teaching, or conducting research, must only be performed within their boundaries of competence (APA, 2017). As mental health providers, competency is important in providing ethical and effective psychotherapy (Jennings et al., 2005; De las Fuentes et al., 2005). APA's competency benchmarks include professionalism (values, attitudes, cultural awareness), relational (relate effectively to others), science (research), application (assessment, intervention, consultation), education (knowledge, skills, supervision), and systems (APA, 2012). These are evaluated at multiple time points during training including the transition to practicum, externship, internship, and entry to practice (APA, 2012).

Previous research has measured self-reported competency in clinical training programs (Bennett-Levy & Beedie, 2007). Logically, as time progresses and trainees gain more clinical experience and further their education, it is likely they will perceive themselves as more competent (Bennett-Levy & Beedie, 2007). However, it is important to consider the accuracy of a self-evaluation of clinical competency. Self-assessment has been studied across research (Mathieson et al., 2009) as well as its use throughout training programs (McDaniel et al., 2002). Self-assessment measures typically focus on whether or not the clinician has the relevant knowledge base, knows how to apply such knowledge practically, can demonstrate the skill, and whether these skills are utilized in practice (Muse & McManus, 2013). Research on self-reported competency, or the

perception of one's competency level, is mixed. Some have found differences between self-rated and objective-rated competency (James et al., 2001; Bennett-Levy & Beedie, 2007) in that self-reported competency might not reflect reality. However, others have found issues with "objective ratings" of competence (Bennett-Levy & Beedie, 2007). Further research in this area is needed to better understand the relationship between self-reported competency and supervisor-reported competency in regard to REBT.

Training

Effective training in empirically supported therapies begins in graduate school. Training in CBT results in better client outcomes (i.e., decreased anxious and depressive symptoms) (Simons et al., 2010). While research on training and the effectiveness of doctoral-level graduate programs tends to be mixed (Bennett-Levy et al., 2009), Bennett-Levy's (2006) DPR model, as discussed earlier, is two-fold. The declarative system refers to one's knowledge base in terms of the theoretical models in which therapy is based, while the procedural system refers to one's ability to apply skills, attitudes, and behaviors in action. In other words, the procedural system focuses on the understanding of how and when to implement declarative knowledge (Haarhoff et al., 2011). The reflective system allows a clinician to consider all the information they have received from the client in collaboration with their declarative and procedural systems in order to reach a comprehensive conclusion for intervention.

In terms of the most effective learning strategies within these training programs, data supports that reading and lectures are best for declarative knowledge, modeling and role play is best for procedural knowledge, and self-experiential work is best for reflective practice (Bennett-Levy et al., 2009). Students gain training across multiple

domains in their graduate studies (Bennett-Levy et al., 2009). Courses and lectures is where they form their knowledge base, practicum courses is where they learn to apply such knowledge, and externship and internship opportunities is where they have the opportunity to grow in knowledge, application, and reflection. Finally, throughout the course of a clinicians career is where this reflection stage continues to foster the development of clinician competency (Haarhoff et al., 2011).

Central to the training of clinical skills is not only teaching and delivering therapy but also, guided supervision (Bearman et al., 2020). The supervisor is required to apply both innovative and traditional techniques in their role in order to serve their students to the best of their ability (Friedberg & Brelsford, 2013). Supervision in CBT typically follows and aligns with the CBT model which includes instruction based on the theories of CBT, learning activities such as modeling and role play, as well as monitoring students clinical performance and providing feedback (Bennett-Levy & Finlay-Jones, 2018). Supervision as an aspect of training has been shown to be an important component in assessing clinician competency (Liness et al., 2018). In formalized training programs such as the REBT practicum focused on in this present paper, participants have the opportunity to practice implementing REBT skills and receive immediate feedback from a certified supervisor in REBT.

From a review of the extant literature in the area, overall, research on the areas of training in DBT, ACT, and Cognitive Therapy are to a larger extent greater than that of one of the originators of CBT: REBT (Luoma et al., 2007; Brodsky et al., 2013; Linehan & Wilks, 2015). As REBT is in the second wave of cognitive behavioral treatment and specific practices are often included in therapist's practices (i.e., challenging irrational

thoughts), even if they do not identify as REBT therapists, it is surprising that there is little research on training clinicians in REBT. Additionally, in order to assess the impact of formalized training, it's surprising there's little research comparing groups who did participate in formalized training vs. those who did not. Thus, further research on formalized training of REBT is important in assessing trainee competency, both perceived and expert rated.

Chapter II

The Present Study

While previous research has focused on the effects of CBT formalized training programs, in that they have shown increases in participants perceived competency and expert rated competency (Bennett-Levy & Beedie, 2007; Milne et al., 1999), there is a lack of research examining REBT formalized training and its impact on perceived and expert-rated competency. As such, the current study focuses on the relation between formalized training in REBT and competency (both perceived and expert-rated). The present study hypothesized that:

1. Those who participated in the REBT training would have higher ratings of perceived competency than those who did not participate in the training.
2. Those who participated in the REBT training would have higher ratings of expert-rated competency of performance in response to simulated video clients than those who did not participate in the training.
3. Participant perceived ratings of competency of performance in response to simulated video clients and expert ratings of competency of performance in response to simulated video clients would be similar across participants.
4. Participant perceived ratings of overall competency in REBT and participant perceived ratings of competency of performance in response to simulated video clients would be similar within participants.

Chapter III

Methods

Participants and Procedures

This study required the direct recruitment of therapist participants (see Appendix A and Appendix B) and expert rater participants (see Appendix C). Therapist participants in the experimental group were recruited using a recruitment flyer via email sent to clinical externs (4th year doctoral students) who registered for and completed the REBT three-day clinical practica training at a mental health facility, the Albert Ellis Institute (AEI), in New York City. In addition, as part of the training, therapist participants also receive 12 hours of supervision by a licensed mental health professional who is trained to supervise in REBT in which clinical skills are practiced, modelled, and feedback is provided. In order to receive the certificate of completion in REBT, therapist participants must receive a minimum of 70% on the examination at the end of training focused on the theory and practice on REBT. Therapist participants in the control group were recruited using a recruitment flyer via email sent to clinical externs who were 4th year doctoral students across listservs of psychological doctoral programs in New York. The control group participants were not registered for and did not complete the REBT training. In order to be considered eligible, participants had to be in their 4th year of a doctoral program, currently on their 4th year clinical externship, and depending on the group (experimental vs. control) reported whether or not they participated in the REBT training. If considered eligible, participants were then asked to complete a REBT perceived competency form as well as provide and record a clinical response to an REBT focused client simulated video prompts discussed further below. Four participants

(two experimental and two control) were eligible to participate. By participating in the study, therapist participants received a $50 Amazon gift card.

All four therapist participants were between the ages of 22-32, have been practicing clinicians for 2 years under supervision, are 4th year doctoral students in PsyD programs in New York, currently on their 4th year clinical externships, and have prior direct clinical hours ranging from 150-250. All participants highest degree level is a Master of Science degree, and they have all received essentially the same level of training, up until the REBT formalized training. Three female and one male participated in the present study. When asked about race, two participants identified as White, and two participants identified as Other. Options included: White, Black or African American, American Indian or Alaska native, Asian, Native Hawaiian or Pacific Islander, or other. When asked about how frequently the participant uses CBT in practice, three participants identified "most of the time" and one participant identified "always." Participants were then asked how frequently they use REBT in practice in which one participant identified "never", two participants identified "sometimes", and one participant identified "most of the time." Two participants identified having received formal REBT training while the other two identified never having received formal training in REBT.

Using the Albert Ellis Institute "Approved REBT Supervisor" contact list, expert raters were recruited. Professionals on this list were contacted via email to participate. This Approved REBT Supervisor contact list includes clinicians who have received a Supervisory Certificate in REBT from the Albert Ellis Institute. Therefore, this was used for recruitment in order to obtain raters who have not only been certified in practicing

REBT, but also were trained in and certified in supervising others practicing REBT. In order to be considered eligible to participate, expert raters were required to have received the supervisory certificate in REBT, provide ongoing supervision in REBT, and participated in the primary practicums in REBT. After completing the demographic survey and obtaining eligibility, expert raters received a document which included instructions, their assigned video link, and survey links to rate each corresponding video response. Five expert raters were eligible to participate. By participating in the study, expert raters received a $100 Amazon gift card.

Of the five expert raters, all five had previously participated in the 3 Day Primary Certificate Practicum in REBT, 4 Day Advanced Practicum in REBT, the Supervisory Certificate Practicum in REBT, and provided ongoing REBT supervision. Two of the raters completed their clinical externship in REBT and another two completed their associate fellowship practicum in REBT. One rater completed their clinical externship, internship, and postdoctoral experience in REBT. Of the raters, three were male and two were female.

Measures

Demographic Information. Prior to participating in the present study, therapist participants completed a brief demographic survey, which included questions about various topics including number of years in practice, current graduate education level, number of direct clinical hours, whether or not they are receiving supervision under a licensed provider, highest degree level, as well as current use of CBT and REBT in practice (see Appendix D).

Expert rater participants also completed a brief demographic survey which included information regarding professional REBT trainings and certificates received, whether or not they are a trained REBT supervisor, whether or not they have provided ongoing supervision using REBT, and degree level. In order to participate in the present study, expert raters must have received certificates from the REBT practicum trainings as well as a supervisory certificate practicum in REBT (see Appendix E).

Expert Rating of Clinical Response. To provide recordings to allow for an evaluation of clinician competency in REBT, all four therapist participants (both the control group and experimental group) participated in a web-based system of simulated practice for psychotherapists, "Skillsetter." Via the platform, all therapist participants were provided with brief video recordings of "clients" presenting with clinical concerns and were informed of specific REBT clinical skills (See Appendix H) that they were asked to demonstrate in response to the video presentation. The Skillsetter system records the clinicians response and this recording is then sent to the objective, REBT expert rater. The expert rater then rated the therapist participant's competency in REBT based on the communicated expected skills and the therapist video recordings of their REBT clinical responses (see Appendix G for expert rater instructions). All therapist participants were provided with five different videos of "clients" presenting with content that relates to five different REBT content areas. These "clients" were recruited via email which included information about the study and their role as "clients." These "clients" were colleagues and acquaintances of the researcher. These five clients included 3 female and 2 male participants, in which each client would say a prompt consistent with a REBT skill that was provided to them by the examiner. Each therapist

participant viewed each client several times, across different skills. By utilizing the same "clients" and situations across therapist participants, this will account for any variability in terms of client complexity for therapist participants. That is, if REBT competency was evaluated by viewing recordings of actual client sessions, competency ratings may be impacted upon by the complexity of issues that the client presents with. The present research provided a standard clinical case presentation that all participants were asked to respond to. In order to control for the expert ratings being impacted by prior ratings of a specific therapist participant, each expert rater viewed a different therapist participant demonstrating a different REBT skill.

As therapy and REBT is complex and consists of multiple skills, consideration was given as to which skills to evaluate in order to evaluate competency. Of the 21 core steps of REBT practice from the REBT competency scale (Dryden et al., 2010), five central skills were chosen. According to a recent survey of most frequently used REBT skills (Wade, 2021), the five skills most commonly utilized by REBT therapists are to "Assess the Activating Event", "Teach the Belief-Consequence Connection", "Assess the Irrational Belief", "Use of Logical Disputation", and "Teach Rational Beliefs." The top-rated skills were reviewed with trainers of REBT and these five skills were also chosen to be part of the evaluation of video recording of clinical competency in REBT. In regard to the client prompts per REBT skill, prompts were developed from previous REBT research and examples throughout the literature (i.e., DiGiuseppe et al., 2013; Terjesen et al., 2023).

An REBT Rating Scale (see Appendices D and E), assessed the quality of therapist participant responses. Both therapist participants and expert raters were

provided with behavioral definitions of the skill utilized in each context. Raters were also provided with sample responses. To examine competency of performance in a standardized manner, raters initially watched a sample competent clinical response to the client prompt prior to watching the participant response. This allows for continuity in rating scales across raters when viewing and rating participant responses. Definitions and samples are included in order for the objective rater to have an understanding as to what is a competent demonstration of the clinical skill being delivered (see Appendix I).

Self-Rating of Clinical Response. Additionally, after completing the video response, all four therapist participants also rated their own competency using the same Skillsetter REBT Rating Scale (see Appendices D and E) that were used by expert raters. It is important to note that therapist participants and expert raters did not see each other's ratings. The independence of their ratings allows us to not only assess expert rated and therapist perceived competency, but also compare the two.

Overall Self-Rating of Perceived Competency. In addition to the therapist participant's completing their own competency ratings based on video responses, therapist participants were also asked to complete their overall perception of competency on REBT in general. To examine participants overall self-ratings of perceived competency in REBT, the REBT Perceived Competency Scale was developed (see Appendix F). This scale focuses on REBT specific clinician perceived competency with items borrowing from the REBT competency scale which was developed based on a training manual in REBT (Terjesen et al., 2023). Consistent with the Counselor Activity Self-Efficacy Scales (CASES; Lent et al., 2003), the present scale utilizes a 10-point Likert scale ranging from "no confidence" to "complete confidence" in assessing where

clinicians view their abilities. While the CASES focuses more on general skills of competency, the REBT Perceived Competency Scale focuses on REBT specific skills. This was completed by all therapist participants, in both conditions (i.e., those who went through the REBT training vs. those who did not). It's important to note that those who did participate in the REBT training completed this perceived competency scale following completion of the training while the participants who did not go through the training did not.

Chapter IV

Results

Expert Rating of Clinical Response

Five REBT skills were assessed using the Skillsetter Rating Scales including "Assess the Activating Event", "Teach the B-C Connection", "Assess Irrational Beliefs", "Use of Logical Disputation", and "Teach Rational Beliefs." Each skill was rated on a 1 (did not demonstrate competency) to 3 (demonstrated competency) scale and the highest total that they could receive across all five responses was 15 competency point ratings. Total rating scores were calculated for each of the four therapist participants, and averages were calculated for the control group (i.e., those who did not go through the REBT training) and the experimental group (i.e., those who did go through the REBT training). Overall, the average rating of expert-rated competency for those who did go through the training is 10 (participant A = 10, participant B = 10) and the average rating for those who did not go through the training is 9.5 (participant C = 11, participant D = 8), indicating very little difference overall between the two groups on the Skillsetter Rating Scale by expert raters.

Self-Rating of Clinical Response

Therapist participants completed the same Skillsetter Rating Scale following completion of their own video responses, which evaluated perceived competency on the video responses. Overall, the average rating of perceived competency for those who did go through the training is 13 (participant A = 11, participant B = 15), while the average rating of perceived competency for those who did not go through the training is 7.5 (participant C = 7, participant D = 8). Interestingly, in response to evaluating their own

performance, average perceived competency ratings between the experimental and control group are of greater difference than the expert rated competency between the two groups. That is, while the expert raters saw no difference, those who went through the REBT training perceived their performance to be better than those who did not go through the training. Further, when comparing the perceived competency and expert rated competency, those who were in the experimental group on average, perceived themselves as more competent on the videos than the experts did. However, when looking at the control group (i.e., those who did not go through the training), there were more similarities between ratings (perceived and expert rated). In this case, the experts rated the control group videos more competent than they rated themselves. In looking at specific REBT skills, two of the skills, "Assess the Irrational Beliefs" and "Teach Rational Beliefs", showed a significant difference (i.e., 25% or above) between perceived competency ratings when comparing the experimental and control groups, with the experimental group rating their skills as higher. There were no differences on specific skills when looking at expert ratings.

Self-Overall Perception

The REBT Perceived Competency Form (Appendix F) examined all four participants perceived general competency across 13 areas consistent with REBT. Each skill was rated on a 1 (not at all confident) to 10 (complete confidence) scale and the highest total that they could receive across all 13 areas was 130 competency point ratings. A rating of a 5-6 on this scale was represented as somewhat confident. As this scale was completed by all participants prior to completing the video responses, this looks at general perception of REBT competency, rather than their actual performance in

response to the simulated client. In terms of perceived competency, averages among the two groups displayed some notable differences. We set a threshold of 25% in looking at these differences, which in this case, serves as a difference between category: not at all confident, to somewhat confident, to complete confidence. Overall, the average rating of perceived competency for the experimental group was 92.5 (participant A = 84, participant B = 101) whereas the average rating of perceived competency for the control group was 57.5 (participant C = 49, participant D = 66). Thus, the therapist participants who went through the REBT training, rated themselves as more competent than those who did not go through the training. In particular, the specific REBT skills that yielded significant differences between the experimental and control groups of a 25% difference or greater included the therapist's confidence in asking for an example of the target problem presented by the client, assess the emotional and/or behavioral consequence, orienting the client to the REBT model, teach the B-C connection, assess the irrational belief, connect the irrational belief to the consequence, teach the rational beliefs, and using logical, empirical, or pragmatic disputation. Therefore, the majority, 8 of the 13 items displayed this difference between groups.

Perceived Competency Comparisons: Self-Rating of Clinical Response vs. Overall Self-Perception

Of the 13 questions on the REBT perceived competency scale, or the overall self-perception ratings for participants, five focused on the same five REBT skills that were focused on in the videos. This includes "Assess the Activating Event", "Teach the B-C Connection", "Assess the Irrational Belief", "Use of Logical Disputation", and "Teach Rational Beliefs." Participants rated their competency in these same five areas overall as well as in response to their specific video. In comparing participant perceived

competency ratings regarding self-ratings of their clinical responses to each video versus their overall perception per skill, there are some notable differences as well as similarities across participants. Table 1 displays the ratings for each participant, per skill.

For three of the five skills, participant A rated herself as somewhat confident and somewhat competent. For “Teach the B-C Connection”, participant A rated herself as somewhat competent (2 out of 3) on her video response and in between some confidence and complete confidence when generally completing this skill (7 out of 10). For “Assess the Irrational Belief”, participant A rated herself as demonstrated competence (3 out of 3) for her video response but rated her confidence in completing this skill a bit lower (7 out of 10), which is in between the “some confidence” and “complete confidence” categories. Participant B rated himself as demonstrating competence on each of the five skills. However, his overall confidence ratings in these areas ranged between somewhat confident to confident. Participant C’s ratings were consistent throughout, in that when she reported she somewhat demonstrated competency or did not demonstrate competency on four of the five ratings, her overall confidence was also pretty low. On one item, “Assess the Irrational Belief”, participant C rated she somewhat demonstrated competency on this item however overall reported low confidence. Participant D had similar style ratings to participant C. For two of the items, “Teach the B-C Connection” and “Use of Logical Disputation”, participant D rated she somewhat demonstrated competency in regard to her video response but when asked about this confidence level overall, she reported low confidence. Overall, when averaging the self-ratings across these five skills, and comparing self-rating of specific video clinical response vs. overall

self-perception regarding confidence level, all participants with the exception of participant B displayed equivalent self-ratings, when comparing the assigned labels per number. These results are summarized in Tables 1 and 2.

Table 1.

Participant Self-Rating of Specific Clinical Response vs. Overall Skill Confidence

Participant	Self-Rating of Specific Clinical Response	Overall Self-Perception per Skill
Participant A		
Assess Activating Event	2	6
Teach the BC Connection	2	7
Assess the Irrational Belief	3	7
Use of Logical Disputation	2	6
Teach Rational Beliefs	2	6
Participant B		
Assess Activating Event	3	7
Teach the BC Connection	3	6
Assess the Irrational Belief	3	7
Use of Logical Disputation	3	7
Teach Rational Beliefs	3	7
Participant C		
Assess Activating Event	2	7
Teach the BC Connection	1	2
Assess the Irrational Belief	2	2
Use of Logical Disputation	1	2
Teach Rational Beliefs	1	2
Participant D		
Assess Activating Event	2	7
Teach the BC Connection	2	3
Assess the Irrational Belief	1	3
Use of Logical Disputation	2	3
Teach Rational Beliefs	1	3

Note. These scores reflect each participant's ratings of their perceived competency in response to the Skillsetter videos compared to their overall perceived confidence level in each REBT skill. Self-ratings are on a scale of 1-3 (3 being the most competent). Overall self-perception ratings are on a scale of 1-10 (10 being the most confident in each skill).

Table 2.

Average Self-Ratings of Specific Clinical Response vs. Overall Skill Confidence with Labels

Participant	Self-Rating of Specific Clinical Response: Average and Label	Overall Self-Perception per Skill: Average and Label
Participant A	2.2 (Somewhat Demonstrated Competency)	6.4 (Some Confidence)
Participant B	3 (Demonstrated Competency)	6.8 (Some Confidence)
Participant C	1.4 (Did Not Demonstrate Competency)	3 (No Confidence)
Participant D	1.6 (Did Not Demonstrate Competency)	3.8 (No Confidence)

Note. These scores reflect the averages per participant for self-ratings of their specific clinical response on Skillsetter vs. their overall perceived confidence level in each REBT skill. Labels of "did not demonstrate competency" to "demonstrated competency" and "no confidence" to "complete confidence" were provided to compare across scales.

Chapter V

Discussion

The purpose of this study was to evaluate the impact of formalized training in REBT on clinician competency, both perceived and expert rated. This study examined two groups: one group who participated in the REBT formalized training and another group who did not participate in the formalized training. All participants are at the same level of graduate training (i.e., 4th year doctoral students on their 4th year clinical externship) and have essentially had an equivalent level of training up until this point. Doctoral level students were recruited for this study to control for greater homogeneity between and within groups. Additionally, it was important to control for seasoned clinicians who might have participated in the REBT training as their competency level following the training would likely be due to other external factors as well (i.e., other trainings, greater amount of clinical practice, etc). Therefore, in order to assess for competency levels following a formalized training, it was important for participants to have had some (but not much) prior clinical experience.

When evaluating perceived competency ratings, results supported the hypothesis that those participants who did go through the REBT training (i.e., experimental group) would have higher ratings when assessing their own perception of competency compared to those who did not go through the training (i.e., control group). This finding was the case for both the self-rating of the specific clinical response (i.e., self-rating on video response) as well as for the overall REBT perceived competency scale. This finding is in support of previous research findings that formalized training courses have led to higher ratings of self-perceived competency (Bennett-Levy & Beedie, 2007;

Milne et al., 1999). Interestingly, of the five REBT focused skills, two in particular yielded the greatest difference in perceived ratings (i.e., 25% or higher). These skills were "Assess the Irrational Belief" and "Teach the Rational Beliefs", in that the experimental group had significantly higher ratings on perceived competency in these areas. It is possible that these two areas are more focused on in formalized training as opposed to informalized training, and could be an area of future exploration. In assessing the differences between the ratings of these skills, it's important to consider whether such differences are a function of the training in REBT. To that end, when comparing groups of clinicians (i.e., those who went through the REBT training vs. those who did not), it might also be important to look at how clinicians differ in their responses. For instance, the REBT clinician might be more likely to focus on evaluative or "hot" cognitions rather than cold cognitions (i.e., descriptions, inferences, and schemas) (David et al., 2005). Future research may warrant looking at the differences in types of training (i.e., CT vs. REBT) when assessing the differences in responses across core skills.

In regard to the second hypothesis, results in the present study were divergent from previous findings in that clinician competency, as rated by experts, were not only pretty much equivalent for both the experimental and control groups, but also that majority of ratings of the experimental group members were rated as "somewhat demonstrated competency." Previous research that has looked at expert rated competency as a result of a training course have found that trainees have demonstrated competency following the training (Branson et al., 2015; Liness et al., 2018). Based on the findings across the literature, one would have expected that the expert ratings of

those in the experimental group would have had significantly higher ratings than those in the control group. In the present study, this finding could have been due to a number of factors. One of the factors, that may be a limitation in this study, could be due to the scale in which expert rated competency was measured on. This was a 3 point Likert scale (did not demonstrated competency, somewhat demonstrated competency, demonstrated competency). Perhaps if this scale included additional options for rating of competency (i.e., a 5 point Likert scale), we would have seen differences between groups. Additionally, perhaps with more options on a scale, those in the experimental group would have received higher ratings overall (i.e., rated in between "somewhat demonstrated competency" and "demonstrated competency") and the control group would have received lower ratings overall (i.e., rated in between "did not demonstrate competency" and "somewhat demonstrated competency"). Another reason behind the similar ratings between groups could be due to the fact that both groups have received essentially equivalent levels of informalized training up until this point. In other words, as all four participants are fourth year PsyD students in New York, currently on their fourth-year clinical externships, the informalized training they have participated in up until this point is very similar. Additionally, all four participants have had a similar number of direct clinical hours up until this point and have received, and are currently receiving, supervision. Therefore, perhaps informalized REBT training for these purposes was sufficient to display more equivalent ratings of competency.

When examining the similarities between expert and perceived ratings of competency (i.e., hypothesis three), the findings were mixed between participants. In terms of group averages, expert and perceived ratings were similar for the control group,

in comparison to the experimental group in which there was a significant difference between expert and perceived ratings. This is consistent with previous research that some have found differences between self-rated and expert-rated competencies (James et al., 2001; Bennett-Levy & Beedie, 2007). However, when we take a closer look at each participant, differences were also found, within groups. Specifically, in the experimental group, participant A did not show a significant difference (expert = 10, self = 11) while participant B did (expert = 10, self = 15). In both cases, the self-rating was higher however the difference between these ratings was more significant for participant B. Previous research has evidenced that a self-assessment bias does exist and that 25% of clinicians view themselves as in the top 10% (Walfish et al., 2012). In regard to the control group, participant C displayed a significant difference between ratings (expert = 11, self = 7), to the opposite effect of participants A and B. In this case, participant C viewed herself as less competent than the experts rated her. It is likely that having not gone through the training, her perception of competence, and thus confidence level, was lower than her actual performance. However, the final control group participant, participant D, had equivalent ratings (expert = 8, self = 8). This finding of equivalent ratings is less consistent throughout the literature. This same participant rated herself previously as "never" using REBT in her own practice and may explain the lower ratings of skills by the experts and the second lowest self-rating of skills. Similar to participant C, this participant was less confident in her ratings than participants A and B. However, as this participant "never" uses REBT in practice, it also makes sense that she received the lowest of ratings from experts.

Regarding participant self-ratings of the five REBT skills in terms of specific video response vs. overall confidence levels, this hypothesis was supported in that the majority of participants (three out of the four participants) displayed equivalent self-ratings by category. While the self-rating of a specific clinical response (i.e., Skillsetter video response) was on a 3-point scale, and the overall perceived confidence level for performing each skill in a competent manner was on a 10 point scale, both scales used three different categories when defining ratings. The scale for video response rating (see Appendix J) used categories of "did not demonstrate competency", "somewhat demonstrated competency", and "demonstrated competency." The scale for overall perceived confidence level per skill (see Appendix F) used categories of "no confidence", "some confidence", and "complete confidence." As such, self-ratings of competency on two different scales were able to be compared based on the category. Participant's A, C, and D evidenced equivalent averaged ratings of their own performance in response to videos and in their response to overall confidence levels (A = somewhat demonstrated competency vs. some confidence; C = did not demonstrate competency vs. no confidence; D = did not demonstrate competency vs. no confidence). Participant B differed from this finding in that he rated his performance on videos as "demonstrated competency" and rated his response on overall confidence level in REBT as "some confidence." In this case, when the videos were skill specific, participant B rated himself as more competent than when the questionnaire asked about general ability on each skill. This could be explained by frame of reference for each participant in that perhaps some participants compare their competency and confidence levels relative to themselves, while other participants might compare themselves to others in the field.

This theory is consistent with the idiographic vs. nomothetic approach in psychology (i.e., within an individual vs. between an individual and others) (McFarland & Miller, 1990). Results also revealed that some might believe their competency in response to a video might differ from their ability and competency to perform in that area overall. Interestingly, while participant's C and D rated their general overall competence pretty low throughout four of the five REBT skills, on one specific skill, "Assess the Activating Event", they rated their general ability much higher. This could be explained by this general skill being utilized across other treatment modalities, such as CBT, and less of a REBT specific skill.

Study Limitations

While this current study was able to compare REBT competency levels, both perceived and expert rated, between those who did participate in a formalized REBT training program vs. those who did not, this study was not without its limitations. First, the small sample size of four participants (two in each group) was a limitation of this study. While the researcher intended to recruit more participants per group, the registration for this round of the REBT training was smaller than anticipated. Due to this small sample size, it is difficult to determine if the results and group averages would have looked different with more participants. Another limitation is in regard to the sample videos provided for the raters. While raters were provided with a sample competent response when rating participants, participants did not receive a sample competent response when rating their own competency levels. It may have been better for participants to also have that model of a competent response, as that would allow them to evaluate their own performance relative to that standard. Having more

individualized standards as to competency, may partly explain the differences between expert and self-ratings. Additionally, as we had five different raters for the present study, all of whom are certified supervisors in REBT, it's possible that there were differences between rater's perceptions across skills. Because of this, raters were provided with the same sample responses and definitions to base their ratings on, to best control for these differences. Despite these efforts, it still could be a possibility that different raters could have varied perceptions, and as such is included here as a potential limitation. A second limitation as mentioned before was the fact that the video rating scale was on a 3 point Likert scale rather, than perhaps a 5 point Likert scale, which might have impacted the ability of raters to differentiate competency responses between groups. Third, as the focus was on five specific and most utilized REBT skills, this research might have looked different if we took a look at additional REBT skills as well. Fourth, we did not utilize client sessions in this regard and thus, could not look at client outcome when assessing competency. In this study, while having standardized simulated client videos was done to control for differences in complexity across clients, future research may wish to also measure competency by rating recorded client sessions.

Future Directions

Future directions could take these limitations into account. For instance, future research should look to include a larger sample size and a larger Likert rating scale to assess competency. Additionally, while this study only focused on simulated client videos, it would also be interesting to assess live recorded REBT client sessions in assessing participant competency. This would also include more than the five focused REBT skills, and instead, use a complete REBT competency scale when rating sessions.

It would be interesting to compare perceived and expert ratings, between the experimental and control groups, in this regard as well. Additionally, by completing demographic measures prior to participating, participants reported their experience and current practice with REBT. However, the demographic questionnaire did not specify what this experience included. Future research may wish to examine to what degree of experience the trainees had in terms of coursework consistent with REBT, understanding of REBT literature and whether they were previously supervised by a supervisor in REBT. In addition to including clients instead of simulated clients to measure participant competency, future research could also implement clients in order to measure client outcome over time. That is: do the clients of those who participated in the training report greater decreases in symptoms of psychopathology when compared to clients of those who did not participate in the training? Future research could expand on perceived competency ratings between groups in investigating the differences between live clinical sessions and overall confidence levels. Finally, this REBT training took place online, in a live virtual format, over the course of three days. Previous research has looked at online vs. in person models of training in psychotherapy and have found mixed results throughout the literature (Frank et al., 2020). Some have found generally the same results between these two training models, and others have suggested that more complex treatment strategies might benefit from in person instruction (Frank et al., 2020). However, as the modality of training has not yet been examined in REBT, future research might wish to include this.

Summary

Overall, formalized training in REBT had an impact on perceived clinician competency ratings between groups. However, it did not have a significant impact on expert competency ratings between groups. Participants in the experimental group displayed higher perceived competency levels than that of the control group. In regard to similar ratings between self and expert, half the participants showed similar ratings and the other half showed significantly different ratings when assessing clinician competency. The results of the current study provide support for formalized training increasing clinician confidence and perceived competency. While perceived competency does not equate to actual competency, it's important to be mindful of this finding in terms of the self-assessment bias (i.e., assessing ourselves as more competent than we are in reality). These findings can lead to the conclusion that a formalized training program in REBT does not lead to complete competency. The difference in these findings can contribute to future research. The current study adds to the limited, yet important, research regarding training in REBT, clinician competency, the overall training of graduate students, and the importance of continued training experiences and supervision throughout graduate school.

Chapter VI

Implications for the Profession of School Psychology

Effective training in evidence-based therapies is vital to our field of school psychology. Research shows that almost 70% of our students who receive counseling and psychological services, do so in school (Farmer et al., 2003; Gonzalez et al., 2004; Camhi, 2013). Training throughout graduate school (both informalized and formalized) impacts clinician competency and professionals as school psychologists. In assessing clinician skill, the standard of therapy is measured by therapist adherence (i.e., the therapist implementing relevant and appropriate procedures) and therapist competence (i.e., implementing procedures in a competent manner) (Blackburn et al., 2001). When training as professionals in the field of school psychology, the second half of that equation (i.e., competence) is just as important as the first part (i.e., adherence). As school psychologists, we can know what modality would best support our students however if we are not competent in implementing, an important question to consider is: how can we be effective in contributing to change?

In assessing competency in graduate school, it's important for trainees to self-reflect and evaluate their own competency and integrate feedback from supervisors/experts about their skill demonstration. As seen in the present study, participants rated themselves as more confident and competent than the experts did. It's important to assess the reasons for these differences and work to close this gap. In particular, when assessing student's competency levels in graduate school, it's essential for supervisors to compare and review their ratings with that of the student. It's important that students understand the differences between ratings and work towards

becoming more accurate self-raters. In order to become effective and influential professionals and clinicians, we need to measure trainee's own abilities to effectively rate themselves and what areas they're most competent in, and in what areas they need further instruction and growth.

In terms of training, while we did not find significant differences between groups from expert raters, it's important to note how informalized training received in graduate school is both similar and different to formalized training programs. All participants are currently being supervised on their fourth-year clinical externship experience and receiving regular, consistent feedback on their skills. A common factor between the formalized and informalized training of participants is this supervisory element. As school psychologists in training, it's important to remain mindful that once we complete all criteria to have been trained in a certain area, that might not always translate to clinical competency. It's important that graduate trainees continue to seek out externship, internship, and post-doctoral opportunities in which they can continue to receive supervision and expand in their skill use, to enhance their competency and growth as clinicians and school psychologists.

Appendix A. Participant Recruitment Letter/Consent Form: Experimental Group

You are invited to participate in a research study, which aims to advance the knowledge about Rational Emotive Behavior Therapy (REBT) training, interventions, and clinician competency. Participants eligible are 4th year doctoral students who are currently on their clinical externships and participating in a three-day REBT focused training at the Albert Ellis Institute (AEI). AEI serves as a training site for clinicians in REBT and Cognitive Behavioral Therapy (CBT). This study will be conducted by Jessica Weiss as part of her doctoral dissertation at St. John's University. Her faculty sponsor is Dr. Mark Terjesen.

As part of this study, you will be asked to complete two measures to evaluate your competency in REBT. The aim of this study is to not only enhance your own competency as a REBT therapist but also examine how informalized training vs. formalized training in REBT contributes to perceived and expert rated competency. By participating in this study, you will receive a $50.00 amazon gift card as well as a one hour individual supervision and consultation session with an REBT expert. This consultation would take place after the completion of the study in order to receive feedback and guidance on REBT skills in practice.

You may refuse to participate or withdraw at any time without penalty. In the event that you need any additional information regarding this research project, you may email Dr. Terjesen at terjesem@stjohns.edu or Jessica Weiss at jessica.weiss18@my.stjohns.edu. For questions about your rights as a research

participant, you may contact the university's Human Subjects Review Board, St. John's University, (718) 990-1440. Your signature on this form means that you understand the information presented and that you want to participate in this study. You understand that participation is voluntary and you may withdraw from the study at any time.

Statement of Consent: I have read and understand the purpose and procedures of the study, as well as the risk/benefits, and voluntary nature of participation. By signing this form with my typed name, I provide consent to participate in the present study. Please select below whether you agree or do not agree to participate.

- I **agree** to participate in this study
- I **do not agree** to participate in this study

Agreement to Participate

_____ _____

Signature of Participant Date

Appendix B. Participant Recruitment Letter/Consent Form: Control Group

You are invited to participate in a research study, which aims to advance the knowledge about Rational Emotive Behavior Therapy (REBT) training, interventions, and clinician competency. Participants eligible are 4th year doctoral students, in their 4th year clinical externship and performing REBT and/or Cognitive Behavioral Therapy (CBT) at their externship sites. Eligible participants have not participated in the formal REBT training at the Albert Ellis Institute. This study will be conducted by Jessica Weiss as part of her doctoral dissertation at St. John's University. Her faculty sponsor is Dr. Mark Terjesen.

As part of this study, you will be asked to complete two measures to evaluate your competency in REBT. The aim of this study is to not only enhance your own competency as a REBT therapist but also examine how informalized training vs. formalized training in REBT contributes to perceived and expert rated competency. By participating in this study, you will receive a $50.00 amazon gift card as well as a one hour individual supervision and consultation session with an REBT expert. This consultation would take place after the completion of the study in order to receive feedback and guidance on REBT skills in practice.

You may refuse to participate or withdraw at any time without penalty. In the event that you need any additional information regarding this research project, you may email Dr. Terjesen at terjesem@stjohns.edu or Jessica Weiss at jessica.weiss18@my.stjohns.edu. For questions about your rights as a research

participant, you may contact the university's Human Subjects Review Board, St. John's University, (718) 990-1440. Your signature on this form means that you understand the information presented and that you want to participate in this study. You understand that participation is voluntary and you may withdraw from the study at any time.

Statement of Consent: I have read and understand the purpose and procedures of the study, as well as the risk/benefits, and voluntary nature of participation. By signing this form with my typed name, I provide consent to participate in the present study. Please select below whether you agree or do not agree to participate.

- I **agree** to participate in this study
- I **do not agree** to participate in this study

Agreement to Participate

_____ _____

Signature of Participant Date

Appendix C. Expert Rater Recruitment Letter/Consent Form

You are invited to participate in a research study, which aims to advance the knowledge about Rational Emotive Behavior Therapy (REBT) training, interventions, and clinician competency. Your role in this study would be to serve as a rater of demonstration of clinical skills in REBT. This entails rating brief recorded REBT video responses to assess clinician competency in 5 different REBT skill areas (i.e., assess the activating event, teach the B-C connection, assess the irrational belief, use of logical disputation, teach the rational belief).

This study will be conducted by Jessica Weiss as part of her doctoral dissertation at St. John's University. Her faculty sponsor is Dr. Mark Terjesen. As part of this study, you will be asked to watch an individual portraying a client and then a sample model response for that skill. Upon watching the demonstration, you will then be presented with 5 different REBT recorded response videos to an individual portraying a client and asked to rate clinician competency which is typically 2-3 skills that they are being rated on for 4 videos. By participating as a rater in this study, you will receive a $100.00 amazon gift card. It is expected that the entire process will take no longer than 40 minutes.

You may refuse to participate or withdraw at any time without penalty. In the event that you need any additional information regarding this research project, you may email Dr. Terjesen at terjesem@stjohns.edu or Jessica Weiss at

jessica.weiss18@my.stjohns.edu. For questions about your rights as a research participant, you may contact the university's Human Subjects Review Board, St. John's University, (718) 990-1440. Your signature on this form means that you understand the information presented and that you want to participate in this study. You understand that participation is voluntary, and you may withdraw from the study at any time. **Statement of Consent:** I have read and understand the purpose and procedures of the study, as well as the risk/benefits, and voluntary nature of participation. Please select below whether you agree or do not agree to participate. By selecting agree to participate, you consent to participate as a rater in this study.

- I **agree** to participate in this study
- I **do not agree** to participate in this study

Appendix D. Participant Demographics Survey

Age
- 22-32
- 33-42
- 43-55
- 55+

Race
- White
- Black or African American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Pacific Islander
- Other

What gender do you most identify with?
- Male
- Female
- Non-binary / third gender
- Prefer not to say

How long have you been in practice as a clinician? _____

How many direct clinical therapy hours, approximately, do you have at this point? (i.e., therapy practicum, externships, etc.)? _____

Are you currently being supervised for your clinical services by a licensed provider?
- Yes
- No

Current Graduate Education Level/Year:
- 1st year
- 2nd year
- 3rd year
- 4th year
- 5th year

Are you currently participating in 4th year clinical externship?
- Yes
- No

How often do you utilize Cognitive Behavioral Therapy (CBT) in treatment?
- Never
- Sometimes
- About half the time

- Most of the time
- Always

How often do you utilize REBT in treatment?

- Never
- Sometimes
- About half the time
- Most of the time
- Always

Highest degree level

- Master's
- PhD
- PsyD
- LSW/LCSW
- LMHC
- Other

Have you received formalized training (received a certificate) from the Albert Ellis Institute in REBT?

- Yes
- No

Appendix E. Expert Rater Demographics Survey

Please check any that apply for the professional REBT trainings you have participated in:

- 3 day primary certificate practicum in REBT
- 4 day advanced practicum in REBT
- Pre-doctoral externship in REBT
- Associate fellowship practicum in REBT
- Post-doctoral fellowship in REBT
- Supervisory certificate practicum in REBT
- Other: _____

Please provide your email address to receive content necessary for rating:

_____

Are you a REBT trained supervisor?

- No
- Yes

If so, approximately how many clinicians have you supervised using REBT?

_____

Have you provided ongoing supervision using REBT?

- Yes
- No

Highest degree level

- MA/MS
- PhD
- PsyD
- LSW/LCSW
- Other: _____

Appendix F. REBT Perceived Competency Scale

General Instructions: The following questionnaire asks about your beliefs about your ability to perform various therapeutic behaviors central to REBT and CBT. I am looking for your honest, candid responses that reflect your beliefs about your current capabilities at this present moment, rather than how you would like to be seen or might look in the future. There are no right or wrong answers to the following questions. Please circle the number that best reflects your response to each question.

Please indicate how confident you are in your current ability to use each of these skills effectively.

No confidence				Some confidence			Complete confidence		
1	2	3	4	5	6	7	8	9	10

1. Ask for a problem
    a. To what extent are you able to obtain a problem, and then if several are provided, work through the issue of agreeing upon a single problem on which to focus
2. Define and agree upon the target problem
    a. To what extent are you able to distinguish between an emotional problem and a practical problem, and emphasize focus on the emotional problem first
3. Ask for a specific example of the target problem: To what extent are you able to guide the client in identifying a target problem as well as a goal with respect to the target program.
4. Assess the emotional and/or behavioral consequence: To what extent are you able to effectively help the client in identifying his/her specific unhealthy feelings and behaviors
5. Assess the activating event (A): To what extent are you able to identify a specific, actual activating event
6. Orient the client to the REBT model: To what extent are you able to provide psychoeducation on the REBT model
7. Teach the B-C connection: To what extent are you able to teach the connection between one's irrational belief (IB) and the unhealthy consequences (C).
8. Assess the Irritational Belief (IB): To what extent are you able to clearly distinguish between Rational Beliefs and Irrational Beliefs with the client
    a. To what extent are you able to assess both the demand form of the IB and the derivative form of the IB
9. Connect the IB and C: To what extent are you able to ensure the clients understanding of the connection between his/her IB and C
10. Teach the Rational Beliefs: To what extent are you able to assist the client in establishing a set of alternative, clearly defined, rational beliefs
11. Question IB and RB: To what extent are you able to perform logical, empirical, and pragamatic questioning for both the IB and RB

    a. Logical questioning: to what extent are you able to question a belief in terms of its logical challenges for a specific problem
    b. Empirical questioning: to what extent are you able to question a belief in terms of its empirical challenges for a specific problem
    c. Pragmatic questioning: to what extent are you able to question a belief in terms of its pragmatic challenges for a specific problem
    d. To what extent are you able to perform logical, empirical, and pragamatic questioning for the rational philosophy
12. Negotiate a homework assignment related to beliefs: To what extent are you able to collaboratively assign homework related to practicing skills learned in session
13. Check the homework assignment: To what extent are you able to ensure you check the assignment was completed as well as review the assignment. If not completed, to what extent are you able to discuss barriers as to why

Appendix G. Expert Rater Instructions

Thank you again for your participation as a rater, it is so greatly appreciated. Below please see instructions. It is very important you read all instructions prior to watching & rating. If you have any questions or issues whatsoever, please do not hesitate to reach out to me at jessica.weiss18@my.stjohns.edu or 516-426-4032

This document contains the following information:

- Directions for accessing, watching and rating videos
- Qualtrics survey links to rate each participant video. Make sure you click on the correct survey link (each says a specific skill name). The links are in the order of you viewing the videos. You will need this document open as you watch and rate.
- REBT skills defined (participants also received these definitions)

Directions for accessing, watching and rating videos:

1. Here is your video link to dropbox: _____

2. All four videos you are rating are combined into this one video. You will be prompted to pause the video at certain time points.
    a. In the video, it begins with the skill being assessed, as well as the "client prompt" video (i.e., the video participants were required to respond to using the assigned skill). You will then see a sample response video which you will use to evaluate the participant response video and sets the expectation for that response.
    b. Then you will see the participant response. Following the participant response, you will be prompted to PAUSE the video and you will see an ID number.
    c. You will then use the corresponding link for each skill (please see below) to rate the participant's competency. This link will take you to a Qualtrics survey form. Please make sure you are using the correct link for each skill (the links are in order of videos)
    d. On this form, it is imperative to include the corresponding ID number provided on the video. You will then rate accordingly and submit the form.

Qualtrics survey links for each rating form you will need (by skill):

Assess the Activating Event

Teach the B-C Connection

Assess the Irrational Belief

Use of Logical Disputation

3. You will repeat these steps FOUR times, which means:
    a. You will watch four different participant videos displaying different REBT skills
    b. You will rate four different participant videos using the corresponding Qualtrics link per skill
4. This should in total take no longer than 40 minutes. Your video (without pausing and rating) is about 11 minutes

Appendix H. REBT Definitions for Reference

1. Assess the Activating Event
"The activating event is a crucial anchor in which the therapist should establish with clarity and specificity before exploring the beliefs. At this step, the activating event (A) is assessed (Dryden et al., 2010)."

2. Teach the B-C Connection
The goal of this step is to help the client understand that the emotional problem is largely determined by his/her beliefs rather than by the activating event. "Unless the client understands this his/her emotional problem is determined by irrational beliefs, then he/she will not understand why the therapist will assess beliefs in the following step (Dryden et al., 2010)."

3. Assess the irrational Beliefs (iB)
A central point in REBT is that the therapist needs to "accurately assess the irrational beliefs that the client is holding about the problematic situation, since such beliefs play a causal role in giving rise to the Consequence (C) (Dryden et al., 2010)."

4. Use of Logical Disputation
The aim of logical disputing strategy is to "weaken the client's endorsement of an iB by pointing out the faulty logic of the iB. The emphasis is on examining and challenging the logic of the clients iB. The therapist's goal is to help the client see why his/her iB is illogical (Dryden et al., 2010)."

5. Teach the Rational Beliefs (RB)
"Helping the client to establish a set of alternative, rational beliefs is a key stage in the process of REBT. The emphasis here is the therapist collaborating with the client to develop a new, more rational, philosophy that will help prevail in their current difficulties (Dryden et al., 2010)."

Appendix I. Skillsetter Prompts and Sample Responses

1. Assess Activating Event: The clinician was able to collaboratively identify the activating event (i.e., what actually happened) that triggered the irrational belief

Prompt: This is Brandon, you have been seeing him for a few weeks in which he has reported having conflicts with his girlfriend of one year. Upon entering session, he shared they got into another fight this week.

Client: My girlfriend and I have been fighting a lot and so she dumped me. I am such a loser. No one will ever like me.

Therapist: Before we dive deeper into our thoughts here, or our beliefs, it is important to identify the event that triggered the belief of "I'm such a loser and no one will ever like me." It sounds like these beliefs began after your girlfriend dumped you, is that correct?

2. Teach the B-C Connection: Using content from the example, the clinician connected the IB and the C effectively with the client.

Prompt: This is Kara. She reported her boyfriend broke up with her and she has been feeling really down.

Client: This is now the third relationship that I have had in the last year that ended with them breaking up with me. It clearly is about me. What's wrong with me? I do not think anyone will ever want to be with me because I am such an idiot and a loser. This makes me so upset that I just want to crawl into a ball and cry. I was so depressed that I cancelled plans with friends and called out sick for work for two days.

Therapist: It sounds like when you feel depressed, you are engaging in a lot of ratings

about yourself, thinking “I am no good, am an idiot, a loser” and “No one will care about me because I am worthless”. These thoughts also then lead to you avoiding important things, like social outings and work. Is that correct? Do you see the connection between thinking “I’m such an idiot and a loser” and your feelings of depression and avoidance

of social and work-related activities?

3. Assess the Irrational Belief: The clinician identified the IB

Prompt: This is Sara. She reported another person in her graduate program got a position she wanted and that it was not fair.

Client: We both applied for the same clinical training position, and it went to a person that I really do not respect. I think she had an “in” with the director. I have better credentials than her and I should at least have been offered an interview. I cannot handle this level of unfairness.

Therapist: It sounds like you have two beliefs here. One is a demand that you should have gotten an interview and the other is that you can’t deal with this level of unfairness. The demanding belief is typically considered to be the primary belief and the one that leads to unhealthy negative consequences like feeling jealous. Do you see how thinking this way is leading to feelings of jealousy as opposed to let’s say disappointment?

4. Use of Logical Disputation: The clinician challenges the IB using logical disputation

Prompt: This is Emma. She reported she has been feeling down lately because she finally worked up the courage to ask a guy out and it went horribly.

Client: He rejected me when I put myself out there and asked him out. I am clearly unlovable and a failure.

Therapist: is it logical to believe that just because a potential relationship you might have been interested in doesn't work out, that you or anybody else is therefore a total failure as a person?

5. Teach Rational Beliefs: The clinician works collaboratively with the client in establishing alternative rational beliefs

Prompt: This is Michael. He just reported his son and daughter in law have an awful relationship and now it is about to directly impact him.

Client: My son and daughter-in-law will be moving in with me for the next 6 months while their home is renovated. I am so anxious that this will be the end of any kind of relationship that we have. They always fight and make my home very uncomfortable. They should have rented a place. The next six months will truly be the worst.

Therapist: Your anxiety about your son and daughter-in-law moving in with you, most likely comes about from a few unhealthy or irrational beliefs. One is a demand that they should have rented another place and the other belief is more of an awfulizing one which is that the next six months will be the worst. A rational belief would be a good, healthy alternative to the irrational ones and may help you feel a healthy level of concern about the next six months. Here, instead of that demanding belief that they should have rented a place, the rational alternative would be "I really wish that they had rented elsewhere, but there is no reason that they must do what I want them to" and instead of

believing that the next six months will be the worst, the rational alternative would be: "The next six months will probably be bad, but not as terrible as I believe."

Appendix J. Skillsetter Scoring Criteria

Skill: _____

Participant ID Number: _____

The participant:

- 1. Did not demonstrate competency
- 2. Somewhat demonstrated competency (demonstrated skill but some problems and/or inconsistencies)
- 3. Demonstrated competency

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