THE RELATIONSHIP BETWEEN CLINICIAN-PERCEIVED COMPETENCY AND EXPERT-RATED COMPETENCY IN REBT USING ANXIETY-FOCUSED SIMULATED-BASED PRACTICE

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ABSTRACT

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Morgan Klein Schall

Though competency is of utmost importance to clinical practice (Muse et al., 2022), there have been minimal studies that have explored the relationship between clinician-perceived competency and expert-rated competency with the REBT framework. Competency in the delivery of psychotherapy is expected, but not well-defined (Fairburn & Cooper, 2011). Differences between perceived competency and expert-rated competency (Paunov et al., 2023) create further challenges in defining competency. While clinical competency in psychotherapy provision has been linked to client outcomes, this relationship varies depending on clinical model of psychotherapy as well as clinical problem (Collyer et al., 2020). Most of the competency in psychotherapy research focuses on adults and on Cognitive Behavior Therapy (Rapley & Loades, 2018). This study aimed to extend this research in examining psychotherapy competency in the utilization of Rational Emotive Behavior Therapy (REBT) in work with youth with anxiety in a simulated clinical setting. Clinicians with varying degrees of training in REBT responded to five video-based vignettes using the clinical training software, Skillsetter and were asked to respond to clients demonstrating many of the core features

of REBT. Experts in REBT rated their responses and participants also rated the skills being assessed. There was some variability in terms of skill ratings and a small correlation was found between self-perceived ratings and expert-coded ratings. Limitations of the current study, future direction, and implications for the field of school psychology and for those engaging in psychotherapy are discussed.

Keywords: competency, psychotherapy, REBT, clinician-perceived competency, expert-rated competency, anxiety, youth

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CHAPTER I

Introduction

Statement of the Problem

The development of clinical competency includes building essential clinical skills, such as developing and continually revising clinical hypotheses, targeting areas of change, and gauging client understanding to develop new perspectives (Stratton et al., 2011; Swank, et al., 2012). Muse and McManus (2013) defined competence in cognitive behavioral therapy as the level at which clinicians demonstrate their knowledge and skills to deliver the appropriate intervention to clients according to the presenting problem and the current evidence for treatment. Fairburn and Cooper (2011) echo this definition as they consider therapist competence constituting both a therapist's knowledge about the treatment being used, its use for the appropriate client population, and the extent to which the treatment is delivered "to the standard needed for it to achieve its expected effect" (p. 374).

Over the past decade, the implementation of evidence-based psychotherapies has increased in public mental health settings and for good reason (Wiltsey-Stirman et al., 2015). Clinical competence in the delivery of evidence-based therapies has been shown to be related to client outcomes (Cook et al., 2017). For example, Espeleta and colleagues (Espeleta et al., 2022) found that higher therapist-perceived competence with trauma-focused cognitive behavioral therapy (TF-CBT) predicted positive treatment outcomes in youth with posttraumatic stress and depressive symptoms. Youth with anxiety also experienced positive clinical outcomes after receiving cognitive behavioral therapy (CBT) from therapists with high adherence and high competence (Bjaastad et al., 2023).

The evaluation of clinical competency remains a challenge in clinical work and clinical training. Direct-observational methods are considered the gold standard for evaluating clinical competence and fidelity of cognitive behavior therapy (CBT) treatment delivery (Waltman et al., 2017). However, direct-observational methods are timely, costly, and sometimes unrealistic. Instead, clinicians and trainees are often asked to self-evaluate their own level of competence. Little is known about the concordance between clinicians' self-reported competency and observed competence evaluations of their performance. To date, only one study, conducted by McManus and her colleagues (2012), has examined agreement between self- and supervisor assessments of clinician competency within CBT. This work found a moderate correlation (Pearson's r = .48) between self- and supervisor assessments of recordings of therapy sessions. Despite Rational Emotive Behavior Therapy (REBT) being one of the original forms of CBT (David et al., 2018), there is no such work examining concordance between self-perceived competency and expert-rated competency of REBT and more so with competency as it relates to their work with youth. As such, the current study assesses the association between perceived competency and expert-rated competency in clinical work in the context of Rational Emotive Behavior Therapy (REBT), a form of CBT, with youth in a simulated clinical setting.

Competence in Psychotherapy

In general, competency refers to a "measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics" (Rodriguez et al., 2002, p. 310). In therapeutic settings, therapist competence is defined as a therapist's capacity to carry out psychotherapy to achieve its intended effect (i.e., lead to a decrease in problematic

symptomology) (Fairburn & Cooper, 2011). In fact, therapist competence is associated with better outcomes for patients. For example, intervention that has been implemented as intended has been shown to be correlated with a decline in problematic symptomology when working with children, and therapist competence matters in relation to symptom improvement with youth (Cross & West, 2011).

Watts (1990) claimed that clinicians who do not engage in self-assessment may end up trending toward incompetent practice. His assertions are supported by a recent empirical study by Mathieson and colleagues (Mathieson et al., 2009). When compared to clinicians who do not self-reflect on their competency, clinicians who learn to question and analyze their competency are less likely to become careless and are more motivated to continue their training in adhering to efficacious psychotherapy (Mathieson et al., 2009). As such, clinicians owe it to their clients to engage in self-assessment through measurement of client progress, use of a guiding model of competencies or a manual, use of valid and reliable assessment tools, review, and reflection of therapy sessions by themselves and with a supervisor or consulting clinician, and continuation of professional development to increase knowledge and work on refining psychotherapy skills (Sburlati & Bennett-Levy, 2014). Despite the importance of self-assessed clinical competencies, there are very few reliable and valid measures of therapist competence (Kohrt et al., 2015).

Competence in CBT

Developing competent clinicians who are able to deliver evidence-based CBT skillfully requires an effective method to continuously assess skillful delivery. Assessing competency of newly trained clinicians can be reliably achieved through objective ratings

of recordings of their therapy sessions by highly trained clinicians (Rozek et al., 2018). For example, Beale and her colleagues (2020) found that there is a positive relationship between self-rated and expert-rated competency scores when using the Cognitive Therapy Scale-Revised (CTS-R). The recording of treatment sessions has been determined to be an ecologically valid way to assess for clinician's competency in carrying out certain features of CBT with their clients (Cooper et al., 2017). However, relying on expert ratings of clinician competency is costly and time-consuming (Fairburn & Cooper, 2011). Instead, the development of reliable training methods for clinical competency is necessary to improve ease of access and reduce burden for clinicians in public mental health settings and ultimately improve treatment outcomes for patients.

Competency and Simulated-Based Practice

Training methods for therapists learning to engage in psychotherapy with a diverse clientele have changed over the years. In teaching evidence-based psychological treatments, little attention has been paid to therapists' ability to deliver these psychological treatments competently (Fairburn & Cooper, 2011; Sharpless & Barber, 2009). Fairburn and Cooper (2011) propose that therapist competency can be measured through the evaluation of patient outcomes, the evaluation of treatment sessions, and the evaluation of standardized role plays. Standardized role plays are a mechanism by which one may measure competency of clinical skills (Ottman et al., 2020). Typically, these role plays emphasize the repetition and practice of skills for the purpose of enhancing the clinician's own abilities at their current level of competence. Standardized role plays are commonly used to assess competency in training physicians; however, video-based vignettes have not been used directly to evaluate training therapists' psychotherapy

competency (Ottman et al., 2020). The current study aimed to use video-based vignettes as a way to measure the competency of clinicians in their psychotherapeutic skills.

Rational Emotive Behavior Therapy

Developed by Dr. Albert Ellis in 1955, REBT is considered by many as the original cognitive behavioral therapy (Turner, 2016). REBT is based on the premise that thinking about events leads to negative emotional and behavioral responses (Turner, 2016). The focus of REBT is to identify beliefs that cause emotional distress, challenge those beliefs, and replace such maladaptive beliefs with more adaptive ones, thereby increasing life satisfaction.

The theory and practice of REBT are based on the premise that, as humans, we have three levels of thinking: (1) inferences, (2) evaluations, and (3) core beliefs (MacLaren et al., 2016). Inferences are automatic thoughts (e.g., “I am going to fail this test”) made based on the available information (Oltean et al., 2017). These inferences are directly related to the client's evaluations about the situation, the people involved, and themselves. REBT clinicians work towards breaking down the four types of evaluative beliefs into (1) demandingness, (2) awfulizing, (3) discomfort intolerance, and (4) people-rating (David, 2014; David et al., 2010). Ellis described demandingness as demands about the self, demands about others, and demands about the world (Froggatt, 2005). Awfulizing is the belief that occurs when a client exaggerates the consequences of an event as being the worst thing that could happen, whereas discomfort tolerance is a client’s belief that they cannot handle an event or circumstance if it were to happen (Scott & Palermo, 2019). Finally, people-rating, refers to the overgeneralization of a trait, behavior, or action such that it becomes equivalent to the individual’s total value or worth

(Froggatt, 2005). Notably, people-rating can be self-directed or directed towards others (Froggatt, 2005). As an example, "if I fail the test, I *am* a failure." Lastly, core beliefs can be irrational or rational. Core irrational beliefs are often rigid and illogical and lead to unhealthy negative affect and behavior, while core rational beliefs are often flexible and logical (DiGiuseppe et al., 2014).

Application of REBT with Youth with Anxiety

REBT has been adapted for children and youth (Vernon, 2019) by teaching youth how to challenge irrational thoughts, minimize reactions to disappointment, be more accepting of themselves, and cope with challenges more effectively (Caruso et al., 2018). REBT has been shown to have a positive impact on youth with regard to school performance and emotional outcomes (David et al., 2018). REBT also has been shown to increase social-emotional skills and self-esteem, as well as help youth work through anger, anxiety, depression, and distress (David et al., 2018; Malhotra & Kaur, 2015).

Youth with anxiety have greater feelings of irrationality, including awfulizing, self-ratings of worth, other ratings of worth, low frustration tolerance, and demandingness than youth without anxiety (Terjesen et al., 2017). REBT has been widely used to target internalizing disorders such as anxiety (Wilde, 2011) and has been effectively used to treat anxiety (Hickey, 2019; Schenk et al., 2020). Therapist competence may be crucial in determining treatment outcomes for individuals with anxiety since it has been established among clients with depression (Weck et al., 2011). Given that clinical competency is known to be positively associated with treatment gains for youth (Cross & West, 2011), it is possible that improved competency in REBT may also improve treatment outcomes for youth with anxiety disorders. However, no work has

yet examined competency ratings among REBT clinicians conducting treatment for youth anxiety disorders. It is possible that competence research within the REBT framework has not been done due to the resources it takes to complete valid and reliable competency research (i.e., time, training toward interrater reliability, and the development, recording, and scoring of videos). As a first step towards closing this gap in the literature, the current study examined perceived competence in the clinical application of REBT and the degree to which perception is consistent with observed ratings of competence.

Purpose of the Current Study

According to the American Psychological Association (APA) Ethics Guide (2017), therapist's competence is an ethical issue that all psychologists are responsible to uphold both in their evaluation of others and in their maintenance of the high standards that they hold for themselves. Further, meta-analytic evidence indicates that there is a significant relationship between improved clinician competence and better youth outcomes (Collyer, et al., 2020).

The assessment of professional competencies among psychotherapists remains challenging (e.g., research, teaching, assessment, and intervention) (Sharpless & Barber, 2010). Although objective observation by expert clinicians has been used when assessing fidelity to evidence-based treatment, the application of such objective observations in many public mental health settings is beyond reach. Instead, the use of self-assessment measures is more efficient and scalable. However, research has not yet examined the concordance between a clinician's self-perceived competence and perception as assessed by more experienced clinicians in their delivery of various aspects of a specific clinical intervention. The current study aimed to establish the concordance between self-assessed

clinical competency and expert-rated clinical competency using REBT for youth with anxiety disorders as a case example.

CHAPTER II

Present Study's Hypotheses

As effective implementation is critical for achieving positive outcomes when providing therapeutic intervention with youth (Cross & West, 2011), this study sought to examine the relationship between self-rated perceived competence and expert-rated competence. Further, does the strength and direction of this relationship change as a function of clinician experience? Results of this study sought to contribute to the knowledge base describing methodologies used to assess clinical competency in psychotherapists. In this study, self-rating perceived competence was defined as the participant's average rating of their own competency to carry out the steps of REBT with individual clients. Expert-rated competence was defined as the participant's average rating by two expert clinicians based on the participant's performance across five simulation-based videos designed to assess their clinical competency across REBT skills. It was hypothesized that there would be a:

1. Small positive relationship between self-perceived competence (average of 28 REBT skill-based questions) and the expert-raters (average of both raters) perception of participant's competence in REBT skill delivery in response to a simulated client.
2. Small positive relationship between overall self-perceived competence (average of 28 REBT skill-based questions.) and self-rated competence in response to the five-assessed videos.
3. Small positive relationship between Skillsetter self-rated competence and expert-rated competence of participant's response to the five assessed videos.

Exploratory Analysis

In consideration with the above hypotheses, I also examined whether the results follow the Dunning-Kruger effect (Kruger & Dunning, 1999). The Dunning-Kruger effect theorizes that people with limited competence are likely to overestimate their competency while those with high levels of competency are likely to underestimate their competency. Thus, according to the Dunning-Kruger effect, those whose self-rated perceived competence of the assessed skills in REBT was on the lower end would receive higher ratings of competence by expert raters. Additionally, those whose self-rated perceived competence was on the higher end would receive lower ratings of competence by expert raters.

CHAPTER III

Methods

Participants and Procedures

Participants in this study were clinicians who identified their clinical orientation as cognitive behavior therapy (CBT) and who have, either in the past or currently, utilized REBT skills in their daily clinical work. Clinicians did not need to have been formally trained in REBT. Of the 14 participants, 5 were male and 9 were female. Participants ranged in age from 24 to 63 years old (M = 37.50, SD = 11.03) and identified as Asian (n =1), Caucasian (n = 10), Hispanic/Latino (n = 2), and one participant did not report their ethnicity. Regarding training, participants highest degree earned varied between Bachelor's degrees (n = 1), Master's degrees (n = 7), Ph.D. (n = 4), and PsyD (n =2). Of the 14 participants, 13 practiced in English in New York (n = 10), Illinois (n = 1), Ohio (n = 1), or California (n = 1), while one participant practiced in Italian in Italy. Additionally, participants' primary place of employment included a university or college counseling center (n = 5), private practice (n = 5), public school (n = 2), correctional facility (n = 1), and an outpatient treatment center (n = 1).

Procedure and Measures

Participants were recruited through emails to practicing clinicians through the Albert Ellis Institute and their affiliated training centers, professional listservs sourced through the APA and Association for Behavioral and Cognitive Therapies (ABCT), and word-of-mouth (Appendix A). Participants were provided with a consent form prior to participation which outlined study activities as well as risks and benefits associated with the research (Appendix B). Prior to completing REBT clinical competency measures,

participants were asked to complete a brief demographic information survey wherein they were asked additional background questions about their training and professional experience (Appendix C). Participants completed a 29-item questionnaire querying their self-perception of themselves as an REBT clinician on a six-point Likert scale (i.e.., 0 = Not at all competent, 1 = Somewhat competent, 2 = Moderately competent, 3 = Competent, 4 = Very competent, 5 = Expert) (Appendix D). Upon completion of this study, participants were entered into a raffle to win one of five $75 Amazon gift cards.

Ratings of Competence in REBT. Competence was assessed through 1) self-perceived rating of performance carrying out REBT core steps in response to the vignettes and 2) expert-rater evaluation of core steps of REBT demonstrated within the responses to the video vignettes. The self-perceived evaluation of performance steps was selected in consultation with an REBT trainer and supervisor at the Albert Ellis Institute in New York, New York. Participants rated themselves on REBT skills that were adapted from Terjesen and colleagues (2023) using a 0- to 5- Likert style scale (i.e., 0 = Did not demonstrate skill, 1 = Clinician demonstration of skill is insufficient, 2 = Clinician demonstration of skill was done with limited skill, 3 = Clinician demonstration of skill was competent but not incomplete with some limitations, 4 = Clinician demonstration of skill was sufficient and effective, 5 = Clinician demonstrated skill on an expert level).

Simulated Based Demonstration of Competency: Self-Evaluation. Participants were asked to respond to and record their responses utilizing REBT to five video-based therapy vignettes on Skillsetter where the simulated client was an adolescent dealing with anxiety (Appendix E). The five skills were selected based on Wade's (2022) study assessing the most commonly used and adapted techniques within Cognitive Therapy

(CT), Cognitive Behavioral Therapy (CBT), and Rational Emotive Behavior Therapy (REBT). The five vignettes were edited from clinical examples provided by Terjesen and colleagues' (Terjesen et al., 2023) *Deliberate Practice in Rational-Emotive Behavior Therapy* and adapted for this study to reflect clinical work with youth. Additionally, these vignettes were recorded with five undergraduate students who acted as high school students wanting to participate in research, completed a consent form (Appendix F), and received a $15 Amazon gift card for their participation.

Each participant utilized the Skillsetter website to watch five sample client prompts. All participants received the same five vignettes which portrayed a client prompt to which the clinician recorded and responded. Each vignette required the participant to respond by demonstrating specific REBT clinical skills (See Table 1). Participants were informed about which clinical skill they were expected to demonstrate in response to the video prompt and after watching the simulated client, the participant was prompted to record a video response to the simulated client demonstrating the clinical skill. Upon completion of the five vignettes, and prior to submitting their responses to the online training software, participants were required to answer yes-no questions regarding their adherence to the skill assessed in each vignette. Once participants submitted their responses to each of the five vignettes, they were sent a link to a questionnaire asking for their self-perceived ratings of competency for each of the skills that they were assessed on (Appendix G).

Simulated-Based Demonstration of Competency: Rater Evaluation

Four licensed psychologists with a supervisory certificate in REBT were recruited and asked to complete a consent form (Appendix H) and a demographic questionnaire

Table 1

Skill-Based Simulated Vignettes

Vignette	Skill Assessed	Skill Description
Vignette 1	Provide psychoeducation about REBT.	To explain the differences between the As, Bs, and Cs of REBT where "A" stands for the activating events, "B" stands for the client's beliefs, and "C" stands for the emotional and/or behavioral consequences that the client experiences as a result of their belief(s).
Vignette 2	Clarifying Healthy vs. Unhealthy Emotions and Behaviors.	To distinguish between dysfunctional negative emotions and maladaptive behaviors and healthy negative emotions and functional behaviors.
Vignette 3	Demonstrate the IB-C connection.	To teach their client about the connection between their irrational belief and the consequence.
Vignette 4	Perform Disputation/Cognitive Restructuring.	To engage in functional or pragmatic questioning of the client's irrational beliefs.
Vignette 5	Present a Rational Belief.	To guide the client to construct a rational alternative belief to replace their irrational belief.

Note. Each vignette was introduced to participants with the skill being assessed. Expert-raters were provided with the skill assessed, in addition to the skill description.

(Appendix I). To examine the competency of performance in relation to participant responses to simulated prompts, the four raters initially watched sample competent clinical responses to the client prompts in which the participants were asked to demonstrate the REBT skill (Appendix J). This allowed expert-raters to view responses that equated to a 5 (Clinician demonstrated skill on an expert level) on the Likert scale and served as a baseline when viewing participant responses to the same client prompt. The raters then used a 6-point Likert scale (i.e., 0 = Did not demonstrate skill, 5 = Clinician demonstrated skill on an expert level) to assess the participant's competency in carrying out the required clinical step in the individual's Skillsetter responses (Appendix K). To assess agreement upon expert coders' ratings of participant responses to the five video-based vignettes, all participant responses were assessed by two coders. Participants were either rated by the first set of coders ($n=7$) or by the second set of coders ($n=7$).

CHAPTER IV

Results

Data Analysis

For the purpose of this study, each participant was assessed using three scores: (1) overall perception of clinical skills as measured by the average of participants' ratings of their own competence in carrying out 28 REBT skills (Appendix D), (2) post-Skillsetter Likert-ratings of average self-perceived competence of assessed core-REBT skills in response to the simulated client video-based vignettes (Appendix G) and (3) an average of the expert raters Likert-ratings for each participant's performance in response to the simulated client video-based vignettes (Appendix K). Participants were asked to rate their perception of their overall ability to engage in Rational Emotive Behavior Therapy (REBT) and asked to rate their level of competence in carrying out 28 steps according to a 0 to 5 Likert style scale (i.e.., 0 = Not at all competent to 5 = Expert).

Self-Perceived Competency

First, participants were asked to rate their perceived level of competency in the utilization of REBT as a clinical intervention. On the 0- to 5- Likert scale, one participant rated themselves as not at all competent, three participants rated themselves as somewhat competent, three participants rated themselves as moderately competent, three participants rated themself as competent, two participants rated themselves as very competent and two participants rated themselves as being expert in REBT (M = 2.57, SD = 1.56). When examining participants' perceived competency according to specific REBT skills, participants' perceptions varied across skills assessed with average ratings ranging from 2.43 to 3.50 (See Table 2). Then, the participant's self-perceived

Table 2

Average Self-Perceived Competency Rating for Overall Competency and Individual Skills

Skill	*M*	*SD*
Overall competency in the utilization of REBT as a clinical intervention	2.57	1.56
Educating the client on the REBT A-B-C model	2.86	1.29
Teaching the client that their unhealthy, disturbed, negative emotion interferes with them achieving their goals and elicits behaviors that are dysfunctional	2.86	1.29
Teaching the client that alternative, healthy, adaptive, negative emotions help them to achieve their goals and elicits adaptive behaviors	3.00	1.24
Proposing an agenda for the session	3.50	.94
Checking in as to the completion of HW from the prior session	3.36	1.15
Proposing that the goal of therapy be to replace an unhealthy, disturbed, negative emotion with a healthy, adaptive negative emotion	2.93	1.33
Proposing that the goal of therapy be the reduction or elimination of a dysfunctional behavior (e.g., social avoidance) by the initiation or increase of a new adaptive behavior (e.g., social engagement)	3.07	1.39
Reflecting the initial inferential thoughts presented by the client	3.14	1.35
Offering psychoeducation to differentiate inferences from irrational beliefs	3.00	1.30
Checking with the client to see if they understand that the irrational demand or evaluative irrational belief will be the target for change	2.64	1.50
Proposing the existence of a demand as well as any derivative evaluative irrational beliefs	2.50	1.65
Distinguishing demands and evaluative irrational beliefs and their consequences from the rational beliefs	2.43	1.79
Reflecting the main irrational beliefs presented by the client	2.43	1.79

Highlighting the one irrational belief that appears to be the primary contributor to the unhealthy consequence	2.64	1.50
Checking with the client for agreement that this belief represents the primary irrational belief to be targeted for change	2.79	1.37
Making a statement that connects the client's irrational belief (IB) with its consequence (C)	2.64	1.45
Checking the client's irrational beliefs as using a functional approach	2.93	1.33
Checking that the client understands that their irrational beliefs are working against their clinical goals	2.93	1.21
Challenging the client's irrational belief using an empirical approach	3.00	1.36
Checking if the client understands that their irrational belief is inconsistent with reality	2.93	1.33
Challenging the meaning of the client's irrational belief	2.64	1.50
Socratically challenging the client's irrational belief	2.43	1.45
Challenging the client's irrational belief using a logical approach	2.71	1.33
Working with the client to formulate the full rational belief(s)	2.57	1.51
Checking if the client sees how the new rational belief(s) results in a healthy negative emotion and adaptive behavior	2.57	1.51
Proposing a homework assignment with the client that is aligned with clinical goals	3.00	1.41
Asking the client to set a specific day, time, and place to complete the homework	3.14	.95
Assessing the presence of any practical, emotional, or cognitive obstacles that would make homework completion more challenging and less likely to be completed by the client	3.14	.95

Note. Participants rated their perception of their overall ability to engage in Rational Emotive Behavior Therapy (REBT) and were asked to rate their level of competence in carrying out 28 steps according to a 0- to 5- Likert style scale (i.e.., 0 = Not at all competent, 1 = Somewhat competent, 2 = Moderately competent, 3 = Competent, 4 = Very competent, to 5 = Expert).

competency ratings across all 28-skills yielded an average between the Moderately Competent and Competent ranges (M = 2.86, SD = 1.23).

Self-Ratings of Competency on Simulated Vignettes

Participants' ratings of their total competence on the five-assessed steps demonstrated within the skill-based simulated vignettes ranged from 4.00 to 25.00 (M = 13.50, SD = 6.81) (See Table 3). Across skills, participants rated their responses to the videos as falling between the Moderately Competent (2) and Competent (3) range (M = 2.70, SD = 1.36) (See Table 4). These skills are referred to throughout as performance-based skills.

Comparison between Self-Perceived and Self-Rated Competency

Participants' self-perception of competency on each of the five assessed skills differed when compared to the rating of their response to each of the vignettes for the related skill (See Table 5).

Provide psychoeducation about REBT. On the self-perceived competency questionnaire, participants endorsed their level of competency in educating the client on the REBT A-B-C model as falling between the Moderately Competent and Competent range ($M = 2.86$, $SD = 1.29$). Similarly, during the skill-based simulated vignette which required participants to demonstrate providing psychoeducation about REBT's A-B-C model to a client, participants rated their competency as falling between the Moderately Competent and Competent range (M = 2.93, SD = 1.21). A one-sample t-test did not find significance between self-perceived competency and self-rated competency in the performance-assessed skill "providing psychoeducation about REBT" ($t(13) = -.21$, p = .84).

Table 3

Total Self-Perceived Rating on the Five-Assessed Skills

Total	Frequency	Percent
4.00	1	7.10
6.00	1	7.10
8.00	2	14.30
9.00	2	14.30
12.00	1	7.10
13.00	1	7.10
15.00	2	14.30
20.00	2	14.30
25.00	2	14.30

Note. Participants rated their performance on the 0-to-5 Likert scale upon responding to the 5 video-based vignettes. Each participant's total ratings were added together and ranged from 4.00 to 25.00.

Table 4

Self-Rated Competency of Skills Assessed on Skill-Based Simulated Vignettes

Skill Assessed	*M*	*SD*
Provide psychoeducation about REBT	2.93	1.21
Clarifying Healthy vs. Unhealthy Emotions and Behaviors	2.64	1.50
Demonstrate the IB-C connection	2.71	1.38
Perform Disputation/Cognitive Restructuring	2.50	1.61
Present a Rational Belief	2.71	1.38

Note. All participant's (n = 14) rating of themselves on each skill-assessed was averaged together in order to determine a single score for each skill.

Table 5

Comparison between Self-Perceived Competency and Self-Rated Competency on Skill-Based Simulated Vignettes

Skill Assessed	*Self-Perceived Competency*		*Self-Rated Competency*	
	M	*SD*	*M*	*SD*
Provide psychoeducation about REBT	2.86	1.29	2.93	1.21
Clarifying Healthy vs. Unhealthy Emotions and Behaviors	2.93 3.07	1.33 1.39	2.64	1.50
Demonstrate the IB-C connection	2.64	1.45	2.71	1.38
Perform Disputation/Cognitive Restructuring	2.93	1.33	2.50	1.61
Present a Rational Belief	2.93	1.33	2.57	1.51

Note. The second skill assessed was best represented by two questions asked on the self-perceived competency questionnaire.

Clarifying dysfunctional negative emotions and maladaptive behaviors from healthy negative emotions and functional behaviors. Participants also endorsed their level of competency in distinguishing between dysfunctional negative emotions and maladaptive behaviors and healthy negative emotions and functional behaviors. This skill is best represented by two questions: how would you describe your level of competency in proposing that the goal of therapy be to replace an unhealthy, disturbed, negative emotion with a healthy, adaptive negative emotion? and how would you describe your level of competency in proposing that the goal of therapy be the reduction or elimination of a dysfunctional behavior by the initiation or increase of a new adaptive behavior? In proposing the goal of therapy to replace an unhealthy, disturbed, negative emotion with a healthy, adaptive negative emotion, participants described their level of competence as ranging between the Moderately Competent and Competent range *(M* = 2.93, *SD* = 1.33*).* Then, in proposing that the goal of therapy be the reduction or elimination of a dysfunctional behavior by the initiation or increase of a new adaptive behavior, participants described their level of competence as ranging between the Competent and Very Competent range *(M* = 3.07, *SD* = 1.39*).* To take participant's responses to these two questions into account, ratings made in response to both questions were averaged (*M* = 3.00). During the skill-based video vignette which required participants to provide psychoeducation to distinguish between dysfunctional negative emotions and maladaptive behaviors and healthy negative emotions and functional behaviors on Skillsetter, participants rated their competence as ranging between the Moderately Competent and Competent range *(M* = 2.64, *SD* = 1.50*).* A one-sample t-test did not find a significant difference between self-perceived competency and self-rated competency in

the performance-assessed skill “clarifying dysfunctional negative emotions and maladaptive behaviors from healthy negative emotions and functional behaviors” ($t(13) = 1.10$, $p = .29$).

Demonstrating the Irrational Belief-Consequence Connection. Regarding the third assessed skill, on the self-perceived competency questionnaire, participants endorsed their level of competency in teaching the belief-consequence connection as falling between the Moderately Competent and Competent range ($M = 2.64$, $SD = 1.45$). During the skill-based video vignette which required participants teach the connection between the irrational belief and the consequence, participants rated their competency as ranging between the Moderately Competent and Competent range ($M = 2.71$, $SD = 1.38$). A one-sample t-test did not find a significant difference between self-perceived competency and self-rated competency in the performance-assessed skill “demonstrating the connection between the irrational belief and consequence” ($t(13) = -.17$, $p = .87$).

Performing Functional or Pragmatic Questioning of the Irrational Belief. The fourth assessed skill measured the ability to engage in functional or pragmatic questioning of the client’s irrational belief. Both participants self-perceived competency in engaging in functional or pragmatic questioning of the client’s irrational belief ($M = 2.93$, $SD = 1.33$) and rating of their response to the video-based vignette ($M = 2.50$, $SD = 1.61$) ranged between the Moderately Competent and Competent Range. A one-sample t-test did not find a significant difference between self-perceived competency and self-rated competency in the performance-assessed skill “engaging in pragmatic questioning of the client’s irrational belief” ($t(13) = 1.21$, $p = .25$).

Presenting a Rational Alternative Belief. The fifth and final skill assessed the ability to guide the client to construct a rational alternative belief to replace their irrational belief. Once again, both participants self-perceived competency (*M* = 2.93, *SD* = 1.33*)* and rating of their response to the video-based vignette (*M* = 2.57, *SD* = 1.51*)* ranged between the Moderately Competent and Competent Range. A one-sample t-test did not find a significant difference between self-perceived competency and self-rated competency in the performance-assessed skill "presenting the client with a rational alternative belief" (*t*(13) = -.35, *p* = .74).

Then, participants' self-perceived rating of competency as assessed by the average of the 28 REBT skill-based questions demonstrated a significant positive correlation with participants self-rated competency on the five-assessed skills (R = .83, *p* <.01) (See Table 6). To determine whether there was a statistically significant difference between average self-perceived competency of the 28 REBT skill-based questions and average self-rated competency on the performance-assessed skills, a one-sample *t*-test was conducted. In this case, the *t*-statistic was not significant, *t* (13) = .50, *p* = .62 (2-tailed), indicating that there was no significant difference between average self-perceived competency of the 28 REBT skill-based questions (*M* = 2.86, *SD* = 1.23) and average self-rated competency on the five-assessed skills (*M* = 2.70, *SD* = 1.36).

Expert-Rated Competency

Ratings made by the first set of coders for each of the five-assessed skills ranged from a moderate to strong inter-rater reliability (See Table 7). Ratings made by the second set of coders for each of the five-assessed skills demonstrated stronger inter-rater

Table 6

Correlation between Self-Perceived Competency on the 28-Skills and Self-Rated Competency of the Five-Assessed Skills

		Self-Perceived Rating
Question 28 Average	Pearson Correlation	.83**
	Sig. (2-Tailed)	<.01
	N	14

Note. **. Correlation is significant at the 0.01 level (2-tailed).

Table 7

Interrater Reliability between Expert-Coders Per Participant Across Skills – Group 1

		Coder 2
Skill 1_Coder 1	Pearson Correlation	.57
	Sig. (2-Tailed)	.18
	N	7
Skill 2_Coder 1	Pearson Correlation	.83*
	Sig. (2-Tailed)	.02
	N	7
Skill 3_Coder 1	Pearson Correlation	.69
	Sig. (2-Tailed)	.08
	N	7
Skill 4_Coder 1	Pearson Correlation	.43
	Sig. (2-Tailed)	.34
	N	7
Skill 5_Coder 1	Pearson Correlation	.74
	Sig. (2-Tailed)	.06
‘	N	7

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

reliability (See Table 8). On average, expert-rated competency of the five-assessed skills ranged between the Moderately Competent and Competent ranges (M = 2.11, SD = 1.55).

Associations between Self- and Expert-Ratings of Clinician Competency

Participant's self-rated competency demonstrated a nonsignificant positive correlation with expert-rated competency on the five-assessed skills (R = .39, p = .17) (See Table 9). To determine whether there was a statistically significant difference between total self-rated competency and total expert-rated competency, a one-sample t-test was conducted. It was determined that there was not a statistically significant difference between total self-rated competency (M = 13.50, SD = 6.81) and total expert-rated competency (M = 10.57, SD = 7.75) ($t(13) = 1.61$, p = .13). Additionally, a one-sample t-test was conducted to determine whether the self-perceived rating of competence (M = 13.50, SD = 6.81) was significantly different from the expert rating of competence. The t-statistic was not significant, t (13) = -1.61, p = .13 (2-tailed), indicating that there was no significant difference in the ratings.

Exploratory Analysis

In order to assess whether the Dunning Kruger effect stood true, participants' total self-ratings of competency on the five-assessed skills were used to assign participants to one of four competency groups using a quartile split. Those in Group 1.00 had the lowest total self-rated competency and those in Group 4.00 had the highest total self-rated competency across the five vignettes. However, those in Group 2.00 had a lower average rating of competence as determined by the expert-assessed competency (See Table 10). According to the Dunning Kruger effect (1999), there would be a negative association between self-perceived competence and expert-ratings of competence such that those

Table 8

Interrater Reliability between Expert-Coders Per Participant Across Skills – Group 2

		Coder 2
Skill 1_Coder 1	Pearson Correlation	1.00**
	Sig. (2-Tailed)	.00
	N	7
Skill 2_Coder 1	Pearson Correlation	.64
	Sig. (2-Tailed)	.12
	N	7
Skill 3_Coder 1	Pearson Correlation	1.00**
	Sig. (2-Tailed)	.00
	N	7
Skill 4_Coder 1	Pearson Correlation	1.00**
	Sig. (2-Tailed)	.00
	N	7
Skill 5_Coder 1	Pearson Correlation	1.00**
	Sig. (2-Tailed)	.00
‘	N	7

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

Table 9

Correlation between Expert Ratings of the Five-Assessed Skills and Participants Ratings of the Five-Assessed Skills

		Self-Rated Rating
Total Expert Rating	Pearson Correlation	.39
	Sig. (2-Tailed)	.17
	N	14

Note. This table demonstrates the correlation between expert ratings of participants' demonstrations of the five-assessed skills and self-rated competency of the five-assessed skills.

Table 10

Average Expert-Assessed Rating Per Group

	N	*M*	*SD*
1.00	4	8.63	10.01
2.00	3	6.67	7.02
3.00	3	10.83	7.97
4.00	4	15.25	5.91
Total	14	10.57	7.95

Note. Participants' total self-ratings of competency on the five-assessed skills were used to assign participants to one of four competency groups using a quartile split. Those in Group 1.00 had the lowest total self-rated competency and those in Group 4.00 had the highest total self-rated competency across the five vignettes.

with lower self-rated perceived competence of the assessed skills in REBT would receive higher ratings of competence by expert raters and those with higher self-rated perceived competence would receive lower ratings of competence by expert raters. Contrary to this theory, this was not the case. There was not a statistically significant difference in expert-ratings across groups ($F(3,10) = 0.79$, $p = 0.53$) (See Table 11). In order to better understand the relationship between self-rated competency and expert-rated competency a scatterplot was created (See Figure 1). Due to the small sample size and lack of normal distribution, two nonparametric Kruskal-Wallis tests were also run. The first Kruskal-Wallis test found no significant difference between the participant's total rating of competence on the five-assessed skills and expert's average ratings of competence ($H(8) = 10.47$, $p = 0.23$) (See Table 12). The second Kruskal-Wallis test found no significant difference between the participant's total rating of competence on the five-assessed skills and the average of self-rated competency on the five-assessed skills ($H(8) = 13.00$, $p = 0.11$) (See Table 13).

Table 11

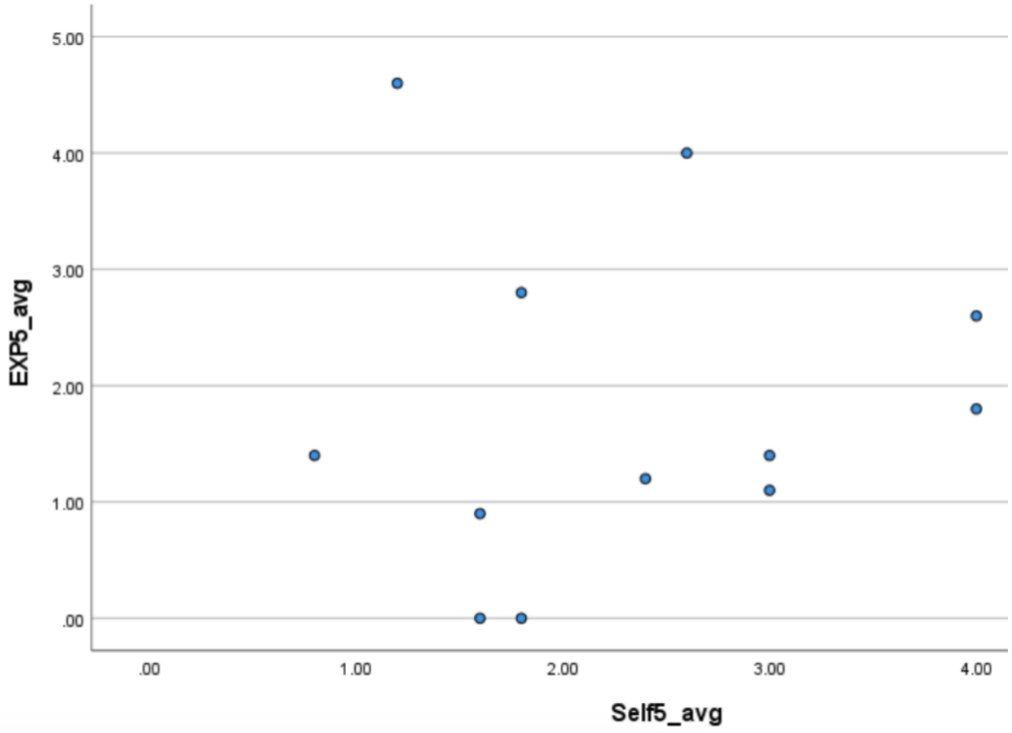
Expert-Rated Competency between Groups One-Way ANOVA

	Sum of Squares	*df*	*Mean Square*	*F*	*Sig.*
Between Groups	148.66	3	49.55	.79	.53
Within Groups	631.27	10	63.13		
Total	779.93	13			

Note. This table demonstrates the result of a one-way ANOVA assessing the relationship between expert-assessed ratings of competency across four groups based on self-rated competency.

Figure 1

Relationship between Average Self-Rated Competency and Average Expert-Rated Competency



Note. This figure shows the relationship between average self-rated competency and average expert-rated competency on the five assessed skills.

Table 12

Average Expert-Rated and Total Self-Rated Competency - Independent-Sample Kruskal-Wallis Test

Kruskal-Wallis H	10.47
df	8
Asymptotic Sig. (2-sided test)	.23

Note. This table demonstrates the result of a Kruskal-Wallis test assessing the relationship between the average of expert-rated competency and the total of self-rated competency on the five assessed skills.

Table 13

Total Self-Rated Competency and Average Self-Rated Competency - Independent-Sample Kruskal-Wallis Test

Kruskal-Wallis H	13.00
df	8
Asymptotic Sig. (2-sided test)	.11

Note. This table demonstrates the result of a Kruskal-Wallis test assessing the relationship between total self-rated competency of the five assessed skills and the average self-rated competency of the five assessed skills.

CHAPTER V

Discussion

As clinical competency is known to be positively associated with treatment gains of youth (Cross &West, 2011), this study aimed to examine the associations between self-perceived competency and expert-rated competency in the delivery of REBT among anxious youth. More specifically, we evaluated if clinicians know the degree of competency with which they perform. Participants in this study ranged in age, degree, level of training, primary employment setting, and years since training was completed. Clinicians were assessed on their ability to respond to video-based client prompts while demonstrating their ability to (1) provide psychoeducation about REBT's ABC model, (2) distinguish the difference between dysfunctional negative emotions and maladaptive behaviors and healthy negative emotions and functional behaviors, (3) demonstrate the connection between the irrational belief and consequence, (4) engage in pragmatic questioning of the client's irrational beliefs, and (5) guide the client to create a rational alternative belief to replace the irrational belief that they have presented with.

Discussion of Specific Hypotheses

Concerning the first hypothesis, wherein it was thought that there would be a small positive correlation between self-perceived and expert-rated competency, this was not supported by the data. These findings indicate that self-perceived competency and objectively rated competency for the implementation of REBT skills are not correlated with one another. In looking at ratings of competency, qualitatively, clinicians rated themselves higher on average than experts did, though the differences were not statistically significant.

Regarding the second hypothesis which sought to assess the relationship between overall self-perceived competency (average of 28 REBT-skill questions) and self-rated competency in response to the five-assessed videos, a significant positive correlation was found. As such, these findings support the second hypothesis that self-perceived competency and self-rated competency are related. Of note, among individual skills, some clinicians rated their skill-based performance to be higher than that of their self-perception and vice versa, though statistically significant differences were not found.

My third hypothesis that there would be a small positive relationship between self-rated competency and expert-rated competency of participant's response to the five assessed videos was not supported by the findings. Prior studies found positive relationships between self-rated and expert-rated competency (Beale et al., 2020; McManus et al., 2012), though this study did not replicate these findings. While a small correlation was found, it was not significant. If we are operating under the assumption that experts are more accurate when it comes to evaluating skills, these results demonstrate that clinicians may not be accurate raters of their own ability and therefore, of their own competency. Thus, training and competency as rated by experts in the field is important until such time as we can reliably assess self-ratings of clinical competency within REBT.

Lastly, the exploratory analysis conducted, based on the Dunning-Kruger effect (1999), was not supported as those whose self-rated perceived competence of the assessed skills in REBT was on the lower end received lower ratings of competence by expert raters than those whose self-rated perceived competence was on the higher end. This leads me to believe that those on the two extremes of the spectrum of competency

(e.g., least competent and most competent) are in fact, aware of their competency, however, for those who fall in the middle, this is not the case.

Limitations

While competency has been defined in many ways, this study defined competency as the level clinicians demonstrate their knowledge and skills to deliver the appropriate intervention for the client's presenting problem while also taking into consideration the most up to date research regarding treatment. Although this study was able to demonstrate the challenges of relying on self-perceived competency, it is limited. First, the small sample size of 14 clinicians impacted our ability to assess a more diverse subset of the population. Though one participant practices in Italian, information cannot be drawn and generalized to determine the impact of culture and language on the implementation of REBT with youth with anxiety on self-perceived, self-rated, and expert-rated competency. Additionally, while this pilot investigation intended to recruit at least 26 clinicians, only 14 clinicians completed measures in their entirety. Response patterns indicated that participants stopped responding after either completing the consent form or the demographic questionnaire. This indicates that clinicians either were burdened by the number of questions asked, did not have the time to record their responses to the vignettes, or felt uncomfortable with the idea that their responses would be recorded and then shown to experts in the field. Future studies may consider not requiring participants to have their cameras on while recording their responses. A second potential limitation of this study was that only 5 skills were assessed through the video-based vignettes. It is possible that the conclusions found may be different depending on the skills being directly assessed. Furthermore, 5 skills are a subset of the skills clinicians

with whom practice REBT will demonstrate in order to be deemed competent and cannot be generalized to REBT competency as a whole. Future studies should consider assessing greater than 5 skills in determining perceived- and expert-rated competency. A third limitation of this study was the lack of direct one-to-one correlation between the questions asked before the participants responded to the video-based vignettes and the questions asked after the participants were asked to complete in recording their responses. As a result, the relationship could be assessed qualitatively but could not be assessed quantitatively. Specifically, participants were initially asked, "How would you describe your level of competency…?" and then after submitting their responses were asked, "How competent do you feel your response to each of the following client prompts was?". Future studies should look to measure the same question before and after the demonstration of the assessed skill. Related to the questions asked, participants were not asked about competency related to their work with youth, though participants were assessed on their responses to simulated youth with anxiety. Future studies should ask specifically about competency related to the population and clinical presentation being assessed. Finally, a fourth limitation was found pertaining to interrater reliability of the expert coders. Although expert raters were paired randomly, the second set of experts demonstrated stronger interrater reliability overall than the first set of experts when rating participant's responses to the video-based vignettes. This shows that ratings of competency are subjective, and incredibly difficult to measure (Koddebusch & Hermann, 2018).

Future Directions

Future studies should include a larger sample size where participating clinicians are from a more diverse range of locations. One respondent pointed out that it would also be beneficial to have had closed captioning on each of the vignettes as not all participants practice in English. A more diverse sample would also allow for the exploration of how REBT has been adapted in different cultures when working with youth with anxiety. It would also be interesting to assess more than five skills within the REBT framework as clinicians are expected to uphold competency across all areas within their chosen therapeutic orientation. Regarding the expert coders, future studies should seek to train coders to a strong interrater reliability to ensure agreement. While coders were provided a model of an expert response, it would be beneficial to have coders be provided with average and ineffective examples of clinician responses to client prompts, in addition, to expert prompts. By doing so, coders will be better able to discriminate between Likert ratings (e.g., Somewhat Competent or Moderately Competent and Competent or Very Competent). Lastly, in assessing the relationship between self-perceived competence before and after responding to a client prompt, it would be important to ensure that the questions asked are identical to ensure the ability to run a correlation between time points. There needs to be more research that explores the validity of self-perceived competence within the field of psychology, as well as research that explores the relationship between competence in REBT and clinical outcome. Together, these findings can be used as a beginning point to study competency prior to people starting an independent practice or when entering an educational setting with a population with high psychiatric needs. As such, reliable assessment of competency is essential in skill

acquisition though a single scale is unlikely to encompass the full scope of therapist competence (Muse et al., 2022).

CHAPTER VI

Application to School Psychology

As school psychologists, we must maintain the utmost competency across the environments in which we work. According to the National Association of School Psychologists (2020), school psychologists should only engage in work for which they have been trained and are therefore qualified and competent in. Additionally, this means that school psychologists need to be aware of their strengths and limitations. One of the many responsibilities that school psychologists have is to provide mental-health-based interventions with youth. Research shows that competence in the delivery of psychotherapy is important in ensuring successful treatment (McLeod et al., 2018).

While in training programs, graduate students are continuously being assessed for their knowledge of laws and policies, decision-making abilities when selecting modalities, and ability to consult with others in the field. However, after leaving graduate and post-doctoral programs, there is little opportunity for assessment of competency. Even though self-assessment is important, this study showed that self-assessment is not always accurate and may be an indicator of self-confidence rather than competency. Therefore, continued training, education, and assessment by other individuals in the field is necessary to ensure the best possible outcome for our clients.

APPENDIX A:
Clinician Recruitment Letter

Dear XXX,

I am looking to recruit clinicians who work with children and adolescents who broadly identify as Cognitive Behavioral Therapists and have either in the past or currently utilized Rational Emotive Behavior Therapy (REBT) skills in their clinical psychotherapy work with clients. Clinicians do not have to have received any formal training in REBT but having received it is not an exclusionary factor for participation.

One of the things we are looking to do is assess how clinicians' perception about their ability in carrying out steps related to REBT and then demonstrate those steps through simulated therapy vignettes. For the purpose of my dissertation, I am interested in how clinicians apply REBT skills in response to a clinical presentation of youth with anxiety.

To this end, if you identity as a CBT clinician, work with youth, and have some experience with REBT we are asking for your assistance in completing two questionnaires (e.g., demographic questionnaire and access to clinical support) and recording a video response to five therapy-based vignettes on a secure web-based platform. We will be providing you with the links to all measures and access to the Skillsetter website.

Upon completion of the study, you will be entered into a raffle to receive one of five $75 Amazon gift cards for your time.

If you are interested in assisting us in this research endeavor, we will provide you with consent, measures, and further information.

For questions, concerns, or complaints about the study, you may contact Morgan Schall at morgan.schall12@my.stjohns.edu or Dr. Mark Terjesen at terjesem@stjohns.edu.

Thank you for your time and consideration,

Morgan Schall, M.S. — Principal Investigator

Mark Terjesen, Ph.D. — Faculty Supervisor

APPENDIX B:
Consent for Clinician Participation

Study Title:
The Relationship between Clinician-Perceived Competency and Expert-Rated Competency in REBT during Anxiety-Focused Vignettes
Researcher: Morgan Schall

This is a consent script for research participation. It contains important information about this study and what to expect if you decide to participate. Your participation is voluntary. Please consider the information carefully. Feel free to ask questions before making your decision whether or not to participate. If you decide to participate, you will be asked to sign this form and you will receive a copy.

Purpose: This study is looking at how clinicians perceive their own professional competency in clinical application of REBT in comparison to ratings of competency by experts of their performance in responding to video vignettes of actors presenting with clinical scenarios.

Procedures/Tasks: You will be asked to complete a brief demographic measure asking questions about your overall clinical experience and your clinical work and training in REBT. Then, you will be asked to view simulated clinical scenarios and record your responses to therapy-based vignettes on Skillsetter, an online psychotherapy training platform. Last, you will be asked to complete a final measure assessing your perceived level of competence on each vignette response.

Audio and Video Recording: Your responses to the vignettes on Skillsetter will be audio and video recorded. These videos will only be shared with the researcher and the two blind expert raters and no identifying information about you will be provided to the raters.

Duration: It is required that you complete both questionnaires and respond to all five of the skill-based vignettes. We will be providing the links to both measures and access to the Skillsetter website for completion of the vignettes.

Confidentiality: It is expected that your study-related information will remain confidential. All measures will be completed through online administration and only the study researchers will have access to your responses.

Participant Rights: You may refuse to participate in this study without penalty or loss of benefits to which you are otherwise entitled. If you choose to participate in the study, you may discontinue participation at any time. By signing this form, you do not give up any personal legal rights you may have as a participant in this study. An Institutional Review Board responsible for human subject research at St. John's University reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of the research participants.

Contacts and Questions: For questions, concerns, or complaints about the study, you may contact Morgan Schall at morgan.schall12@my.stjohns.edu or Dr. Mark Terjesen at terjesem@stjohns.edu. For questions regarding your rights as a research participant, please contact Dr. Raymond DiGiuseppe (718) 990-1955 from the Institutional Review Board.

I have read this form, and I am aware that I am being asked to participate in a research study. I have been given an opportunity to ask questions and will only continue if I have had them answered to my satisfaction. By checking the "Consent" button, I voluntarily agree to participate in this study. I am not giving up any legal rights by consenting to participate.

Consent ❑: Signature: _____ Date: _____

APPENDIX C:
Clinician Demographic Questionnaire

Please answer all of the following questions.

1. What is your gender?
   Male
   Female
   Other
   Prefer not to say

2. Please indicate your age. _____

3. Please select the race/ethnicity group that you identify with.
   American Indian/Alaskan Native
   Asian
   Black or African American
   Caucasian
   Native Hawaiian or Other Pacific Islander Hispanic/Latino
   Other: _____
   I prefer not to answer this question

4. Please indicate the highest degree that you have earned:
   Master's Degree (30+ credits) in _____
   Doctoral Degree (Ph.D.) in _____
   Doctoral Degree (Psy.D.) in _____
   Doctoral Degree (Ed.D.) in _____
   Other: _____

5. Please indicate which program you earned your degree in:
   School Psychology
   Clinical Psychology
   School and Clinical Combined Program
   Social Work
   Other: _____

6. How many years ago did you complete your graduate/training program?
   _____
7. Please select your PRIMARY employment setting:

   Clinic
   Hospital
   Private Practice
   University/College
   University/College Center for Psychological Services

In-patient treatment center
Out-patient treatment center
Other _____

8. How many hours a week do you work in that setting?

9. How many hours a week do you provide direct clinical work?

10. In what state/country do you PRIMARILY work?
    _____

11. In what language do you PRIMARILY treat clients?

    _____

12. Are you a clinician who is actively seeing clients and practicing CBT?

    Yes
    No

13. Have you ever received formal training in REBT?
    Yes
    No

14. How many total years of professional experience (i.e. externship, internship, post-doctoral training, and so on) do you have in providing clinical therapeutic services using CBT?

15. How many total years of professional experience (i.e. externship, internship, post-doctoral training, and so on) do you have in providing clinical therapeutic services using REBT?

    _____

16. How many hours/sessions per week do you **presently** provide clinical therapeutic services using REBT as your **primary** clinical intervention?

    _____

17. What is the approximate total number of hours that you have provided clinical therapeutic services using **REBT as your primary clinical intervention in your career**?

_____

18. Please select all of the relevant professional REBT trainings that you have participated in:

    Didactic Training embedded in my graduate training.
    If so, how many hours: _____
    Experiential Training embedded in my graduate training.
    If so, how many hours: _____
    3-Day Primary Certificate Practicum in Rational Emotive Behavior Therapy
    4-Day Advanced Practicum in Rational Emotive Behavior Therapy
    Associate Fellowship Practicum in Rational Emotive Behavior Therapy
    Pre-Doctoral Externship Program part-time, one-year appointment in Rational Emotive Behavior Therapy.
    Post-Doctoral Fellowship Program part-time, one-year appointment in Rational Emotive Behavior Therapy.
    Other training experience: _____

APPENDIX D:
Self-Perception of REBT Competency Questionnaire

1. How would you describe your level of competency in the utilization of REBT as a clinical intervention?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

2. How would you describe your level of competency in educating the client on the REBT A-B-C model?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

3. How would you describe your level of competency in teaching the client that their unhealthy, disturbed, negative emotion interferes with them achieving their goals and elicits behaviors that are dysfunctional?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

4. How would you describe your level of competency in teaching the client that alternative, healthy, adaptive, negative emotions help them to achieve their goals and elicits adaptive behaviors?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

5. How would you describe your level of competency in proposing an agenda for the session?
    a. Not at all competent
    b. Somewhat competent

   c. Moderately competent
   d. Competent
   e. Very Competent
   f. Expert

6. How would you describe your level of competency in checking in as to the completion of HW from the prior session?
   a. Not at all competent
   b. Somewhat competent
   c. Moderately competent
   d. Competent
   e. Very Competent
   f. Expert

7. How would you describe your level of competency in proposing that the goal of therapy be to replace an unhealthy, disturbed, negative emotion with a healthy, adaptive negative emotion?
   a. Not at all competent
   b. Somewhat competent
   c. Moderately competent
   d. Competent
   e. Very Competent
   f. Expert

8. How would you describe your level of competency in proposing that the goal of therapy be the reduction or elimination of a dysfunctional behavior (e.g., social avoidance) by the initiation or increase of a new adaptive behavior (e.g., social engagement)?
   a. Not at all competent
   b. Somewhat competent
   c. Moderately competent
   d. Competent
   e. Very Competent
   f. Expert

9. How would you describe your level of competency in reflecting the initial inferential thoughts presented by the client?
   a. Not at all competent
   b. Somewhat competent
   c. Moderately competent
   d. Competent
   e. Very Competent
   f. Expert

10. How would you describe your level of competency in offering psychoeducation to differentiate inferences from irrational beliefs?

a. Not at all competent
b. Somewhat competent
c. Moderately competent
d. Competent
e. Very Competent
f. Expert

11. How would you describe your level of competency in checking with the client to see if they understand that the irrational demand or evaluative irrational belief will be the target for change?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

12. How would you describe your level of competency in proposing the existence of a demand as well as any derivative evaluative irrational beliefs?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

13. How would you describe your level of competency in distinguishing these demands and evaluative irrational beliefs and their consequences from those of the rational beliefs?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

14. How would you describe your level of competency in reflecting the main irrational beliefs presented by the client?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

15. How would you describe your level of competency in highlighting the one irrational belief that appears to be the primary contributor to the unhealthy consequence?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

16. How would you describe your level of competency in checking with the client for agreement that this belief represents the primary irrational belief to be targeted for change?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

17. How would you describe your level of competency in making a statement that connects the client's irrational belief (IB) with its consequence (C)?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

18. How would you describe your level of competency in checking the client's irrational beliefs using a functional approach?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

19. How would you describe your level of competency in checking that the client understands that their irrational beliefs are working against their clinical goals?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

20. How would you describe your level of competency in challenging the client's irrational belief using an empirical approach?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

21. How would you describe your level of competency in checking if the client understands that their irrational belief is inconsistent with reality?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

22. How would you describe your level of competency in challenging the meaning of the client's irrational belief?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

23. How would you describe your level of competency in Socratically challenging the client's irrational belief?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

24. How would you describe your level of competency in challenging the client's irrational belief using a logical approach?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

25. How would you describe your level of competency in working with the client to formulate the full Rational Belief(s)?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

26. How would you describe your level of competency in checking if the client sees how the new Rational Beliefs(s) results in a healthy negative emotion and adaptive behavior?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

27. How would you describe your level of competency in proposing a homework assignment with the client that is aligned with clinical goals?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

28. How would you describe your level of competency in asking the client to set a specific day, time, and place to complete the homework?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

29. How would you describe your level of competency in assessing the presence of any practical, emotional, or cognitive obstacles that would make homework completion more challenging and less likely to be completed by the client?
    a. Not at all competent
    b. Somewhat competent
    c. Moderately competent
    d. Competent
    e. Very Competent
    f. Expert

APPENDIX E:
Skillsetter Vignette Scripts

Vignette 1: Psychoeducation about REBT's A-B-C Model

Participant's Skillsetter Prompt:

Client: I'm so scared watching the news. Between the flu, COVID, and whatever else is going around, I'm not even sure how I'm supposed to go to school and focus on what my teachers are saying. I know that I can't control what happens, but I'm constantly anxious thinking about how I could bring COVID home to my parents who are so much older than me. How am I just supposed to go to school and pretend like everything is fine?

Skill Criteria Questions:

- Did you use content from the client's statement to educate the client on the REBT A-B-C model?
- Did you check for the client's understanding of the REBT model?

Vignette 2: Psychoeducation Distinguishing between Dysfunctional Negative Emotions and Maladaptive Behaviors and Healthy Negative Emotions and Functional Behaviors

Participant's Skillsetter Prompt:

Client: I'm so scared watching the news. Between the antisemitic attacks and the war in Ukraine, I'm not even sure how I'm supposed to go to school and focus on what my teachers are saying. I know that I can't control what happens, but I'm constantly anxious thinking about how horrible people are to each other. I've been trying to pay attention in class, but when I get anxious, I just can't focus, and my teacher is starting to notice. I'm a horrible student.

Skill Criteria Questions:

- Did you teach the client that their negative emotion interferes with their ability to achieve their goals and elicits dysfunctional behaviors?
- Did you teach the client an alternative, healthy emotion that helps them achieve their goals and elicits adaptive behaviors?
- Did you explain that the goal of REBT is to replace the unhealthy, dysfunctional emotion with a healthy, adaptive emotion?

Vignette 3: Belief-Consequence Connection

Skillsetter Prompt:

Client: I am so worried about my interview for college. I'm happy that I'm actually graduating, but now I'm stressed because I really want to get into this school, and if I screw up the interview that would be pretty terrible. I struggle with sleep as I keep thinking about how I might embarrass myself during the interview and if I don't get into this school, I might have to wait and apply to other schools in the Spring, which would be awful.

Skill Criteria Questions:

- Did you make a statement that connects the client's irrational belief with the consequence?
- Did you ask a question that checks for the client's understanding of the B-C connection?

Vignette 4: Functional Disputation of Irrational Beliefs

Skillsetter Prompt:

Client: I am quite sure my boyfriend is going to break up with me. I am so anxious about this and now I've become super clingy, and I can't stand this feeling. I would much rather be concerned instead of anxious. If he did break up with me, it would be terrible!

Skill Criteria Questions:

- Did you highlight the main irrational beliefs presented by the client?
- Did you challenge the client's irrational beliefs using a functional approach?
- Did you check that the client understands that their irrational beliefs are working against their clinical goals?

Vignette 5: Construction of Rational, Alternative Belief to Replace the Irrational Beliefs

Skillsetter Prompt:

Client: I really want to be friends with this girl in my class, and we talk every once in a while. Sometimes we even joke around, and I feel like we could be good friends. It's been a couple of months since school started, but she hasn't ever come to sit next to me during lunch or to hang out on the weekend. At one point, I thought maybe I should see if she'd like to sit with me at lunch, but I'm so anxious. If she says no and thinks I'm weird, that would be horrible, and I couldn't stand seeing her in class for the rest of the year. I know these beliefs get in the way of me making a new friend. I wish I could be less anxious about the possibility that she doesn't want to be my friend but still give it a shot.

Skill Criteria Questions:

- Did you formulate the rational belief?
- Did you check with the client to see if they understand how the new rational beliefs results in a healthy negative emotion and an adaptive behavior?

APPENDIX F:
Self-Perceived Post-Vignette Competency Questionnaire

On a scale from 0 (Did not demonstrate skill) to 5 (expert), how competent do you feel your response to each of the following client prompts was?

1. Provide psychoeducation about REBT's A-B-C model
2. Provide psychoeducation to distinguish between dysfunctional negative emotions and maladaptive behaviors and healthy negative emotions and functional behaviors
3. Teach the belief-consequence connection
4. Engage in the functional disputation of the irrational beliefs
5. Construct a rational, alternative belief to replace the irrational beliefs

APPENDIX G:
Expert-Rater Consent

You are invited to participate in a research study, which aims to advance the knowledge about Rational Emotive Behavior Therapy (REBT) training and clinician competency. Your role in this study would be to serve as a rater of clinical skills in REBT. This entails rating brief recorded REBT video responses to assess clinician competency of 5 different REBT skill areas (i.e., provide psychoeducation about REBT's A-B-C model, distinguish between dysfunctional negative emotions and maladaptive behaviors and healthy negative emotions and functional behaviors, teach the belief-consequence connection, engage in functional disputation of the irrational beliefs, and construct a rational, alternative belief to replace the irrational beliefs). This study will be conducted by Morgan Schall 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 different REBT recorded response videos and asked to rate clinician competency for each skill. This will be repeated across 5 skills. It is expected that the entire process will take no longer than 1 and a 1/2 hours. By participating as a rater in this study, you will receive a $75.00 Amazon gift card. Participation in this study is voluntary. 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 Morgan Schall at morgan.schall12@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. Your 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.

Consent:

I agree to participate.

I do NOT agree to participate.

APPENDIX H:
Expert-Rater Demographic Questionnaire

1. Please check that you have received a supervisory certificate in REBT.
   Yes
   No

2. Please provide your email address to receive the content necessary for rating.

3. Highest degree level
   MA/MS
   PhD
   PsyD
   LSW/LCSW/DSW
   Other

4. Approximately, how many clinicians have you supervised using REBT as a primary treatment modality?

5. Do you provide ongoing supervision using REBT as a primary treatment modality?
   Yes
   No

6. Approximately, how many clinicians do you **currently** supervise using REBT as a primary treatment modality?

APPENDIX I:
Sample Client Prompt and Clinician Response

Vignette 1: Psychoeducation about REBT's A-B-C Model

Demonstration Example:

Client: I'm so scared watching the news. Between the flu, COVID, and whatever else is going around, I'm not even sure how I'm supposed to go to school and focus on what my teachers are saying. I know that I can't control what happens, but I'm constantly anxious thinking about how I could bring COVID home to my parents who are so much older than me. How am I just supposed to go to school and pretend like everything is fine?

Clinician Response: I hear that you're experiencing anxiety and the primary event that you get upset about is the spread of COVID. You're correct, that you cannot control what may happen, but maybe we can work on the anxiety. In REBT, we look at the situation, or the Activating Event, or A, which in this case is the spread of COVID. The Emotional Consequence or C is the feeling of anxiety and your behaviors – you see or hear the news, you freeze, and can't focus on school. The Beliefs, or B, are the beliefs that you have about this potential COVID spread. In REBT, we work on looking at whether these beliefs are helpful, logical, and true, and if not, then work on changing them to more rational or healthier beliefs. Does this approach make sense?

Vignette 2: Psychoeducation Distinguishing between Dysfunctional Negative Emotions and Maladaptive Behaviors and Healthy Negative Emotions and Functional Behaviors

Demonstration Example:

Client: I'm so scared watching the news. Between the antisemitic attacks and the war in Ukraine, I'm not even sure how I'm supposed to go to school and focus on what my teachers are saying. I know that I can't control what happens, but I'm constantly anxious thinking about how horrible people are to each other. I've been trying to pay attention in class, but when I get anxious, I just can't focus, and my teacher is starting to notice. I'm a horrible student.

Clinician Response: So, the dysfunctional unhealthy negative emotion you are experiencing is anxiety that immobilizes you; and the anxiety leads to behaviors that do not help you. The war in Ukraine and the recent increase in antisemitic attacks are bad and it makes sense to have some negative emotions about it. In REBT we work to replace the anxiety with some type of apprehension that recognizes a problem but allows you to focus on what you can do about it. Would you agree that we can focus our session on changing your unhealthy anxiety to a healthier adaptive negative emotion such as apprehension or concern?

Vignette 3: Belief-Consequence Connection

Demonstration Example:

Client: I am so worried about my interview for college. I'm happy that I'm actually graduating, but now I'm stressed because I really want to get into this school and if I screw up the interview that would be pretty terrible. I struggle with sleep as I keep thinking about how I might embarrass myself during the interview and if I don't get into this school, I might have to wait and apply to other schools in the Spring, which would be awful.

Clinician Response: It sounds like you're having difficulty sleeping because you're causing yourself to get anxious by thinking about how awful and terrible it would be if you don't get into this school. Is that correct? Do you see the connection between your "awful and terrible" beliefs and your feelings of anxiety and difficulty sleeping?

Vignette 4: Functional Disputation of Irrational Beliefs

Demonstration Example:

Client: I am quite sure my boyfriend is going to break up with me. I am so anxious about this and now I've become super clingy, and I can't stand this feeling. I would much rather be concerned instead of anxious. If he did break up with me, it would be terrible!

Clinician Response: It sounds like your belief that "this would be terrible" is what leads to you feeling anxious and becoming very clingy. It also sounds like you do not think you can stand or tolerate this feeling of anxiety. These awfulizing beliefs as well as discomfort avoidance won't help you work towards your goal of feeling concerned instead of anxious and less clingy. If this belief about how "terrible" this would be is what causes that feeling of anxiety and clingy behavior, do you see how they are not consistent with your goal?

Vignette 5: Construction of Rational, Alternatives Belief to Replace the Irrational Beliefs

Demonstration Example:

Client: I really want to be friends with this girl in my class, and we talk every once in a while. Sometimes we even joke around, and I feel like we could be good friends. It's been a couple of months since school started, but she hasn't ever come to sit next to me during lunch or to hang out on the weekend. At one point, I thought maybe I should see if she'd like to sit with me at lunch, but I'm so anxious. If she says no and thinks I'm weird, that would be horrible, and I couldn't stand seeing her in class for the rest of the year. I know these beliefs get in the way of me making a new friend. I wish I could be less anxious about the possibility that she doesn't want to be my friend but still give it a shot.

Clinician Response: From what you are saying, your anxiety is coming from the irrational beliefs that if you ask her to have lunch with you and get rejected it would be horrible and then you couldn't stand running into her all year in class. As you pointed out those beliefs get in the way of you doing something. We could replace those irrational beliefs with healthier alternative rational ones such as, "If she didn't want to be my friend that would really stink, but it wouldn't be horrible." And "I would not like being around her in school if she didn't want to be my friend, but even though I would not like it I certainly could stand it." If you really believed these alternative ideas, you could probably experience a healthy concern about her response, and if it did not turn out as you hoped, you might feel uncomfortable around her at school, but you could survive it. Does that make sense?

APPENDIX J:
Expert-Rated Competency Questionnaire

On a scale from 0 (Did not demonstrate skill) to 5 (Clinician demonstrated skill on an expert level), how competent do you feel the following participant's responses were to each client prompt?

Participant XXX:

1. Provide psychoeducation about REBT's A-B-C model
2. Provide psychoeducation to distinguish between dysfunctional negative emotions and maladaptive behaviors and healthy negative emotions and functional behaviors
3. Teach the belief-consequence connection
4. Engage in functional disputation of the irrational beliefs
5. Construct a rational, alternative belief to replace the irrational beliefs

APPENDIX K:
Consent for Audio and/or Video Recording

Study Title: The Relationship between Clinician-Perceived Competency and Expert-Rated Competency in REBT using Anxiety-Focused Simulated-Based Practice
Researcher: Morgan Schall

I have read this form and am aware that I will be audio and video-recorded reading off of a therapy-based script to be shared with clinicians and that my personal information will not be included in this recording. I am also aware that I am being asked to allow permission for my audio and/or video recording to be shared for the purpose of research practices. By checking the "Consent" button I voluntarily agree to allow the sharing of my audio and/or video recording. I am not giving up any legal rights by consenting to participate.

Agreement to Share Audio and/or Video Recording

_____

_____

Subject Signature Date

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