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Series Preface

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We are pleased to introduce the Essentials of Deliberate Practice series of training books. We are developing this book series to address a specific need that we see in many psychology training programs. The issue can be illustrated by the training experiences of Mary, a hypothetical second-year graduate school trainee. Mary has learned a lot about mental health theory, research, and psychotherapy techniques. Mary is a dedicated student; she has read dozens of textbooks, written excellent papers about psychotherapy, and receives near-perfect scores on her course exams. However, when Mary sits with her clients at her practicum site, she often has trouble performing the therapy skills that she can write and talk about so clearly. Furthermore, Mary has noticed herself getting anxious when her clients express strong reactions, such as getting very emotional, hopeless, or skeptical about therapy. Sometimes this anxiety is strong enough to make Mary freeze at key moments, limiting her ability to help those clients.

During her weekly individual and group supervision, Mary's supervisor gives her advice informed by empirically supported therapies and common factor methods. The supervisor often supplements that advice by leading Mary through role plays, recommending additional reading, or providing examples from her own work with clients. Mary, a dedicated supervisee who shares tapes of her sessions with her supervisor, is open about her challenges, carefully writes down her supervisor's advice, and reads the suggested readings. However, when Mary sits back down with her clients, she often finds that her new knowledge seems to have flown out of her head, and she is unable to enact her supervisor's advice. Mary finds this problem to be particularly acute with the clients who are emotionally evocative.

Mary's supervisor, who has received formal training in supervision, uses supervisory best practices, including the use of video to review supervisees' work. She would rate Mary's overall competence level as consistent with expectations for a trainee at Mary's developmental level. But even though Mary's overall progress is positive, she experiences some recurring problems in her work. This is true even though the supervisor is confident that she and Mary have identified the changes that Mary should make in her work.

The problem with which Mary and her supervisor are wrestling—the disconnect between her knowledge about psychotherapy and her ability to reliably perform psychotherapy—is the focus of this book series. We started this series because most therapists experience this disconnect, to one degree or another, whether they are beginning trainees or highly experienced clinicians. In truth, we are all Mary.

To address this problem, we are focusing this series on the use of deliberate practice, a method of training specifically designed for improving reliable performance of complex skills in challenging work environments (Rousmaniere, 2016, 2019; Rousmaniere et al., 2017). Deliberate practice entails experiential, repeated training with a particular skill until it becomes automatic. In the context of psychotherapy, this involves two trainees role-playing as a client and a therapist, switching roles every so often, under the guidance of a supervisor. The trainee playing the therapist reacts to client statements, ranging in difficulty from beginner to intermediate to advanced, with improvised responses that reflect fundamental therapeutic skills.

To create these books, we approached leading trainers and researchers of major therapy models with these simple instructions: Identify 10 to 12 essential skills for your therapy model where trainees often experience a disconnect between cognitive knowledge and performance ability—in other words, skills that trainees could write a good paper about but often have challenges performing, especially with challenging clients. We then collaborated with the authors to create deliberate practice exercises specifically designed to improve reliable performance of these skills and overall responsive treatment (Hatcher, 2015; Stiles et al., 1998; Stiles & Horvath, 2017). Finally, we rigorously tested these exercises with trainees and trainers at multiple sites around the world and refined them based on extensive feedback.

Each book in this series focuses on a specific therapy model, but readers will notice that most exercises in these books touch on common factor variables and facilitative interpersonal skills that researchers have identified as having the most impact on client outcome, such as empathy, verbal fluency, emotional expression, persuasiveness, and problem focus (e.g., Anderson et al., 2009; Norcross et al., 2019). Thus, the exercises in every book should help with a broad range of clients. Despite the specific theoretical model(s) from which therapists work, most therapists place a strong emphasis on pantheoretical elements of the therapeutic relationship, many of which have robust empirical support as correlates or mechanisms of client improvement (e.g., Norcross et al., 2019). We also recognize that therapy models have already-established training programs with rich histories, so we present deliberate practice not as a replacement but as an adaptable, transtheoretical training method that can be integrated into these existing programs to improve skill retention and help ensure basic competency.

About This Book

This book in the series is on rational emotive behavior therapy (REBT). REBT was developed by Albert Ellis in 1955 and is considered the pioneering and original form of cognitive behavioral therapy. The theory, and, as a result, the clinical approach, is based on the premise that negative emotional and behavioral responses are a result of unhealthy, illogical irrational beliefs held by clients (DiGiuseppe et al., 2014). Irrational beliefs are considered to be rigid and extreme in nature and inconsistent with reality (Turner, 2016), and they may reflect an overall view or philosophical belief system about oneself, others, and the world or life conditions. That is, while an individual may communicate that they believe "My partner should respect me," they may also have an underlying belief system of "Those who are important people in my life should respect me." Rational beliefs, on the other hand, are consistent with reality and are both flexible and logical in process. Clinicians help clients to understand that those irrational beliefs are not helpful in goal attainment and are inconsistent with what is true and result in emotional and/or behavioral distress. This process is accomplished through challenging or disputing those irrational

beliefs. Finally, clinical work focuses on developing more functional or adaptive beliefs to replace the irrational ones to enable clients to experience healthier reactions to adverse events (D. David et al., 2018).

Training in REBT typically involves learning the theories that underlie the REBT model, observing expert practice, experiential exercises (e.g., role-playing), and supervised clinical work. The formal training offered at the Albert Ellis Institute has for more than 50 years involved direct practice and demonstration of REBT skills under the supervision of an expert REBT clinician. We see deliberate practice as an additional component designed to enhance REBT training. Deliberate practice is not intended to be the only delivery format through which REBT skills are acquired, nor is this book by itself sufficient for obtaining full competence in REBT. However, the practice of the skills set forth in this book provides trainees with the opportunity to translate their didactic learning of REBT to a simulated environment that mimics the clinical interaction, which can later be applied with actual clients. This book provides opportunities for trainees to experiment with using REBT skills with a range of client presentations and clinical scenarios and to practice what they would say and how they would say it. Our goal in writing this book is to encourage interest and engagement in REBT and support your ongoing development as REBT therapists in training.

CHAPTER 1

Introduction and Overview of Deliberate Practice and Rational Emotive Behavior Therapy

When training individuals in rational emotive behavior therapy (REBT), a common reaction from participants is that it sounds a lot like cognitive behavior therapy (CBT). As the pioneering form of CBT, there are many similarities but several unique differences. Another typical response from new trainees is that REBT is a simple approach to psychotherapy. Although some may agree that on the surface it appears simple, the application of REBT to real clients with a variety of clinical problems and emotional and behavioral disturbances is anything but easy. If that were the case, there would be no REBT practitioners because everyone would be solving their own problems. Listening to lectures on REBT or reading books on the theory can be very misleading. The intricacies of the theory become evident when trainees and practitioners begin to apply the skills. Upon review of Ray DiGiuseppe, Kristene Doyle, and Mark Terjesen's collective early experiences of REBT under the direct mentorship of its founder, Dr. Albert Ellis, it became clear that there were elements of deliberate practice embedded in our training and clinical practice, albeit not as structured or explicit. Albert Ellis required that we audio record our therapy sessions and play them during clinical supervision, and he would ask which aspects or skills in REBT were found to be more challenging in our practice, which is consistent with a deliberate practice approach to skill development. Dr. Ellis would not tell us what to do but would work with us to identify strategies to build our skills, and we would often practice these skills during group supervision. Suggestions were made about how to enhance our practice of REBT, such as being given a homework assignment between supervision sessions to listen to our session recordings and identify what we think we could have done better and practice what we could have said. Always a supportive supervisor, Al would follow up with us regarding our insights and provide reinforcement. Deliberate practice as it is presented in this series, and specifically in this book on REBT, is an organic next step or ingredient to the high-quality training we all received. The addition of continuing to work on one or several of the specific skills addressed in this book until a sense of mastery is achieved by the trainee as agreed on by an expert REBT supervisor serves to promote further professional development. The exercises provided for each of the skills included in this

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Deliberate Practice in Rational Emotive Behavior Therapy, by M. D. Terjesen, K. A. Doyle, R. A. DiGiuseppe, A. Vaz, and T. Rousmaniere

book contain different clinical presentations of emotional and behavioral problems with varying levels of difficulty to allow the reader the opportunity to enhance their REBT skills as well as develop their own unique style of delivering REBT.

Overview of the Deliberate Practice Exercises

The main focus of the book is a series of 14 exercises that have been thoroughly tested and modified based on feedback from REBT trainers and trainees. Each of the first 12 exercises represents an essential REBT skill. The last two are more comprehensive, consisting of an annotated REBT transcript and improvised mock therapy sessions that teach practitioners how to integrate all these skills into more expansive clinical scenarios. Table 1.1 presents the 12 skills that are covered in these exercises.

Throughout the exercises, trainees work in pairs under the guidance of a supervisor and role-play as a client and a therapist, switching back and forth between the two roles. Each of the 12 skill-focused exercises consists of multiple scripted client statements grouped by difficulty—beginner, intermediate, and advanced—that calls for a specific skill. For each skill, trainees are asked to read through and absorb the description of the skill, its criteria, and some examples of it. The trainee playing the client then reads the statements. The trainee playing the therapist then responds in a way that demonstrates the appropriate skill. Trainee therapists will have the option of improvising and supplying their own response or, if they have trouble coming up with one, reading aloud an example response supplied in the exercise.

After each client statement and therapist response couplet is practiced several times, the trainees will stop to receive feedback from the supervisor. Guided by the supervisor, the trainees will be instructed to try statement–response couplets several times, working their way down the list. In consultation with the supervisor, trainees will go through the exercises, starting with the least challenging and moving through to more advanced levels. The triad (supervisor–client–therapist) will have the opportunity to discuss whether exercises present too much or too little challenge and adjust up or down depending on the assessment.

Trainees, in consultation with supervisors, can decide which skills they wish to practice and for how long. On the basis of our testing experience, we have found practice sessions

TABLE 1.1. The 12 Rational Emotive Behavior Therapy Skills Presented in the Deliberate Practice Exercises

Beginner Skills	Intermediate Skills	Advanced Skills
1. Psychoeducation about rational emotive behavior therapy's ABC model 2. Psychoeducation about dysfunctional versus functional negative emotions and behaviors 3. Agreement on the session goals 4. Clarifying inferences from irrational beliefs	5. Assessing irrational beliefs about the activating event 6. Prioritizing which irrational beliefs to target for change 7. Teaching the belief–consequence connection 8. Functional disputation of irrational beliefs	9. Empirical disputation of irrational beliefs 10. Semantic disputation of irrational beliefs 11. Constructing full rational alternative beliefs to replace irrational beliefs 12. Collaborative homework development

last about 1 to 1.25 hours to receive maximum benefit. After this, trainees become saturated and need a break.

Ideally, REBT learners will both gain confidence and achieve competence by practicing these exercises. *Competence* is defined here as the ability to perform an REBT skill in a manner that is flexible and responsive to the client. Skills have been chosen that are considered essential to REBT and that practitioners often find challenging to implement.

The skills identified in this book are not comprehensive in the sense of representing all one needs to learn to become a competent REBT clinician. Some skills will present particular challenges for trainees. A short history of REBT and a brief description of the deliberate practice methodology are provided to explain how we have arrived at the union between them.

The Goals of This Book

The primary goal of this book is to help trainees achieve competence in core REBT skills. Therefore, the expression of that skill or competency may look somewhat different across clients or even within a session with the same client.

The REBT deliberate practice exercises are designed to achieve the following:

1. Help REBT therapists develop the ability to apply the skills in a range of clinical situations.
2. Move the skills into procedural memory (Squire, 2004) so that REBT therapists can access them even when they are tired, stressed, overwhelmed, or discouraged.
3. Provide REBT therapists in training with an opportunity to exercise the particular skill using a style and language that is congruent with who they are.
4. Provide the opportunity to use the REBT skills in response to varying client statements and affect that represent a range of clinical problems. This is designed to build confidence to adopt skills in a broad range of circumstances within different client contexts.
5. Provide REBT therapists in training with many opportunities to fail and then correct their failed response on the basis of feedback. This helps build confidence and persistence.

Finally, this book aims to help trainees discover their own personal learning style so they can continue their professional development long after their formal training is concluded.

Who Can Benefit From This Book?

This book is designed to be used in multiple contexts, including in graduate-level courses, supervision, postgraduate training, and continuing education programs. It assumes the following:

1. The trainer is knowledgeable about and competent in REBT.
2. The trainer can provide good demonstrations of how to use REBT skills across a range of therapeutic situations via role-play. Or the trainer has access to examples of REBT being demonstrated through the many psychotherapy video examples available.

3. The trainer can provide feedback to students regarding how to craft or improve their application of REBT skills.

4. Trainees will have accompanying reading, such as books and articles, that explain the theory, research, and rationale of REBT and each particular skill. Recommended reading for each skill is provided in the sample syllabus (Appendix C).

The exercises covered in this book were piloted in seven training sites from two continents (North America and Europe). This book is designed for trainers and trainees from different cultural backgrounds worldwide.

This book is also designed for those who are training at all career stages, from beginning trainees, including those who have never worked with real clients, to seasoned therapists. All exercises feature guidance for assessing the adjusting the difficulty to precisely target the needs of each individual learner. The term *trainee* in this book is used broadly, referring to anyone in the field of professional mental health who endeavors to acquire REBT psychotherapy skills. For further guidance on how to improve multicultural deliberate practice skills, see the forthcoming book *Deliberate Practice in Multicultural Therapy* (Harris et al., in press).

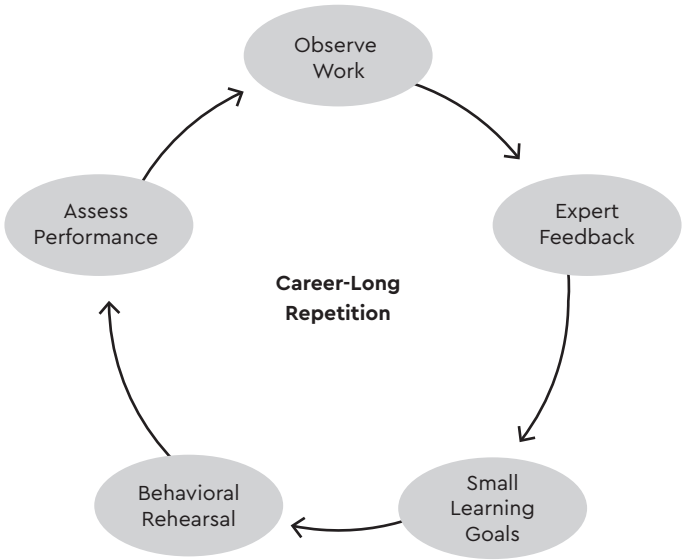
Deliberate Practice in Psychotherapy Training

How does one become an expert in their professional field? What is trainable, and what is simply beyond our reach due to innate or uncontrollable factors? Questions such as these touch on our fascination with expert performers and their development. A mixture of awe, admiration, and even confusion surrounds people such as Mozart, Leonardo da Vinci, or more contemporary top performers, such as basketball legend Michael Jordan and chess virtuoso Garry Kasparov. What accounts for their consistently superior professional results? Evidence suggests that the amount of or time spent on a particular type of training is a key factor in developing expertise in virtually all domains (Ericsson & Pool, 2016). Deliberate practice is an evidence-based method that can improve performance in an effective and reliable manner.

The concept of deliberate practice has its origins in a classic study by K. Anders Ericsson and colleagues (1993). They found that the amount of time practicing a skill and the quality of the time spent doing so were key factors predicting mastery and acquisition. They identified five key activities in learning and mastering skills: (a) observing one's own work, (b) getting expert feedback, (c) setting small incremental learning goals just beyond the performer's ability, (d) engaging in repetitive behavioral rehearsal of specific skills, and (e) continuously assessing performance. Ericsson and his colleagues termed this process *deliberate practice*, a cyclical process that is illustrated in Figure 1.1.

Research has shown that lengthy engagement in deliberate practice is associated with expert performance across a variety of professional fields, such as medicine, sports, music, chess, computer programming, and mathematics (Ericsson et al., 2018). People may associate deliberate practice with the widely known "10,000-hour rule" popularized by Malcolm Gladwell in his 2008 book, *Outliers*, although the actual number of hours required for expertise varies by field and by individual (Ericsson & Pool, 2016). This idea, though, perpetuates two misunderstandings. First, that this is the number of deliberate practice hours that everyone needs to attain expertise, no matter the domain. In fact, there can be considerable variability in how many hours are required.

FIGURE 1.1. Cycle of Deliberate Practice



Note. From *Deliberate Practice in Emotion-Focused Therapy* (p. 7), by R. N. Goldman, A. Vaz, and T. Rousmaniere, 2021, American Psychological Association (https://doi.org/10.1037/0000227-000). Copyright 2021 by the American Psychological Association.

The second misunderstanding is that engagement in 10,000 hours of work performance will lead one to become an expert in that domain. This misunderstanding holds considerable significance for the field of psychotherapy, where hours of work experience with clients has traditionally been used as a measure of proficiency (Rousmaniere, 2016). Research suggests that the amount of experience alone does not predict therapist effectiveness (Goldberg, Babins-Wagner, et al., 2016; Goldberg, Rousmaniere, et al., 2016). It may be that the quality of deliberate practice is a key factor.

Psychotherapy scholars, recognizing the value of deliberate practice in other fields, have recently called for deliberate practice to be incorporated into training for mental health professionals (e.g., Bailey & Ogles, 2019; Hill et al., 2019; Rousmaniere et al., 2017; Taylor & Neimeyer, 2017; Tracey et al., 2015). There are, however, good reasons to question analogies made between psychotherapy and other professional fields, like sports or music, because by comparison psychotherapy is so complex and free-form. Sports have clearly defined goals, and classical music follows a written score. In contrast, the goals of psychotherapy shift with the unique presentation of each client at each session. Therapists do not have the luxury of following a score.

Instead, good psychotherapy is more like improvisational jazz (Noa Kageyama, as cited in Rousmaniere, 2016). In jazz improvisations, band members coconstruct a complex mixture of group collaboration, creativity, and interaction. Like psychotherapy, no two jazz improvisations are identical. However, improvisations are not a random collection of notes. They are grounded in a comprehensive theoretical understanding and technical proficiency that is only developed through continuous deliberate practice. For example, prominent jazz instructor Jerry Coker (1990) listed 18 skill areas that students must master, each of which has multiple discrete skills, including tone quality, intervals, chord arpeggios, scales, patterns, and licks. In this sense, more creative and artful improvisations are actually a reflection of a previous commitment to repetitive skill

practice and acquisition. As legendary jazz musician Miles Davis put it, "You have to play a long time to be able to play like yourself" (Cook, 2005).

The main idea that we would like to stress here is that we want deliberate practice to help REBT therapists become themselves. The idea is to learn the skills so that you have them on hand when you want them. Practice the skills to make them your own. Incorporate those aspects that feel right for you. Ongoing and effortful deliberate practice should not be an impediment to flexibility and creativity. As in the arts, deliberate practice should enhance flexibility and creativity. We recognize and celebrate that psychotherapy is an ever-shifting encounter and by no means want it to become or feel formulaic. Strong REBT therapists mix an eloquent integration of previously acquired skills with properly attuned flexibility. The core REBT responses provided are meant as templates or possibilities, rather than "answers." Please interpret and apply them as you see fit, in a way that makes sense to you. We encourage flexible and improvisational play!

Simulation-Based Mastery Learning

Deliberate practice uses simulation-based mastery learning exercises (Ericsson, 2004; McGaghie et al., 2014). That is, the stimulus material for training consists of "contrived social situations that mimic problems, events, or conditions that arise in professional encounters" (McGaghie et al., 2014, p. 375). A key component of this approach is that the stimuli being used in training are sufficiently similar to the real-world experiences, so that what they mimic provokes similar reactions. This facilitates *state-dependent learning*, where professionals acquire skills in the same psychological environment where they will have to perform the skills (Fisher & Craik, 1977). For example, pilots train with flight simulators that present mechanical failures and dangerous weather conditions, and surgeons practice with surgical simulators that present medical complications. Training in simulations with challenging stimuli increases professionals' capacity to perform effectively under stress. For the psychotherapy training exercises in this book, the "simulators" are typical client statements that might actually be presented in the course of therapy sessions and call upon the use of the particular skill.

Declarative Versus Procedural Knowledge

Declarative knowledge is what a person can understand, write, or speak about. It often refers to factual information that can be consciously recalled through memory and often can be acquired relatively quickly. In contrast, procedural learning is implicit in memory, and "usually requires *repetition of an activity*, and associated learning is demonstrated through *improved task performance*" (Koziol & Budding, 2012, pp. 2694, emphasis added). *Procedural knowledge* is what a person can perform, especially under stress (Squire, 2004). People can display a wide difference between their declarative and procedural knowledge. For example, an "armchair quarterback" is a person who understands and talks about athletics well but would have trouble performing those skills at a professional ability level. Likewise, most dance, music, or theatre critics have a very high ability to write about their subjects but would be flummoxed if asked to perform them.

The sweet spot for deliberate practice is the gap between declarative and procedural knowledge. In other words, effortful practice should target those skills that the trainee could write a good paper about but would have trouble actually performing with a real client. We start with declarative knowledge, learning skills theoretically and observing others perform them. Once learned, with the help of deliberate practice, we

work toward the development of procedural learning, with the aim of therapists having "automatic" access to each of the skills that they can pull on when necessary.

Let us turn to a little theoretical background on REBT to help contextualize the skills of the book and how they fit into the greater training model.

REBT: Theoretical Overview

REBT is an evidence-based psychotherapy originally designed by Albert Ellis (1957, 1962, 1994) to treat anxiety and relationship problems, but which grew into a transdiagnostic approach used to treat a wide range of emotional and behavioral problems. REBT grew out of Ellis's attempt to use principles of Stoic and other philosophical approaches to control one's emotional and behavioral symptoms. REBT was one of the first approaches to psychotherapy to advocate the empirical, scientific testing of therapy outcome. It also believes that people are psychologically adjusted when they use the scientific method to analyze their own thinking. As such, REBT was one of the first modern approaches to CBT (D. David et al., 2018).

REBT maintains that people's beliefs are the principal factors that trigger their emotional and behavioral symptoms. REBT maintains that irrational beliefs, which are rigid, illogical, antiempirical, and block our goals, lead to unhealthy, disturbed negative emotions and maladaptive behaviors. Correspondingly, rational beliefs, which are flexible, logical, consistent with reality, and helpful in reaching goals, lead to adaptive, nondisturbed negative emotions and adaptive behaviors. Irrational and rational beliefs are imperative or evaluative thoughts. That is, they might lead individuals to be demanding of themselves, others, or the situation or to evaluate the situation in an unhealthy way by thinking it to be awful, too difficult to deal with, or attach a rating of worth to oneself, others, or life conditions.

Irrational beliefs do not represent the person's perceptions about a negative distortion or the perception of reality, but how the person evaluates their perceptions of reality and what they think reality should be. Therefore, clinical interventions based on REBT focus on identifying and examining and challenging a client's irrational beliefs and replacing them with more rational beliefs. REBT represents a philosophical approach to therapy because it focuses on these evaluative and imperative beliefs and not the presence or absence of negative distortions of reality.

REBT highlights several beliefs as more central to disturbance than others are. The first is the idea of demandingness. Demandingness represents an unrealistic and absolute expectation that events or individuals will be the way a person desires them to be—that is, "Because I want it a certain way, it should be that way." Most other irrational beliefs are thought to be a derivative of this process and are discussed later. The rational alternative to demandingness is acceptance. Acceptance represents the acknowledgment that one prefers the world, themselves, or people to be a certain way but that the world is as it is. Acceptance of a reality that is different from how you want it to be is the first step to coping with problems.

Research (DiGiuseppe et al., 2020) has demonstrated that a second irrational belief (global evaluation of human worth) appears to stand on its own and is an independent belief construct from other irrational beliefs. Global evaluations of human worth, either of the self or others, imply that human beings can be rated and that some people are worthless, or at least less valuable than others are. People often base their ratings of worth based on specific behaviors. The rational alternative to this idea is that all

humans have equal value and are important regardless of behavior; however, individuals are still responsible for their behaviors. Negative global evaluations of the self can lead to depression, shame, guilt, or anxiety, while negative global evaluations of others can lead to anger, contempt, and hatred. REBT stresses that people strive to achieve unconditional self-acceptance rather than self-esteem. We accept ourselves (and others) with our flaws and failures and recognize that we have worth despite them.

Another central irrational belief is that of frustration or discomfort intolerance. This idea represents a demand for comfort and a belief in one's inability to survive or tolerate discomfort and frustration. The rational alternative to this idea is that, even when things might be difficult, one can be strong and live with discomfort to accomplish long-term goals.

The fourth of the core irrational beliefs is the idea of awfulizing. This occurs when a person believes that an event is 100%+ bad or worse, that nothing could be worse, that nothing good can come from this, and that they cannot overcome this (Dryden, 2020). The rational alternative to this idea is that although bad things may happen, and we will validate and acknowledge that clinically, we do not attach the label or belief that this bad event is truly awful or beyond bad.

REBT takes a strong theoretical stance on human emotions that is different from other clinical approaches. First, REBT maintains that for each negative human emotion, people have several possible alternative emotions that they can experience along a continuum of intensity. Some of these negative emotions are unhealthy and disturbed and prevent us from achieving our goals. Other emotions are healthy and adaptive yet negative in that they motivate us to recognize problems and work toward a resolution. Adverse activating events will always occur in life. Our emotional and behavioral reactions to such events are determined by our beliefs about the adverse events. The theory and science of REBT proposes that irrational beliefs lead to the unhealthy disturbed negative emotions and rational beliefs lead to the healthy, adaptive negative emotions, not neutral feelings. Thus, tolerance of negative events and negative emotions is important to achieving psychological adjustment. In REBT, psychological adjustment comes from acceptance of the world, of ourselves and others, and of our frustrations and discomforts.

The identification, challenging, and replacement of irrational beliefs are the most common therapeutic activities in REBT. Teaching clients to practice this set of verbal skills remains the most frequent task used in clinical work. However, from its inception (A. Ellis, 1957), REBT has advocated the use of a wide range of emotive, imaginal, and behavioral activities to facilitate change. It was one of the first approaches to advocate between-session homework activities, which is addressed in Exercise 12. This remains a crucial part of the therapy. Helping clients use these varied tasks to think, feel, and act differently between sessions is a crucial set of skills in REBT.

The exercises included in this book are aimed at developing REBT skills across all the concepts mentioned previously (see also the later section describing the skills that are covered in this book's exercises).

The Role of Deliberate Practice in REBT Training

Training in REBT—like deliberate practice more broadly—has always made the distinction between declarative and procedural knowledge. In fact, like the discussion of deliberate practice in general, we have for decades made the analogy between learning REBT and learning an athletic skill. Knowing the REBT theory and what to do in REBT does not mean

that you can or will do it. Practicing the skills is crucial. For the 47 years that the most senior coauthor of this book (R.A.D.) has been involved in teaching REBT, the Albert Ellis Institute has included training activities similar to, but not using the term, of deliberate practice.

The Albert Ellis Institute has been offering a primary certificate training program in REBT for more than 50 years and has conservatively trained 25,000 clinicians in REBT around the world. This training has always involved three types of activities. First, they learn declarative knowledge about the theory and activities of REBT from readings and lectures. Second, a senior REBT trainer provides a demonstration of a therapy session. The therapists are cognizant of clearly demonstrating specific skills to provide modelling of the skills for the learners. Finally, the participants pair up and do what we have called peer counseling. The first person takes the role of the client and presents a minor emotional or behavioral problem to the second trainee who plays the therapist with the objective being that they demonstrate the REBT skills learned. The therapist then receives feedback on their performance. Then the two participants change roles. Over the course of the training, the expectations of demonstration of REBT skills increases building off the prior demonstration and feedback. Over the years, we have had numerous discussions concerning how to identify the skills, the order of skill difficulty, and the sequence in which the skills would be taught. REBT has always included deliberate practice skill training in therapist training, just not as explicitly as done within this book. In the supervisory training practicum offered at the Albert Ellis Institute, we have long advocated the importance of supervisors teaching the declarative knowledge concerning what the therapist would do, then modelling exactly what the therapist would say, emphasizing the tone of voice, and then having the therapist actually do it. Next, the supervisor asks the therapist to demonstrate the response with an actual client (Beal & DiGiuseppe, 1998; DiGiuseppe 2011; Doyle et al., 2022).

Originally, we had trainees make audio recordings of their peer counseling skills and then met to review the recordings and provide feedback. However, all the trainees usually made the same mistakes, and we would listen to the same error over again on each trainee's recordings. We corrected this process and reduced the length of our training to achieve competency in the basic REBT skills mentioned here by providing trainees with immediate feedback after live versus recorded practice sessions. So immediate feedback of one skill at a time appears to be the best way to proceed and is consistent with the deliberate practice approach toward developing clinical skills.

Once trainees have mastered the skills, it can still be difficult for them to produce the skills in a sequential order, as they have to do in an actual therapy session. This book does not follow the reader's course of development to that level, but this is what we hope to teach in Exercises 13 and 14. So we advise you to expect that you will need more trials to learn to put these skills together into a coherent therapy session.

We want to also recognize that we focus here on REBT skills. REBT skills build on the common factors in psychotherapy, especially the therapist skills of expressing empathy, congruence, and achieving a good therapeutic alliance, which are the cornerstones of good clinical practice and advocated by all REBT trainers (DiGiuseppe, 2022).

The deliberate practice exercises in this book are not sufficient by themselves for obtaining full competence in REBT. However, they closely represent the criteria set by the International Training Standards Committee on REBT as the necessary skills to achieve the primary certificate in REBT from the Albert Ellis Institute. The skills included here are suited to a first course in REBT and are presented in a sample syllabus (see Appendix C). Trainees should have more extensive exposure to REBT theory and application

in coursework and readings. We look forward to developing more deliberate practice exercises that will include more advanced level skills.

REBT Skills in Deliberate Practice

The REBT Skills Presented in Exercises 1 Through 12

When clients present clinical problems to a therapist, they usually start by identifying a strong disturbed emotion or an activating event that troubles them. That is, they present with either the A (activating event) or the C (emotional and/or behavioral consequence) in the ABC model. The skill exercises presented in this book follow the format that represents how the therapist would progress through helping a client go through the steps of doing an REBT analysis for such a problem. The skills are presented in the sequence that therapists usually follow in applying REBT to a clinical problem. The beginning steps represent teaching the client about REBT, the ABC model, and how therapists identify the A and C and then the Bs (beliefs). Also presented are the steps in achieving agreement on the goals and tasks of therapy, which form two steps in the formation of the therapeutic alliance and are necessary to move forward to the more advanced steps of disputing the irrational beliefs, developing rational alternative beliefs, and collaborating on homework. As it turns out, this order of presentation also represents the order of difficulty that trainees have reported to us over the years. These 12 skills go from a beginning level early in the REBT sequence, to later skills that are of more moderate difficulty, then to the late-stage skills that are more advanced and more difficult. The order of the skills appears in Table 1.1. We want to emphasize that the skills presented here help therapists to both build a collaborative therapeutic alliance and provide information to construct a case conceptualization.

The beginner-level exercises consist of the most basic REBT skills used in most sessions. This includes teaching clients about the ABC model (Exercise 1). This skill provides clients with an orientation to think about whether their problem is an activating event, their beliefs and thoughts, or the emotions and behaviors they have. Understanding these distinctions will make it easier for clients to identify the goals of therapy and the tasks that will be used to achieve them. The second skill involves psychoeducation about the difference between various types of emotions and behaviors (Exercise 2). We believe that learning these distinctions will also help clarify the goals of the therapy with the client. This leads to the next skill, which is getting explicit agreement on the goals of therapy (Exercise 3). The final beginner skill (Exercise 4) involves clarifying the differences between inferences or cognitive distortions as opposed to irrational beliefs. Understanding this distinction helps the client focus on the main core activities of REBT and also helps the therapist and client establish agreement on the tasks of therapy.

The intermediate skills involve identifying the core aspects of the ABC model and beginning the process of change. Exercise 5 involves the therapist and client collaborating on assessing which irrational belief(s) the client has about the problematic activating event that leads them to experience unhealthy negative emotions or behaviors. Clients usually endorse more than one irrational belief, and in Exercise 6, the therapist helps the client prioritize which belief they want to change first. Again, this skill is crucial in establishing the agreement on the task aspect of the therapeutic alliance. Once we identify the client's irrational beliefs, a mistake that we have found that beginning REBT clinicians often make is that they either simply try to replace the belief or to dispute it. Although an important part of the REBT process, challenging or replacing

irrational beliefs makes no sense unless the client understands the relationship of the beliefs to their emotions and behaviors. This is the focus of Exercise 7, and, again, this skill helps foster agreement on the task aspect of the therapeutic alliance. Once the therapist proceeds through these skills, it is time to get to the process of changing the irrational beliefs. This begins in Exercise 8, where therapists learn the easiest of the disputation strategies: functional disputation of irrational beliefs.

The advanced level skills involve two more difficult disputation strategies: the empirical disputation of irrational beliefs (Exercise 9) and the semantic disputation of irrational beliefs (Exercise 10). In the next step, the therapist helps the client construct a new alternative rational replacement belief (Exercise 11). Once this is done, therapists will engage in the most difficult task covered here, which is collaboratively developing homework activities for the client to do between sessions (Exercise 12).

Overview of the Book's Structure

This book is organized into three parts. Part I contains this chapter and Chapter 2, which provides basic instructions on how to perform these exercises. We found through testing that providing too many instructions up-front overwhelmed trainers and trainees, and as a result, they skipped past them. Therefore, we kept these instructions as brief and simple as possible to focus only on the most essential information that trainers and trainees will need to get started with the exercises. Further guidelines for getting the most from deliberate practice are provided in Chapter 3, and additional instructions for monitoring and adjusting the difficulty of the exercises are provided in Appendix A. **Do not skip the instructions in Chapter 2, and be sure to read the additional guidelines and instructions in Chapter 3 and Appendix A once you are comfortable with the basic instructions.**

Part II contains the 12 skill-focused exercises, which are ordered as they would be used in an actual therapy situation. This order also corresponds to the difficulty level of the skills: beginner, intermediate, and advanced (see Table 1.1). The discussion of each of the 12 skills contain a brief overview of the exercise, a list of criteria for mastering the relevant skill, example client–therapist interactions to help guide trainees, and step-by-step instructions for conducting that exercise. The client statements and sample therapist responses are then presented, also organized by difficulty (beginner, intermediate, and advanced). The statements and responses are presented separately so that the trainee playing the therapist has more freedom to improvise responses without being influenced by the sample responses, which the trainee should turn to only if they have difficulty improvising their own responses.

While the focus of each scripted response was written explicitly for that specific skill exercise, we took considerable effort in crafting prompts and responses that provide an opportunity for the clinician to see the application of REBT skills. We consistently presented client prompts for five key emotional experiences (anger, depression, guilt, anxiety, and jealousy). Although the prompts differed in background, context, and presenting problem, having these key emotions appear consistently allows for readers to consider all 12 skills across these five key emotions. That is, readers will become more skilled in applying REBT across these different emotions because these are the ones that we believe they are most likely to experience in clinical practice. As they become more proficient in the application of these skills for treatment of these emotions, it is expected that they can generalize these REBT skills to other emotional and behavioral consequences.

Another important distinguishing feature of the client prompts across the 12 exercises is the inclusion of consequences that are both emotional and behavioral in nature to allow for readers to develop skills in working with both types of problems. At the core of REBT is cognitive restructuring or disputation, and, for the three disputation exercises, we kept the client prompts identical. This allows trainees to see how best to dispute these irrational beliefs across three types of disputation strategies. Relatedly, we made efforts to balance the specific client irrational beliefs to provide the reader with more opportunities to practice the different disputation skills for different types of irrational beliefs presented by clients. That is, in Exercises 8 through 10 all client prompts are the same, but the disputation skill and criteria vary across the skills.

In developing these skills and the practice scenarios, we put considerable thought into how to help clinicians develop these specific REBT skills through deliberate practice in a way that also considers the process of REBT as a therapeutic approach. Given that each prompt does not provide an opportunity for a back-and-forth dialogue with a client, there were times when we considered what else may be important clinically but perhaps not be as specific to this skill. That is, when you read a prompt for a specific skill, you may be tempted to think that you would do something else first before demonstrating this skill. As an example, you may think it important to develop goals in a session before disputing. And you would be correct within a natural therapeutic context. We ordered the skills to reflect what may happen within a typical REBT session. That is, psychoeducation about REBT (Exercise 1) would come before functional disputation (Exercise 8). We encourage you to focus on the specific skills for each specific skill set and assume that the clinician and client have already done the prior steps competently. Do not be tempted, as an example, to provide psychoeducation (Exercise 1) when trying to demonstrate the skills of functional disputation (Exercise 8). We simply highlight this for additional context when comparing one's improvised response with the scripted therapist response.

The last two exercises in Part II provide opportunities to practice the 12 skills within simulated psychotherapy sessions. Exercise 13 provides a sample psychotherapy session transcript in which the REBT skills are used and clearly labelled, thereby demonstrating how they might flow together in an actual therapy session. REBT trainees are invited to run through the sample transcript with one playing the therapist and the other playing the client to get a feel for how a session might unfold. Exercise 14 provides suggestions for undertaking mock sessions, as well as client profiles ordered by difficulty (beginner, intermediate, and advanced) that trainees can use for improvised role-plays.

Part III contains Chapter 3, which provides additional guidance for trainers and trainees. While Chapter 2 is more procedural, Chapter 3 covers big-picture issues. It highlights six key points for getting the most out of deliberate practice and describes the importance of appropriate responsiveness, attending to trainee well-being and respecting their privacy, and trainer self-evaluation, among other topics.

Three appendixes conclude this book. Appendix A provides instructions for monitoring and adjusting the difficulty of each exercise as needed. It provides a Deliberate Practice Reaction Form for the trainee playing the therapist to complete to indicate whether the exercise is too easy or too difficult. Appendix B includes a Deliberate Practice Diary Form that can be used to during a training session's final evaluation to process trainees' experiences, but its primary purpose is to provide trainees a format to explore and record their experiences while engaging in additional, between-session deliberate practice activities without the supervisor. Appendix C presents a sample syllabus demonstrating how the 14

deliberate practice exercises and other support material can be integrated into a wider REBT training course. Instructors can choose to modify the syllabus or pick elements of it to integrate into their own courses.

Downloadable versions of this book's appendixes, including a color version of the Deliberate Practice Reaction Form, can be found in the "Clinician and Practitioner Resources" tab online (https://www.apa.org/pubs/books/deliberate-practice-rational-emotive-behavior-therapy).