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PhD THESIS ABSTRACT

THE EFFICACY OF RATIONAL-EMOTIVE AND BEHAVIOURAL THERAPY (REBT) IN REDUCING THE DISTRESS OF RELIGIOUS PEOPLE

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Keywords: Rational Emotive Behaviour Therapy (REBT), standard REBT, religious oriented REBT, emotional distress, intrinsic religiosity, extrinsic religiosity, spirituality, irrational cognitions, religious coping, rational prayer.

CHAPTER I. THEORETICAL GROUNDS

1.1. Introduction and research issues

This paper is an approach towards a controversial area in scientific literature, in general, and towards a field less studied in the scientific Romanian context, in particular, namely the implications of religiosity on health, with a focus on the mental health.

The spiritual / religious field is considered to be significantly associated with many aspects of adaptive functioning based on the following views: gives a sense of life (Clark, 1958, cited in Hathaway, Scott & Garver, 2004), contributes to quality of life (Miller, McConnell, Klinger , 2007), maintains hope and optimism (Cotton, Puchalski, Sherman, Mrus, Peterman, Feinberg, Pargament, Justice, Leonard & Tsevat, 2006), contributes to a better management of dysfunctional behaviour (addiction, substances use) (Saunders, Lukas, Kuras, 2007), facilitates coping with difficult life situations (Pargament, 1997), facilitates social support (Smith, Poll & McCullough, 2003), gives a meaning to the perishable nature of the human being providing a sense of life and death (Hill & Pargament, 2008). Despite all these positive implications, the spiritual / religious field and its possibilities for human health is not given enough attention.

1.2. Conceptual clarification

The term "religiosity" is an individual and institutional construct, multifaceted, incorporating cognitive, behavioural, emotional and motivational aspects deriving from the search of the sacredness (Koenig, 2001; Hill & Pargament, 2008; Hackney & Sanders, 2003). The concept of religiosity refers to several of its dimensions; the religiosity of the participants in the suggested studies was operationalized based on the criterion of internalisation-externalization of concepts and religious values, the distinction between intrinsic and extrinsic religiosity being possible. *Intrinsic religiosity* involves internalization of religious beliefs and living by them regardless the external consequences; *extrinsic religiosity* refers to the use of religion in order to obtain benefits consistent with the self, with a utilitarian character. Intrinsic religiosity is more regulatory than the extrinsic one, being itself an aim, while the extrinsic one is conceptualized as a means to access the desirable personal goals.

Most studies advocate the superiority of intrinsic religious orientation regarding adaptation and adjustment to various problematic situations as compared to the extrinsic one,

whose benefits are limited in time, the latter having also an ordinary character (Donahue, 1985; Ghorpade, Lackritz & Moore, 2010).

1.3. The major dimensions of religion

There are several dimensions of religiosity identified in literature, such as: religious beliefs, religious affiliation, organizational religiosity, non-organizational religiosity, subjective religiosity, religious commitment, religious coping. Other dimensions of religiosity are also mentioned, such as religious knowledge (the information a person has regarding the doctrine to which he/she accedes); religious well-being (assigning a sense to life through the relationship with divinity and the satisfaction resulting from this fact); religious implications / consequences (referring to the actual implications of religiosity in the person's life, as demonstrated by the religious selfless actions – volunteering, financial support, voluntary involvement in personal activities or in activities organized by religious institutions); religion as "questioning" (understood as source of explanations of questions derived from negative life experiences); religious experience, dimension focusing on major aspects of the religiously influenced existence (religious conversion, religiously explained healing, various spiritual experiences). In light of these dimensions, an integrated picture of the religious phenomenon in its multiple aspects can be achieved.

2. The role of cognitive-behavioural interventions in relieving distress

2.1. Philosophical origins of REBT

The historical grounds for Rational Emotive Behaviour Therapy (REBT) can be found in the psychoanalytic tradition.

The Rational Emotive Behaviour Theory (REBT) is based largely on certain postmodern ideas and, particularly, borrows the ideas of postmodern social constructivism (Watson & Culhane, 2005). Combining constructive-postmodern ideas with active-directive therapeutic methods, REBT becomes effective in the changes occurred at the cognitive-behavioural level, with their implications on other levels of the human psyche.

REBT promotes the model of the scientist's behaviour relating to the knowledge of reality; the scientist launches hypotheses, performs experiments that he assess empirically, without claiming to possess the absolute truth and, especially, without trying to impose personal views.

2.2. REBT integration in the context of cognitive-behavioural theories

The Rational-Emotive Behaviour Therapy promotes selective eclecticism. This means that REBT integrates techniques from other therapeutic approaches that are effective for the therapy recipient's features. REBT can be included in the parameters of cognitive theories, but it is distinguished by emphasizing the relevance of a particular type of cognition, the so-called evaluative and imperative cognitions. These issues are less addressed in the context of other cognitive theories, such as that of Beck and Meichembaum.

REBT borrows from the Rogerian therapy the principle of unconditional acceptance of others and of the self, the human tendency towards self-actualisation, but blames it for its passivity in the relationship with the client, which is similar to the psychoanalytic orientation, the orientation towards the individual's background, the neglecting of the role of behaviour in the client's conduct and therapy. As compared with Gestalt therapy, REBT is relating to its shortcomings regarding helping people to be healthier, not just to feel better. Regarding the relationship between REBT and the existential therapy, there is a partial agreement in that one must be very involved in the process of change and improvement of his personal condition, that he must make choices to achieve goals in life, far from being easily prone to act in accordance with achievement of personal well-being and freedom. The search for meaning and significance of life are motivations deeply rooted in the human beings. REBT complements the principles of existential therapy with the active - directive manner of the therapeutic process and with the support in order to achieve change.

2.3. The theoretical grounds of REBT

The basic principle of cognitive-behavioural theories sees cognition as the most important proximal conditioned element of the affective-emotional/subjective, cognitive, behavioural and psychophysiological responses, all of these being in close interaction. Events, people or things do not make us feel good or bad; we achieve these states cognitively, by the processing we make regarding a certain reality;

Dysfunctional thinking is a major determinant of emotional distress. Dysfunctional thinking is characterized by the following errors: dichotomous thinking, arbitrary inference, selective abstraction, minimization and maximization, over-generalisation, emotional thinking, labelling, the "tunnel" perspective, personalisation;

Starting from the principle according to which thinking is the main determinant of emotions, we can infer that emotional problem solving begins with an analysis of cognition.

Change of thinking leads to distress relief. The multiple factors, which refer to genetic and environmental influences, are the etiological history of irrational thinking and of psychopathology. Emphasizing the present rather than emphasizing the historical influences on behaviour is another feature of modern psychological theories, thus another feature of REBT.

2.3.1. Classification of irrational beliefs

REBT subscribes to Epictetus' dictum, according to which people are not affected by the events they experience, but by how they interpret these events (Bruno, 2002). Therefore, this type of therapy emphasizes the centrical dimension of cognitions in determining emotions and behaviour. The author of this therapy is Albert Ellis. The author believes that cognitions can be rational or irrational, the first being followed by positive consequences at the behavioural and emotional level, the latter being followed by negative, dysfunctional consequences. Ellis (1994) fundaments the psychopathology on the irrational beliefs, which he considers to be: "must", "catastrophizing", "low frustration tolerance“, "overall assessment" of human value. The author believes that the "must" absolutist requirement is the central irrational cognition from which the other three intermediate irrational beliefs derive. Irrational beliefs are considered to be general vulnerability factors (David, 2006).

2.4. REBT values

REBT philosophy is based on two explicit values: survival and pleasure (enjoyment) (Wallen, Di Giuseppe & Dryden, 1992).

The values promoted by REBT are demonstrable in achieving the goals of human existence: living the life that we have and being contented with his life despite the limitations of the human body, of the physical and social world; relating effectively and satisfactorily to others; promoting positive relationships in the groups we belong to. The sub-aims mentioned by Ellis and Bernard (1986, as cited Wallen, Di Giuseppe & Dryden , 1992) which are based on REBT values are: personal interest, social interest, self-determination, tolerance, flexibility, acceptance of uncertainty, commitment, self-acceptance, risk taking, realistic expectations, increased tolerance to frustration, self-responsibility.

2.5. REBT ethics

The REBT theory states that generalisation of ethical principles of right and wrong is distorted. What is ethical is specific to each situation. There is no absolute right and wrong. REBT believes that rigidity, dogmatism and absolutism are the worst traits of any philosophical system; they are thinking styles that lead to neurosis and dysfunction. Defining

good and bad by personal criteria and imposing these definitions to others leads to guilt, shame, anxiety, depression, hostility and intolerance of others. Moral dilemmas, as REBT philosophy claims, can be solved by putting the mind to action, which involves a non-dogmatic, non-absolutist, and socially responsible philosophy. REBT ethics can be summed up as promotion of socially responsible attitudes and behaviour or "do to others as you would have others do to you."

REBT promotes the idea that all people are prone to committing errors, which is a characteristic of human nature. Quitting the absolutist claims of being perfect and developing the unconditional self-acceptance and acceptance of others are ways to survive pleasantly and happily.

Regarding the time, REBT is a present-centred and future oriented psychotherapy (Dryden, 2001), without neglecting the person's past. REBT believes that the past does not determine the present, but that it can be an influential factor.

2.6. REBT therapy: the A-B-C model

To demonstrate the role that thoughts play at the emotional level, Ellis developed a conceptual relevant model ABC. Under this *system*, A constitutes the activating event that relates to the person's perception of the problem faced. (C) refers to the behavioural and emotional consequences with psychophysiological resonance; contents at this level send the patient to a specialist for support. Ellis believes that between the activating event (A) and consequences (C) beliefs about the event are interposed (B). These beliefs can be rigid or flexible. Flexible cognitions will be associated with functional emotions, and rigid cognitions will be associated with dysfunctional emotions. Functional emotions can be positive or negative and reflect the experiencing of subjective positive states and of adaptive behavioural consequences. Dysfunctional emotions (negative) indicate the presence of subjective negative experiences and of maladaptive behavioural consequences. The goal of therapy is to change dysfunctional emotions into functional emotions and / or to reduce the intensity of a negative and functional emotion (David, 2006).

3. The role of spiritual and religious interventions in relieving distress

3.1. Impact of religion on health

Studies indicate a beneficial relationship between religion and physical health (Paloutzian & Park, 2005), this relationship being mediated by the psychological aspects

(coping with the disease, healthy behaviours, etc.) as well. Koenig, 1992 (as cited in Koenig, 1998) has identified the preventive and curative role of religious involvement on mental health, specifically in improving cognitive symptoms of depression. Implications relating to relationships between mental health and religion refer to the following: Ellison (1994, as cited in Koenig, 1998) believes that religious involvement reduces the risk and impact of acute and chronic stressors; offers a cognitive frame of interpretation of aversive events in life by maintaining a sense of life, the optimism and hope; contributes to the development of social support resources; improves personal protective resources in relation to health and disease prevention (self-esteem, sense of value, etc.).

The causal relationship between religious cognition and psychopathology was not supported scientifically (Hathaway, Scott & Garver, 2004; Nielsen, Johnson & Elis, 2001).

3.2. Theoretical models of the role of religion on mental health

Elison (1994) (as cited in Koenig, 1998) explains the role that religion plays in human life, in the light of several explanatory models: *the suppressor model*, *the restraint of distress model*, *the moderator model*, *the healthy effects model*.

Causal mechanisms or the ways in which religiosity affects health are (Paloutzian & Park, 2005): a) promotion of functional (healthy) behaviours - (prevention of alcohol addiction and of heavy drinking (Velten, 1996); forgiveness as a coping mechanism (Robb, 2007); decreasing domestic violence (Watlington & Murphy, 2006); b) improving the psychological condition/state of the individual which has a positive impact in improving the physical health of the body: gives a sense of life (Park, 2006); helps to maintain an optimal well-being state (Wink & Dillon, 2003; Lee, 2007), c) coping resource having a beneficial role in dealing with stressful life events (Wachholtz, Pearce & Koenig, 2007, Hill & Pargament, 2008; Koszycki, Raab, Aldosary & Bradwejn, 2010); d) source of social support (Kilbourne, Cumming & Levine, 2009; Watlington & Murphy, 2006); e) less studied because transcend empirical support are the super-empiric or “psi” mechanisms of the religious influence on mental health (the effects of some types of prayer on the body are beyond natural understanding) (Paloutzian & Park, 2005).

3.3. The relationship between religion and mental illness

The relationship between religiosity and emotions is a deep one; religiosity is considered the source of deep emotional experiences, with an important role in emotional adjustment.

Most studies have found a moderate reverse relationship between depression and religiosity. Suicide, the most serious complication of depressive pathology, can be prevented with the help of religion (Regnerus, 2003 as cited Paloutzian & Park, 2005).

The correlations between religiosity and anxiety were generally small (as effect sizes), and the relationship between them is poorly defined. Thus, most studies have shown a negative relationship between the two terms, noticing that anxiety leads to increased religious involvement, but that religious people are not necessarily more susceptible to anxiety.

The relationship between religiosity and manifestations of schizophrenia is strongly influenced culturally as schizophrenic patients can be found in all known religions. When symptoms of schizophrenia are associated with religious elements, they are stronger and are associated with a more difficult remission (Siddle, Haddock, Tarrier & Faragher, 2002 as cited in Miller and Kelley, 2005 Paloutzian & Park, 2005).

Negative symptoms of schizophrenia have a negative influence on the spiritual and religious life of the patients. In the pre-psychotic stage, an increase in the religious activity of the patient can be noticed; this increase can be explained by the patient’s search for a cure for the disintegration that he/she feels (Wilson, as cited in Koenig, 1998).

Religious or spiritual interventions do not significantly influence the development of schizophrenia and its associated symptoms: depression, hopelessness, self-esteem. More caution should be showed with patients who experience paranoid delirium due to their wrong interpretation of the therapist’s attempt to adjust their religious cognitions as having a negative purpose (Wilson, as cited in Koenig, 1998). However, patients with schizophrenia who received religious interventions became more collaborative in terms of self-disclosure of experiences lived due to the disease, showed better emotions and mentioned fewer somatic symptoms. The suicide rate for patients who had a prodromal religious substrate was lower as compared with the suicide rate for those without such a substrate (Breier & Astrachan, 1984 Koenig, McCullough & Larson, 2001).

Obsessive-Compulsive Disorder. Obsessive-compulsive manifestations were usually associated with religious scrupulosity. Hathaway, Scott & Garver, (2004) mentions

scrupulosity as a form of hyper-religiosity present in obsessive-compulsive disorder, which consists of rigid practice of religious rituals to reduce anxiety in a religious context.

The difference between religious rituals and pathological religious obsessions is given by the self-perceived distress and by the resistance to change of religious obsessions. Also some ADHD symptoms such as lack of spiritual focus, instability and faith internalization deficit, spiritual-religious alienation could be associated with religiosity.

3.4. Conditions for integration of religion in REBT context

The arguments underlying the need for integration of religious beliefs in REBT system refer to the following: a) the existence of religious people who may be religious clients in REBT therapy (Koening & Pritchet, in Koenig, 1998), b) religious beliefs of clients provide an essential structure of their cognitive schemes organization, thus having an essential role in how one perceives life's challenges and in the way one can find solutions for coping with them; the most important spiritual needs of patients are related to religious cognitions (perception of involvement of divinity in human life, the purpose and meaning of life); needs related to religious practice (church attendance, sacramental practice); needs regarding religious support (Koenig 1998); c) emphasizing the importance of beliefs is a specific aspect both for religious systems and for REBT (strengthening them, changing and adjusting them when errors occur are essential for a better / more rational life); d) the desire of most religious systems is similar to the REBT: long-term happiness and pleasure, mitigation of personal self-destruction; e) the congruence between the assumptions of the religious systems and beliefs and the REBT values and beliefs system lead to a better course of events during psychotherapy programs, determining at the same time, a more accurate understanding and acquisition of religious principles (Nielsen, Johnson & Ellis, 2001).

3.5 Features of religious REBT interventions

The similarities between REBT and the scriptural content would consist, from a preliminary point of view, in that both emphasize the centrality of beliefs, of cognitions. Ellis believes that intervention at the level of beliefs, of people’s views regarding the reality, can reduce or eliminate psychological distress. This truth promoted by the theory and practice of REBT is smoothly constructed by the theory author in the A-B-C model.

A congruence found between the REBT philosophy and Judeo-Christian tradition refers to their common existential and philosophical nature. Another similarity between

REBT and the organized religious systems refers to emphasizing education and learning. Ellis (Dowd & Nielsen, 2006) highlights the following points shared both by REBT and by the Christian philosophy: unconditional acceptance of self and of others, increased tolerance to frustration, self-control and change exercise, desire rather than need for approval, acceptance of responsibility, acceptance of self-directioning, acceptance of life dangers, non-perfectionism philosophy and the philosophy of acceptance of life difficulties.

3.6. Ethics and deontology in psychological interventions on religious people

APA suggests some general recommendations regarding treatments applied to religious people (Paloutzian & Park, 2005): informing the client through the consent form relating to the religious perspective on abstracting the problems; assessing the religious background of the client and determining the current status of spiritual / religious operation prior to the intervention; growing a relationship of trust with the client; attention to the appropriateness of intervention from a religious perspective or its contraindication; describing the intervention suggested by the therapist and demanding the client's opinion on its application before the implementation; the intervention implementation must be carried out respectfully; respect for the client's religious values, client's freedom of expressing them; using flexible and various spiritual / religious interventions on clients; seeking support for the use of spiritual and religious interventions from representatives of the doctrine to which the client adheres.

3.7. Barriers to REBT psychological interventions with religious people

Obstacles related to personality and therapist training are mentioned, such as: lack of experience and lack of knowledge regarding the client's religiosity issues can be barriers in therapy; another obstacle is the lack of respect for religion and religious practices of the client, therefore when religious clients are involved in therapy, the therapist must be prepared and informed in this sense.

Another obstacle is the early introduction of spiritual interventions, for which the client is not ready: his problem at that stage either does not include religious elements, or the religious cognitions have not been comprehensively enough assessed and the religious concepts have a different meaning for him. Shafranske & Maloney (1990) believes that spiritual and religious approaches affect at a certain level both the specialists' attitudes and the therapeutic intervention, which influences the results of therapy.

Obstacles from the client-therapist relationship could be: disparity between client and therapist in terms of religious orientation, adherence to religious values recommended to be disclosed initially; it is also recommended to make clear the content of religious norms and values from the beginning. The similarity between client and therapist can be an obstacle arising from the relationship between therapist and client due to excessive transfer and counter-transfer, thus occurring the risk of distraction from health issues relevant to the customer and the risk of focus on theological or doctrinal discussions.

As contextual factors Nielsen, Johnson & Ellis (2001) nominate the lack of collaboration between the therapist and the client close friends or relatives, layperson or clerics, which may discourage the client's involvement in the search for professional and/or traditional services to relief his problems.

The general principles underlying the work of religious people are: competence, integrity, scientific and professional responsibility, respect for the rights and dignity of clients, dedication to clients' welfare, social responsibility (Yarhouse & VanOrman, 1991).

CHAPTER II. PERSONAL CONTRIBUTIONS AND RESEARCH

Study 1. Relationship between religious coping and psychological adjustment to stress: meta-analytical study

Introduction and research issues

In the first part of the paper a meta-analytical study on the relationship between religious coping and psychological adjustment is described. The study brings scientific evidence supporting the positive relationship between positive religious coping and positive psychological adjustment, this relationship being found when we consider both the religiosity of people, and their spirituality.

The **objectives** of this study are: highlighting the efficacy of religious coping strategies in terms of adjusting to stress and studying the efficacy of coping strategies differentiated according to religiosity and spirituality of people going through situations generating distress.

Method

Assumptions: Specifically, the following hypotheses are investigated:

Positive religious coping strategies are associated with good adjustment to stress when the religious coping is assessed in terms of *religiosity.*

Negative religious coping strategies are associated with deficient adjustment to distress when the religious coping is assessed in terms of *religiosity.*

Positive religious coping strategies are associated with good adjustment to stress when the religious coping is assessed in terms of *spirituality.*

Article selection

The articles were selected from Ebsco Academic Search Premier, PsychInfo, PsychArticles databases, these having been investigated from 2005 to 2011 using the following keywords: religion, religiosity, spirituality, religious coping, stress, psychological adjustment. A number of 48 relevant studies were identified, which were systematically reduced by some inclusion criteria, the meta-analysis being performed on15 articles.

Results

Table 1. Short statistics religious coping /psychological adjustment for the religiosity variable

religiosity	D	Var D	Confidence interval (95%)
positive religious coping / positive psychological adjustment	.38	.30	.13-.63
negative religious coping / negative psychological adjustment	.15	.10	.02-.28

Table 2. Short statistics religious coping / psychological adjustment for the spirituality variable

spirituality	D	Var D	Confidence interval (95%)
positive religious coping / positive psychological adjustment	.36	.22	.15-.57

Conclusions and discussion

Regarding the first assumption, a moderate positive relationship between positive religious coping strategies and positive outcomes in terms of psychological adjustment was identified.

The last assumption is supported by the meta-analytical study, reinforcing the fact that negative religious coping strategies are associated with the deficient psychological adjustment to stress.

Regarding the ratio between the positive coping strategies and positive psychological adjustment, a similar positive relationship is indicated, when we compare the results according to religiosity or spirituality. Meta-analysis supports the positive effect of the religiosity / spirituality inclusion in the coping to stress models, thus highlighting its beneficial value. Positive religious coping, both religious and spiritual, is associated with positive adjustment to distress.

Study 2. Characteristics of Rational Emotive and Behavioural Therapy on intrinsically religiously oriented people - *controlled clinical study*

Introduction and research issues

The subsequent research studies the impact of standard REBT as compared to religious REBT on the emotional distress of some intrinsically religiously oriented students during the pre-assessment period. The study is focused on the primary prevention of distress.

Objectives

The objectives of this research were to study the relationship between religiosity and mental health through the REBT model in conjunction with elements of the Christian religion. We intended to highlight the effectiveness of REBT on religious participants by combining the therapeutic principles of standard REBT with scriptural techniques.

The study focuses on improvement of emotional distress. The religious phenomenon is taken into starting from the dichotomy of intrinsic and extrinsic religious orientation. The present research is based on a single factor *experimental design*; the participants are randomly placed in one of the experimental groups: participants who attended group therapy activities based on the standard REBT principles, subjects who underwent therapeutic group activities based on the principles of REBT in combination with religious elements and the control group where no therapeutic intervention was undertaken.

The present study was conducted in April / May 2011 during the participants' pre-assessment period with the aim of preventing distress.

Method

The participants in the present study are Christian students from Emanuel University of Oradea with average age of 20.63 years (s.d.1.06). The total number of participants was 52 (N = 52). All the students were intrinsically religious oriented.

Tools and work techniques. Participants were assessed using the following scales: Scale Allport Ross; Beck Depression Scale (*BDI*); Anxiety as state and trait scale (STAIS, STAIT, Spielberger et al., 1983); Automatic Thoughts Questionnaire (ATQ); Dysfunctional attitudes and beliefs Scale (ABS II); Emotional distress profile (PDE); General Attitudes and Beliefs Scale-Short Form (GABS-SF, Lindner et al., 1999); Anger Scale - STAXI (State-Trait Anger Expression Inventory); Levenstein Stress Perception Scale. Measurements were performed pre-test and post-test.

Treatments

There were two experimental conditions: the first condition involved a sample of subjects that had attended standard REBT psychotherapy and another that involved a different group of subjects who followed religious REBT. The participants attended eight psychotherapy sessions lasting approximately 1.30 h each. Informative materials regarding standard REBT (Rational Emotive and Behavioural Therapy Guide, Dryden & DiGiuseppe, 2003) and religious REBT were used between the sessions as "psychological pills"; moreover, the effectiveness of cognitive restructuring by using the "rational prayer" method was tested on the religious REBT group. In both of the experimental conditions, *monitoring forms* were used following the ABCD cognitive model (David, 2007). They were introduced to facilitate the learning of the ABCD model and to facilitate its practice outside the context of the intervention group for cognitive restructuring following the REBT model.

Results

First, the results of the intra-group analysis ("t") and then the results of the inter-group analysis (ANOVA -"F") will be displayed.

The results indicate that both types of therapy had similar efficacy in terms of improvement of emotional distress operationalized by: *main / target results*: total distress ($t = 5.17$ (standard REBT), ($t = 5.32$ (religious REBT), ($p = .00$), ($F(2, 49) = 11.93$, $p = .00$), self-

perceived stress (t = 4.16 (standard REBT), t = 4.44 (religious REBT), p = .00), (F (2; 49) = 15.31, p = .00); *secondary results*: depression (t = 4.91 (standard REBT), t = 11.55 (religious REBT), (p = .00), (F (2, 49) = 8.70, p = .00), anxiety as state (t = 5.54 (standard REBT), t = 6.21 (religious REBT), p = .00), (F (2, 49) = 3.68, p> .05), anxiety as trait (t = 5.52 (standard REBT), t = 14.15 (religious REBT), (p = .00), (F (2, 49) = 6.24, p = .01), anger (t = 5.44 (standard REBT) t = 8.08 (religious REBT), p = .00), F (2, 59) = 3.51, p> .05). Significant changes were also obtained in regard to changes in the cognitive substrate that activates distress (*presumed mediating variables*) irrational beliefs: "must" (t = 8.30 (standard REBT), t = 6. 44 (religious REBT), (p = .00), (F (2, 49) = 7.52, p = .00) , low frustration tolerance (t = 6.36 (standard REBT), t = 6.73 (religious REBT), (p = .00), (F (2, 49) = 8.54, p = .00; catastrophizing (t = 6.36 (standard REBT), t = 6.73 (REBT religious), p = .00), (F (2, 49) = 7.52, p = .00), overall assessment (t = 5.64 (standard REBT), t = 3.74 (REBT religious), p = .00), (F (2,49) = 10.60, p = .00). These results were obtained by comparison with the control group. The effect size was calculated ("d" Cohen) results indicating elevated levels.

Conclusions and discussion

Our proposed interventions aimed to reduce distress levels of students who participated in the pre-assessment period by adjusting cognitions related to stressful events that they experimented. The cognitive changes were made possible by using both methods of treatment, leading to a decrease in distress levels. The usage of rational prayer and reading of sacred texts during the psychotherapeutic process leads to an improvement of client outcomes, facilitates the therapeutic relationship and improves their quality of life (Weld & Eriksen, 2007).

Regarding the relief of depressive symptomatology, the statistical results allow us to ascertain the similarity between the standard and religious cognitive behavioural interventions (REBT) on the intrinsically religious motivated participants.

Self-perceived stress was changed following the classical and religious REBT interventions. The global test highlights the effectiveness of interventions in relieving stress, "t" test values were accompanied by significance thresholds lower than .05. The responses of participants in self-perceived stress scale were similar in the two intervention groups. There is a tendency that participants who received intrinsic religiously oriented REBT interventions with scriptural elements to have lower values on the self-perceived stress scale. Both of these therapies have proved their effectiveness in relieving distress.

The anxiety of intrinsically religiously oriented students was modified, resulting in changes in anxiety as state and as trait and global tests indicate this. Changes in anxiety as trait appear to be slightly more obvious in the case of students who received religious oriented REBT, which is consistent with other research that identified the superior efficacy of religiously adapted psychotherapy versus supportive psychotherapy in generalised anxiety (Koszycki, Raab, Aldosary & Bradwejn, 2010).

In tempering anger, the results are similar both for the group that received standard REBT and for the one that followed REBT with religious elements.

The research supports the cognitive-behavioural model of distress mediation by irrational cognitions, cognitive changes being correlated with a better emotional and behavioural adjustment.

What can be concluded is that Rational Emotive Behaviour Therapy is valid for relieving distress and the standard and religious therapies lead to similar effects when the participants are religious individuals. According to previous research in the field, religious orientation of REBT is preferred by religious clients. The integration of scriptural elements (rational prayer, psychological statements with religious content based on REBT ideas) in the REBT context is possible and beneficial in relieving distress to religious participants.

Study 3. REBT effectiveness in reducing distress on religious mothers of children with neuropsychomotor disabilities

Introduction and research issues

Using a comparative study, the last research examines the impact of standard REBT and religious REBT in relieving distress on mothers of children diagnosed with cerebral palsy, hospitalised in a rehabilitation ward.

This study aims to validate REBT interventions for relieving distress of this special category – mothers hospitalized in a neuromotor recovery ward for the treatment of neuropsychomotor problems of their children. Customised intervention plans based on REBT model were designed, focusing on the psychopathological frame of the accompanying people of the children with disabilities, as found in scientific literature.

Our proposed interventions were modelled by standard REBT and religious REBT. These two types of intervention were applied to religious mothers who came under two

patterns according to the criterion of intrinsic religiosity versus extrinsic religiosity. Standard REBT intervention was applied to extrinsically oriented people, while religious REBT intervention was applied to mothers intrinsically religiously oriented. These methods of intervention tested the effectiveness of standard and religious “psychological pills” in terms of cognitive restructuring during the periods between psychotherapy sessions. The model of “rational prayer” was introduced as well in the sample of mothers who followed the religious REBT.

Objectives

The objective of this study is to investigate the effectiveness of standard REBT as compared to religious REBT on a group of 62 mothers of children diagnosed with cerebral palsy, hospitalised in a rehabilitation ward over a period of three weeks. The approach towards distress on these mothers was performed at multiple levels as our therapeutic protocol aimed at changing dysfunctional cognitions of mothers in order to improve the emotional impact of raising a child with disabilities. The research was focused on automatic thoughts and on dysfunctional irrational cognitions. Through changes at this level, emotional distress changes were monitored, resulting in the focus on the level of depression, of self-perceived stress, of anxiety as state and trait, and of anger and emotional distress operationalized by emotions related to fear and sadness.

Method

The experimental design of the study is unifactorial. Subjects were distributed into two experimental groups, one consisting of subjects with intrinsic religiosity, the other consisting of subjects with extrinsic religiosity and the control group.

Participants

The average age of mothers participating in the research is at (m =33.30; s.d. 5.46). Demographic aspects that describe the participants in the study are summarized in the table below.

Variables	**Extrinsic Religiosity/ standard REBT N=20**	**Intrinsic Religiosity/religious REBT N=21**	**Control group N =21**
Sex	f	f	f
Age, average ± S.D.	33.04 ± 5.73	34.38 ± 5.16	32.00 ± 5.54

(years)			
Training			
Lower-	3	4	4
intermediate school	6	8	6
Vocational school			
Upper-	7	4	9
intermediate school	4	5	2
University studies			
Marital status			
Married	17	19	17
Divorced	3	2	3
Coabitation	0	0	1
Religion			
Orthodox	18	17	18
Reformed	0	0	1
Catholic	1	2	1
Protestant	1	2	1
			N total: 62

Instruments

The participants were assessed with the following scales: Allport Ross Scale; Beck Depression Scale (*BDI*); State and Trait Anxiety Scale (STAIS, STAIT, Spielberger et al., 1983); Automatic Thoughts Questionnaire (ATQ); Dysfunctional Attitudes and Beliefs Scale (ABS II); Profile of Emotional Distress (PDE); General Attitudes and Beliefs Scale-Short Form (GABS-SF; Lindner et al., 1999) Anger Scale - STAXI (State- Trait Anger Expression Inventory); Levenstein Scale of Perceived Stress. Measurements were performed pre-test and post-test.

Treatments

There were two experimental conditions: the first in which a sample of subjects underwent standard REBT psychotherapy and another in which a different group of subjects followed religious REBT. Participants completed a number of 7 psychotherapy sessions lasting between 1.40 and 2 h.

Results

First shall be displayed the intra-group analysis results ("t") and then the inter-group analysis results (ANOVA -"F").

The interventions tested in this research led to comparable results in post-test. Thus, the *main variables/target* results indicate: total distress (t = 2.19 (standard REBT), t = 3.22

(religious REBT), p <.05) (F(2, 59) = 7.62, p = .00), and for self-perceived stress (t = 2.37 (standard REBT), (t 5.54 (religious REBT), p<.05), (F(2; 59)=8.40, p = .00). For *secondary variables* the following results were obtained: for depression: (t = 4.15 (standard REBT), t = 2.62 (religious REBT), (F(2, 59)=6.26, p< .05), p<.01); for anxiety as state (t = 2.61 (standard REBT) t = 4.65 (religious REBT) p<.01), (F(2, 59) =7.51, p = .00); for anxiety as trait: (t = 3.64 (standard REBT), t = 4.66 (religious REBT), p = .00), (F(2, 59) = 6.10, p = .00); for anger (t = 1.86 (REBT standard), p > .07, t = 4.12 (religious REBT), p = .00), (F (2, 59) = 6.59, p = .00). Standard intervention has not reduced anger significantly.

Significant changes have also been achieved at the level of the substrate cognitive that triggers distress, *allegedly distress mediating variables*: irrational cognitions: “must” (t = 3.76 (standard REBT), t = 6. 69 (religious REBT), p = .00), (F (2, 59) =21.55, p = .00); low frustration tolerance (t = 4.20 (standard REBT), t = 8.27 (religious REBT), p = .00), (F (2, 59) =17.57, p = .00); catastrophizing (t = 4.43 (standard REBT), t = 7.06 (religious REBT), p = .00), (F (2, 59) = 14.99, p = .00); overall assessment (t = 2.03 (standard REBT), t = 5.71 (religious REBT), p = .00), (F (2,59) = 13.76, p = .00). The recorded averages are relatively similar in both intervention groups as compared to the control group. These results were obtained by comparison to the control group.

Conclusions and discussion

The suggested therapeutic interventions for relieving distress of mothers hospitalised in a rehabilitation ward for the treatment of their children diagnosed with neuromotor health problems resulted, in post-test, in significant differences between the groups for all measured variables. These differences refer to higher scores on mothers from the intervention groups compared to the control group, which means that the therapy was effective. Effect sizes are medium and large for all measured variables.

Therefore, the three groups - standard REBT group, scriptural elements REBT group, control group-differ significantly in post-test in terms of improving operationalized distress by decreasing the level of depressive symptoms, by decreasing the level of state anxiety, thus being influenced trait anxiety as well, by decreasing the level of anger and distress operationalized through functional and dysfunctional fear and sadness. The three groups differ in post-test after attending therapy. Therefore, therapy has a significant influence and medium and high effect sizes on the corresponding variables. The suggested therapeutic treatment included the use of “psychological pills”, that is, psychological rational statements

meant to facilitate cognitive restructuring, and each REBT method (the classical and the religious version) has been associated with corresponding psychological pills. These statements were intended for the group that received REBT with religious elements, their design being based on the ones already known from the standard REBT (David, 2006), but with a religious content added.

According to the results, their effectiveness can be derived as a contributing factor to continuous cognitive restructuring through homework. Rational prayer taught and shown in the group of people who have benefited from REBT with religious elements is another particularity of this work. The cognitive restructuring was favoured by the rational prayer modelled by ABCD pattern.

CHAPTER III. GENERAL CONCLUSIONS AND DISCUSSION

Theoretical contributions

In the present study we integrated spiritual-religious elements in the context of cognitive- behavioural paradigm modelled on Rational-Emotive Behaviour Therapy to relieve distress of some religious people.

The information discussed in this thesis are consistent with the recent research trend of emphasizing the concern towards the impact of religion in human life. Religiousness/ spirituality can be considered endogenous variables being important components of personal development.

The thesis also summarises information from the literature regarding the way of incorporating psychotherapy recipients' spiritual and religious elements and its effectiveness, providing not only declarative information but also working procedures in this area.

Practical contributions

Implementation of standard and religious oriented REBT allows the drawing of conclusions based on practical experience. We can talk about a theoretical and practical approach in the first part of the paper, but also about an approach from theory to practice in the last part of the thesis. This study gives a synthetic view of the research to date, resulting in the development of the information set regarding the field of cognitive-behavioural paradigm in interaction with Christian religious philosophy.

The interventions carried out by us comply with the recommendations in the field on the peculiarities of religious people therapy; we experimented on the impact that prayer,

reading of sacred texts and usage of psychological pills with religious content can have on cognitive restructuring of some religious people.

Limits and new research directions

Further research should focus on studying the mechanisms by which the religious factor helps to maintain mental and physical health and to prevent disease; other research should consider ways to improve the therapeutic programs for religious customers.

This thesis highlights the impact of religiosity on mental health and it recommends deeming this dimension as an important variable in the therapeutic process, which will improve the therapy efficacy, the treatment relevance and the competent practice.

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