Chapter

Including Religion in Rational-Emotive Behavior Counseling

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Abstract

Cognitive-behavioral therapies (CBT) have been disseminated worldwide. This therapeutic approach is being considered some of the best empirically supported treatments for a large variety of psychological disorders. The core tenet of CBT is to restore mental health and promote psychological well-being by focusing on cognitive dysfunctional patterns that cause emotional distress and maladaptive behaviors. First, a general view of the basic principles and origins of cognitive-behavior therapies constitute the basis on which the chapter is built. Thereafter, a more in-depth discussion on specific forms of CBT, namely cognitive therapy (CT) and rational-emotive behavior therapy (REBT) provides further support for the integration of religion and psychological intervention. Next, a thorough analysis of the theoretical premises of this integration and the ways in which religious beliefs and psychological mechanisms merge in practice is provided. Finally, the REBT conceptualization, techniques, and strategies are illustrated in a practical situation; here, the relationship between religious beliefs and practices on the one hand, and irrational beliefs, dysfunctional emotions, and maladaptive behaviors, on the other hand, is easy to observe. The example provided aptly illustrates the many ways in which REBT can incorporate religious principles, beliefs, and practices; all of them, advocating for the harmonious relationship between Christian values and REBT.

Keywords: cognitive behavior therapy, Christian counseling, religious beliefs and practices, religious clients, case study

1. Introduction

Cognitive-behavioral therapy (CBT) is considered to be the most well-founded in terms of scientific support. It has been widely disseminated worldwide, through numerous training programs, workshops, conferences, and also through a large number of monographs and practical manuals for practitioners in the field of clinical psychology and psychotherapy [1]. The goal of this therapeutic approach is to restore mental health and address a number of issues faced by individuals, by focusing on cognitive dysfunctional patterns that cause emotional distress and dysfunctional behaviors. In a synthetic definition formulated by Amy Wenzel, CBT is considered an active, semi-structured, and time-sensitive psychotherapeutic strategy [2]. Its active character results from the way in which the two actors of the therapeutic act are
involved, the psychotherapist and their client; both prepare for counseling sessions, contribute to the analysis and assessment of the client’s condition, and collaborate in the constructive approach to the problems they face. CBT is considered semi-structured, because the therapist, although flexibly positioned in relation to their client’s problems, usually prepares for each session a kind of organized scheme to guide the stages of the session, which ensures that the therapeutic process is targeted and effective. Finally, this approach is anchored temporarily/in a time-sensitive manner, in the sense that the clients assume, consciously and with motivation, the proposed therapeutic approach, anticipating that the treatment followed will have an end, that what happens in each session produces a positive development, that this development is noticeable after each session, and that they can implement therapeutic strategies in their daily lives without the need for permanent assistance from the therapist.

Cognitive-behavioral therapy is founded upon three central assumptions, which are as follows:

1. Cognitive activity influences our behavior

2. Cognitive activity can be monitored, but also modified

3. The behavioral changes we target can be achieved through cognitive changes.

The first of these assumptions is, in fact, a brief and up-to-date reformulation of the central thesis of the mediation model, proposed by Michael Mahoney. Since 1974, Mahoney has argued that changes in behavioral therapy necessarily require cognitive mediation. Today, there is an impressive body of empirical evidence indicating that cognitive assessments of life events affect our responses and that changes in the content of these assessments have an indisputable clinical value [3–6].

The second thesis tacitly incorporates the assumption that we can have access to cognitive activity and that our cognitions can be known and evaluated. Undoubtedly, there are enough reasons to believe that our access to our own cognitions is not perfect and that people often report their mental activity based on the likelihood of thoughts occurring rather than their actual occurrence [7]. A corollary of this second assumption is that the assessment of cognitive activity is only a prelude to the changes we can make at this level. In other words, accessing and evaluating one’s own cognitions is necessary, but it does not automatically bring about the change we want.

Finally, the third assumption is a direct result of the adoption of the CBT in the model proposed by Mahoney. It explicitly states that the behavioral changes we seek to produce with our clients can only be achieved if we make cognitive changes. Specifically, although CBT theorists accept that a number of external, reinforcing contingencies can influence human behavior without direct cognitive intervention, this does not mean that they are independent and do not involve cognitive changes; moreover, the same changes, as well as others, can be produced by direct intervention on cognitions. To substantiate this assumption thoroughly, cognitive-behavioral researchers have collected a very large volume of experimental evidence.

2. The origins of cognitive-behavioral therapy (CBT)

There were several favorable circumstances that created adequate premises for the development of cognitive-behavioral therapy. Thus, since the 1950s, Hans Eysenck
has published several studies that vehemently criticized one of the prevalent therapeutic approaches of the time, namely, psychoanalytic psychotherapy, proposing behavioral therapy as a more viable alternative. In his challenging attempts, Eysenck argued that the resolution of neuroses does not require a focus on intrapsychic conflicts and that they can be treated completely by a direct approach to the symptoms that portray them [8, 9]. As a result of these warnings and encouragements, in the late 1950s and early 1960s practitioners turned their attention to behavioral therapeutic approaches; these were based on direct behavioral changes, founded upon the two paradigms of learning—classical conditioning, respectively, operant conditioning. However, as interest and involvement in this new commitment grew, it became increasingly clear that a strictly behavioral conceptualization was insufficient for explaining the full spectrum of clinical problems that therapists were facing in their practice. Moreover, there was already evidence that an exclusively behavioral intervention would leave a significant number of issues uncovered, such as the obsessions that are part of obsessive-compulsive disorder, or paranoid ideation [9–11].

A second favorable context was represented by the cognitive revolution, which started in the mid-1950s. Information processing models that began to attract the attention of contemporary psychologists in their attempts to explain psychic life and provide support to artificial intelligence specialists had made a significant contribution to the development of CBT. The new current, which had brought some fresh air to the field of psychology, through its emphasis on cognitive processes, greatly favored the inclusion of the cognitive component in traditional behavioral interventions. In the mid-1970s, a number of academics concerned with the development of therapeutic practice began to draw attention to the importance of the cognitive moment in our actions and propose a model of mediation in this regard. In this way, they explicitly advanced the idea that cognitive processes influence our emotions and behaviors and that cognitive intervention can lead to significant behavioral changes [2]. Once these premises had been accepted, the interest in cognitive-behavioral approaches increased considerably. As a result, a number of new psychotherapeutic approaches based on this new perspective have begun to develop. We mention here some of them: rational-emotive behavior therapy, cognitive therapy, schema-focused cognitive therapy, stress inoculation training, third wave therapies (acceptance and commitment therapy, dialectical behavior therapy, mindfulness therapy). Given the large and ever-increasing number of these new therapeutic guidelines, attempts have also been made to group them based on predefined criteria. Thus, toward the end of the 1980s, Mahoney and Arnkof proposed organizing them into three main categories: a. cognitive restructuring therapies; b. therapies focused on the development of coping strategies; c. problem-solving therapies. Cognitive restructuring therapies are based on the premise that emotional distress is the consequence of maladaptive thoughts. Therefore, clinical interventions aim at examining and replacing dysfunctional thought patterns with their adaptive variants. The second therapeutic category aims to develop a repertoire of skills designed to equip clients for coping with stressful life situations. Finally, the third group of therapies, those focused on problem solving, can be described as a combination of the first two. The latter emphasizes the importance of developing general strategies for the client to deal with a wide range of personal issues, emphasizing the importance of active collaboration between the therapist and their client in the planning of the corrective intervention program [1]. The first category is the most widely used in therapeutic practice, and the best-known paradigms of this family are—rational-emotive behavior therapy (REBT), respectively, cognitive therapy (CT). We will briefly describe each of the two therapeutic approaches, placing more emphasis on REBT, which is also the central object of this chapter.
3. Rational-emotive behavior therapy (REBT)

Chronologically, rational-emotive behavior therapy (REBT) is considered to be the first of the cognitive-behavioral approaches in the category of those that focus, explicitly, on cognitive restructuring. Initially, it was called rational therapy, then rational-emotive therapy, and finally, starting in the 1990s, it became known as the rational-emotive behavior therapy (REBT). The fundamental theoretical and practical principles of REBT were formulated by Albert Ellis, considered the father of REBT and, respectively, the grandfather of cognitive-behavioral therapies. Originally trained in the psychoanalytic school of psychotherapy, after only a few years of therapeutic practice, Albert Ellis began to doubt the quality and effectiveness of this approach. Less and less motivated to continue in the spirit of this school, Ellis successively tested different treatment techniques, most of which involved an active and a directive approach, respectively. The first results of these experiments allowed him to formulate a personal theory on the genesis of emotional disorders, as well as to develop a set of treatment methods. Although ardent proponents of the psychoanalytic paradigm considered the methods proposed by Ellis to be heretical, the advent of behavioral therapy in the 1960s and, above all, the gradual recognition of the fundamental role of cognition in understanding human behavior, led to the acceptance of REBT (at the time called RET) as a viable and credible alternative to classical models of psychotherapy.

The central assumption of this approach is the belief that human cognition (our thoughts) plays a key role in the genesis, maintenance, or modification of the emotional and/or behavioral responses we produce. To make this perspective concrete, Albert Ellis developed the ABC Model of the genesis of emotional responses. The three components of the model are operationalized as follows: A represents the activating element—life events together with our inferences about these events; B refers to the system of personal beliefs (inferences and evaluations) that generate consequences, that is, those that lead to our reactions; C represents the answers that a person produces as a result of the presence of specific beliefs, which can be of a wide variety—emotional (e.g., anxiety), behavioral (e.g., motor agitation), and cognitive (e.g., thoughts of helplessness) [12].

The central objective of REBT therapy is vulnerabilization, namely the elimination of the personal system of irrational (unhealthy) beliefs characterized by exaggeration and rigidity, followed by the adoption of a flexible belief system that promotes/enhances psychological health. In this sense, REBT involves a multidimensional approach that incorporates cognitive, emotional, and behavioral techniques. Of all these, the principal strategy of therapeutic intervention is a logical-empirical method of questioning, challenging, and scientifically disputing the unhealthy thoughts that Albert Ellis called irrational cognitions [13]. Beyond this main healing method, REBT individualizes its intervention strategy using a wide variety of techniques, such as rational-emotive imagery, operant conditioning, modeling, role play, shame attach exercises, thought monitoring, library therapy, and development of various skills and so on [14].

4. Cognitive therapy (CT)

The father of cognitive therapy is Aaron Beck. Like Albert Ellis, Aaron Beck was originally trained in psychoanalysis, but he also became relatively dissatisfied with the conceptualizations that the psychodynamic paradigm offered for various emotional
disorders [3]. For example, in the 1960s, Beck found that a number of cognitive factors frequently associated with depression were systematically ignored in favor of psycho-analytic conceptualizations that accentuated the motivational-affective dyad [1].

The cognitive model proposed by Aaron Beck emphasizes the idea that distorted thinking and unrealistic cognitive assessments can negatively affect our emotions and behaviors. Evaluations are pre-formed (shaped) by mental schemas, that is, cognitive structures that organize and process information taken from the outside. The cognitive patterns of mentally developed people allow/make realistic assessments of life events and lead to functional, healthy emotional experiences. In contrast, individuals who have developed dysfunction are primarily engaged in distorted assessments that lead to emotional dysfunction [5].

The central goal of cognitive therapy is to replace the distorted assessments that clients apply to life events with their realistic and adaptive variants. Cognitive-type therapeutic interventions are based on collaborative psycho-educational approaches and involve the design of specific learning experiences through which clients are guided/prepared:

a. to recognize the relationship between their thoughts and the emotions they experience, respectively, the behaviors attached to them.

b. monitor and control their automatic thoughts;

c. to verify the validity of automatic thinking;

d. to identify and then modify their beliefs, assumptions, or cognitive patterns that favor and support their engagement in psychopathogenic patterns of thinking [15].

5. Integrating religion with REBT

5.1 Theoretical premises of integration

Several reasons (arguments) can be identified that prove the possibility that REBT can be easily and elegantly adapted for the treatment of religious clients. In what follows, we present some of these synthetically [16].

First of all, REBT therapy has proven to be an excellent treatment for religious clients (practitioners) because it is a therapeutic strategy expressly focused on the beliefs of individuals [17–20]. In particular, this approach bears a strong resemblance to the Christian perspective. More specifically, the REBT psychotherapeutic system proves a high convergence with many of the basic principles of the Christian tradition [21–23]. For example, the Christian view that people are all equally worthy and that all sins can be forgiven can serve as admirable support for REBT techniques focused on eliminating the tendency of human beings to appreciate their own worth, respectively, the worth of others. In addition, the position of the Christian Church regarding sin, more exactly, the fact that it condemns sin and not the sinner, is clearly found in the principles of REBT. Moreover, Ellis has explicitly iterated that REBT does not approve of immoral acts, but instead fully accepts the humanity and fallibility of those who commit such acts [24].

The ABC model, already discussed above, with its emphasis on the role of cognitions in the production but also the elimination of emotional-behavioral
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dysfunctions, is found in most religious doctrines. In fact, the principles of instilling, maintaining, or changing specific beliefs that are fundamental in most religions, can also be found, carrying equal importance, in the manner in which REBT examines and understands the role played by our cognitions in the genesis of emotional disorders. Furthermore, understanding religious beliefs, both in terms of content and personal quality and worth, is essential for a correct understanding of religion, both as a human phenomenon, and as a determining force in the client’s life. Both religious doctrines and REBT theory support and prove the centrality of beliefs in the emotional, behavioral, and cognitive life of the human being [19].

A second convergence between several religious traditions and REBT is their deeply existential and philosophical nature. Therefore, due to the fact that religious systems adhere firmly to the principle of free will, to the benefits and blessings of self-determined involvement in work, but also to the need to change erroneous (dysfunctional) beliefs, we can say with conviction that REBT elegantly meets all these objectives. More specifically, we can argue that religious clients are ideal for philosophical dispute strategies used by REBT therapists, whose major purpose is to change their philosophy of life. In fact, many clients who strongly believe in the strength (power) and usefulness of their religious beliefs are very receptive to the REBT perspective, which states that the deeper a belief is manifested, the more likely it is to manifest itself in the thinking, emotions, and behavior of a person [25].

The third similarity between REBT and the religious perspective concerns the ways in which fundamental principles are expressed. These take the form of behavioral tasks (canons/homework), beliefs, iconographic/pictographic representations, creative musical expressions, etc. In fact, REBT therapists often recommend to their clients that between therapy sessions (face to face or online) they complete/perform various home tasks; most of these topics are behavioral tasks that complement and promote cognitive change processes [26].

Finally, most religious traditions, beliefs, stories, and parables take the form of hymns and represent particular ways of expressing religious worship [27]. It is obvious that combining fundamental religious principles with melodic lines, rhythm and rhyme increases the possibility of making these principles easier to remember at the same time increasing their level of persuasion and emotional relevance [28]. In fact, the transmission of many of the central principles of REBT through therapeutic poems or songs has become a very common practice by therapists.

5.2 Concrete practical ways to integrate REBT with religious beliefs and practices

Considering the arguments regarding the convergences between organized religious systems and REBT theory, it is natural to think of concrete ways in which, at a practical-applied level, there is a possibility of integrating REBT intervention strategies with religious beliefs and practices, in particular, with Christian ones. A primary level of practical integration of the two approaches can be limited to highlighting elements extracted from the religious tradition of the denomination to which the client belongs that are overtly congruent with the specific principles and strategies of REBT intervention.

In fact, all modalities of integration will start by going over and understanding the ABC model that underpins REBT theory and practice. It must be read and interpreted both in the spirit of REBT’s central assumption (the emotions and behavioral disorders we experience are the results of our private interpretations and assessments) and of the philosophy behind the client’s religious system. For example, when we work with
these clients, rather than threatening or undermining their religious beliefs, through REBT-type interventions we can help them to focus and boost the long-term strength and function of their faith by appealing to several strategies, such as (a) highlighting or reactivating components neglected by the customer [29, 30]; (b) reinterpretation/reconceptualization of some religious writings in the spirit of REBT; (c) disputation of rigid personal beliefs that overlap and interfere with the authentic religious ones and that can thus generate dysfunctions. For example, in the interpretive pattern of the religious client can be identified a series of irrational cognitions that have no basis in the Bible or in the Christian tradition, such as “God does not love me as much when I sin,” “Because I am a Christian, God will always guard me against bad things/events that may happen to me,” “Because I am a Christian, I should be perfect,” “I should condemn and hate myself when I sin because this is the only way I can be saved.” All these misinterpretations and misjudgments that religious clients may generate, after being identified, will be the subject of disputes (logical, functional, or empirical), so that they can be made vulnerable and then eliminated.

On the other hand, once the process of disputing erroneous beliefs has begun, the therapist must initiate and offer rational alternatives extracted from religious writings (Bible, Holy Fathers) or the oral religious tradition. Thus, from the very beginning, clients can be offered healthy thinking alternatives, by extracting Bible verses or statements made by credible (holy) religious authorities, that should serve as correct interpretive substitutes which can ensure a healthy and beneficial mental development for the client, from an emotional perspective [18, 31]. Here are some examples of irrational religious thinking: “Let this mind be in you, which was also in Christ Jesus” (Philippians 1,5), “The simple man has faith in every word, but the man of good sense gives thought to his footsteps” (Proverbs 14: 5), “For (man) as he thinks in his heart, so he is” (Proverbs 23: 7).

In the second part of this chapter, for an ecological illustration, we have decided to illustrate the use of the REBT conceptualization, techniques, and strategies in a practical situation. In this section, the relationship between religious beliefs and practices on the one hand, and irrational beliefs, dysfunctional emotions, and maladaptive behaviors, on the other hand, is easy to observe. Several reasons underlie our preference for this particular case:

1. Religious beliefs and practices play a central role in the client’s worldview;

2. The client holds very rigid personal ideas about religious beliefs and practices, that are often formulated irrationally;

3. Often the client focuses on some religious tenets while ignoring others;

4. The client irrationally demands that people around her share her religious views;

5. The client’s relationship with God is highly distorted, based on need, punishment, and conditional love, reflecting the relationship she has with her mother;

6. The client perceives God’s traits and character in a distorted manner, at odds with both the Christian view and the REBT philosophy of unconditional self, other, and life acceptance;

7. The client has a distorted sense of responsibility, denying the role of her thinking in the genesis of her dysfunctional emotions, justifying her maladaptive behaviors, yet assuming the cause of her misery to be a deviation from religious norms.
5.3 Case study—Working with a religious client; Specifics in assessment, case formulation, and treatment

5.3.1 Case history—focusing on the relationship between basic tenets of REBT and the client’s religious beliefs

Maria is a 31-year-old woman, single, with no children. Presently, she lives with her brother and his wife to be. She has a high school education and has worked in a beauty parlor since graduation.

Maria comes from a traditional family (i.e., mother, father, and two children). She describes her mother as “perfect housewife and professional.” At the same time, her mother believed that the best way to raise a child is to be critical of her/his mistakes and punish them right away. Rewards were considered to be “for the weak” and thus inappropriate for a child’s education. Because she worked hard to provide everything for her children, her mother believed they should always be obedient and respectful. Even now, as an adult, Maria says her mother is never wrong, and always knows everything better than anybody else. Maria’s father left when the children were young and stopped any relationship with his family. After graduating high school, Maria remained in her mother’s house, who instructed her to save money to buy things for her future home. Whenever Maria wanted to go out with some friends, her mother would correct her and force her to save all her income just to buy things. Moreover, even the things she bought for her future house were picked by her mother, regardless of her preferences. As a consequence, Maria did not date or make any friends.

Maria decided to see a mental health professional about 16 months ago. By the time she came to see this therapist, she had already been treated by other mental health professionals (psychologists and psychiatrists), whom she visited successively. At the time of her admission, Maria complained about her unsatisfactory relationships (“I have nobody to love and support me,” “My life is a mess,” “People around me cannot stand me anymore, although all I do is for their benefit”), her developing panic attacks (“I am so scared not to have another panic attack that I do not dare go to work anymore”), and her lack of pleasure in life (“There is nothing good now. I won’t be able to go to work, and that was the only place where I am appreciated”).

Maria has always been a person very different from her brother, her friends, and everybody around her. She does not believe she had ever been loved by her mother, whose affection had been constantly seeking since she was a baby. She feels permanently threatened by the prospect of being abandoned by her family and dreads the idea she would one day be forced to live alone. Because she believes her present problems are due to the fact she has a cold, insensitive mother who does not love her (only her brother), she tries to make up for maternal love by searching for surrogate mothers.

In approaching this difficulty during the intervention, the basic tenets of REBT (“You prefer to be loved by your mother, but do not have to have her love”) will align with Christian religious tenets (“God loves you always, so you do not need the love of others, although you prefer that.”).

For quite a few years now she has been visiting a whole range of churches, believing she could find some priest or believer who could adopt her (“If I cannot be loved by my mother, I will find another one. Nothing can replace the love of a mother and I do not want to remain mutilated like this forever”). For a while, she found a woman (member of a nontraditional religious community) who agreed to “adopt her,” because her own daughter lived in another country and was more independent than
she would have wanted. Maria remembers those moments as some of the best of her life. Eventually, one day the real daughter visited her mother; the woman informed Maria that she could not see her for a few days because she took a trip with her real daughter. At this point, Maria was so enraged that she entirely rejected her surrogate mother and told her she was no longer available as a daughter. Although they work together, the relationship between the two was distant ever since.

In approaching this difficulty during the intervention, the basic tenets of REBT (“You prefer to have exclusive love from somebody, but do not have to have that”) will align with Christian religious tenets (“God loves you and expects all people to love each other. It is ok she also loves her biological daughter”).

Following this episode, Maria joined a few Bible study groups, hoping people in these groups would love her “because they are Christians, and they should.” As soon as she realized her colleagues accept her but do not grant her their time exclusively, Maria started looking for someone else. She keeps going weekly to study the Bible because she believes God will be the one to love her forever—if and only if she struggles daily to become a good Christian. Meanwhile, while watching a TV show, she got the telephone number of a woman pretending to get rid of the bad spirits, curses, and malevolent forces residing in people’s houses. At this point, Maria was ready to believe her loneliness (she could never have a boyfriend) and lack of attraction was due to her aunt cursing her because she inherited some money from her grandmother. As soon as she called, the woman on the TV asked for a large sum of money for a “counter-spell” to help Maria get rid of the evil spirits. A long period of hope and despair, love and hate followed—either the woman would not be available for months, or she would be pointing to objects in Maria’s house, which should be destroyed because the evil spirits resided in them. Although Maria wanted to move away from her parents’ house, she could not stand to be alone, so her brother and his fiancée came to live with her. But their relationship, which has always had ups and downs because of Maria’s exaggerated need for attention, severely deteriorated when she started destroying the things in the house, in an attempt to remove evil spirits (as indicated by her “spiritual mother”). Just as Maria felt both loves and hate toward her mother, she began feeling love and extreme anger toward her brother. Arguments escalated when Maria threatened to throw the brother in the street because it was her house.

Acceptance and good relationship with one’s brother as recommended in Christianity will constitute a point of discussion and cognitive restructuring, focusing the argument on both disputing IB (e.g., “He must support me in everything I do”) and reaffirming the Christian values of love and tolerance.

On the other hand, when he and his fiancée decided to move out, Maria was so desperate that she refused to eat, so they decided to stay. Presently, their relationship suffers because Maria believes she has to be perfect (“I must be perfect like my mother”) and every criticism from her brother is perceived as a disaster (“He should not say I am fat”). Trying to cope with the situation, she engages in frequent binge-eating episodes, which do not help her lose weight, a consequence that is very detrimental to her self-image: “Nobody will like me like this”.

Cognitive restructuring will focus on both the irrational nature of demanding perfection and God’s perspective on imperfection as understood in Christianity (Christ died for us when we were imperfect.)—Convergence of religious tenets with REBT principles. Main religious ideas and beliefs are neglected by the client.

Moving into a new house was also a stress factor for Maria; soon after moving in (and before her brother came to live with her) she started fighting with some of her neighbors over different issues, which was sorted out by police intervention.
Although she really hates upsetting other people, Maria equally finds their lack of understanding for her unbearable.

*Cognitive restructuring will focus on both the irrational nature of low frustration tolerance and the Christian religious beliefs about forgiveness and tolerance, as well as love for one’s neighbors.*

The only place where she feels better is her work. Here Maria is appreciated and likes interacting with the clients. The main problems occur here when the customers demand some new, unusual procedure, which Maria perceives as a threat to her image as “perfect professional.” Because of this, at times she acts aggressively.

*Behavioral intervention will make use of the idea of learning how to react assertively, and the religious strive for bettering yourself in God’s eyes.*

Recently, these episodes became more frequent and Maria started developing panic attacks related first to her workplace (then to other public places). At about the time she was supposed to go to work, Maria would feel dizzy, choke, have palpitations, lose her balance, and feel like fainting. She began to fear these symptoms and avoid going to work by calling in sick. At the same time, Maria developed feelings of sadness and depression because she believed she might lose her job, which was the only place she felt good. She started to believe the situation was not going to get better in the future, while her inability to control her feelings scared her immensely. For about 3 weeks before she began therapy, she was sad and depressed and had difficulties sleeping and concentrating.

*Emotional symptoms*—sadness, depression about lack of affection, fear of not being able to control her life, panic over going to work, both love and hate for her mother, surrogate mothers, and her brother, incontrollable anger, guilt.

*Cognitive symptoms*—believing she must have a mother’s affection, believing people around her must be as considerate toward her as she is toward them, believing her recent symptoms mean she is sick and things are going to be even worse, believing she is never going to be like her mother, like her mother wants her to be, thinking she could not stand to be alone, thinking people are bad and unjust toward her (occasionally she believes her neighbors are plotting to throw her out of the building), believing people can put evil spells on her and they would do it for financial benefit, thinking that arguing with and upsetting people around is terrible, being convinced she cannot control her overeating, being convinced she is inadequate and incompetent.

*Behavioral symptoms*: avoidance of physical effort (when she feels sick), constantly searching for somebody to attach to, binge eating, aggressive behavior.

*Physiological symptoms*: feeling dizzy, choking, palpitations, loss of balance, and feeling like fainting.

*Life philosophy*: Maria’s life view is organized around religious tenets. Religious beliefs are highly important to Maria, relating to all aspects of her life. She will only accept the authority of leaders or the influence of friends if she is convinced, they are doing God’s work. Maria has very rigid ideas and beliefs about what religion represents, which she defends irrationally and demands they are shared by all around her. She will get very excited about a religious group she just learned about, spending the next few weeks or months convinced she found the perfect match for her needs and beliefs. But, as soon as somebody from that group behaves in a way she does not approve of, Maria will reject the group altogether and start looking for a new one, “a real one.” Maria prefers the company of people belonging to religious groups that conform to certain rules of behavior and human interaction.

Maria’s relationship with God is highly similar to the relationship she has with her mother. She craves love and acceptance she is deeply convinced she cannot obtain.
because she is not perfect. She perceives both God and her mother as demanding and punishing and the idea of unconditional love is very hard to understand and accept. As a consequence, all her efforts are devoted to behaving perfectly so can be accepted at last. When her efforts inevitably fail, she becomes angry first at herself, then at her mother and God, followed by a lot of guilt and remorse. In Maria’s case, a lot of negative dysfunctional emotions are a direct consequence of perceived disobedience and behaviors that go against her religious beliefs, evaluated irrationally.

Since religion and religious behaviors play such a major role in Maria’s life, many of her problems (both emotional and practical) revolve around her religious involvement. Her major life decisions are directly affected by her religious beliefs and the spiritual mentors she reveres at the time (although they change quite often). As such, challenging irrational beliefs, negative automatic thoughts, and maladaptive schemas might mean touching on some religious content Maria is sensitive about (e.g., God’s unconditional acceptance vs. His acceptance/punishment predicated on one’s behavior/decisions).

Maria exhibits mainly extrinsic religiousness; often using religion in an instrumental way to achieve company, assistance, approval, and status. She experiences joy, purpose, and well-being when her religious group admires her, approves of her behaviors, and takes her advice. For Maria, group approval is also the indicator that God himself approves of her. Quite often, Maria’s religiousness conflicts with her goals, relationships, well-being, and social and professional life. Following an idea, she likes or the suggestion of a spiritual leader, Maria would engage in behaviors that irritate her friends, family, and coworkers, which fuel conflicts and distress. These situations occur mostly because of Maria’s proclivity for understanding all concepts in black and white, interpreting all gray areas as sinful.

The evaluation revealed a few potential problems with Maria’s religiousness:

• Using religion and religious behavior as a means to approach and solve everyday problems and initiate relationships with other people;

• Using religion to explain lack of ability, poor decisions, and maladaptive behaviors by refusing responsibility and blaming mysterious spiritual forces;

• Changing religious groups frequently when people do not respond to her needs according to her expectations and explaining her decisions based on doctrine and belief;

• Obsessing over sin, mistakes, and being rejected by God because of imperfection while holding rigidly to poorly understood concepts.

In conclusion, Maria’s religious beliefs are usually formulated in very rigid terms, in an absolutistic and irrational manner. Moreover, she is focused on a small number of beliefs that contradict other major tenets of Christianity. (For a theoretical discussion, see this chapter “Concrete practical ways to integrate REBT with religious beliefs and practices”). As a consequence, conflict with other people (including her religious community) occurs frequently, which has a negative impact on her morale and well-being.

Since religion is at the core of Maria’s worldview, the conceptualization of her problems and the explanations offered to her will have to take into consideration her sensibilities regarding the subject. Also, the therapeutic objectives will be aimed at improving her ability to live a satisfactory practical and spiritual life.
The major stresses in Maria’s life are mostly the lack of friends, social interaction, and isolation. The interactions with her family (i.e., her brother, his fiancée, religious community) are tense and unsatisfactory. Also, her exaggerated need for attention and constant reinforcement makes relating to others much more difficult. A few months ago, Maria was treated for anxiety symptoms with Xanax in an outpatient setting. Maria does not have any medical problems that could influence her psychological functioning or treatment process. Following psychological evaluation, she was diagnosed with panic disorder with agoraphobia, depressive symptoms that do not meet the criteria for an affective disorder, borderline personality disorder as well as some traits of avoidant personality disorder and obsessive-compulsive personality disorder.

5.3.2 Case formulation—integrating the psychological conceptualization and the client’s religious beliefs

Stress situations (like moving to a new house, having to face a demanding client, or being confronted by her brother on an important issue, etc.) are those in which the feelings of inadequacy and incompetence develop. Poor anger management abilities and the ensuing prospect of losing the job she liked precipitated the panic attacks. Overwhelmed, Maria began feeling depressed and desperate.

Central beliefs: “I am inadequate,” “I cannot be loved,” “I am incompetent,” and “I cannot stay in control.”


Automatic thoughts: “I will never be as perfect as my mother,” “I will never be how my mother wants me to be,” “My mother will never love me,” “My symptoms mean I am sick and is only going to be worse, and this is awful,” “People are bad and unjust,” “People can and will put curses on you for financial benefits,” “I cannot refrain from eating too much,” “Men will not like me this fat,” “No matter how much I try I cannot change anything and it is only going to get worse,” “Bad spirits came to my house because I am a bad Christian.”

Irrational beliefs: Demandingness—“I must have my mother’s affection,” “People around me must be as considerate toward me as I am toward them,” “I must find somebody to love me,” “I must have control over myself at all times,” “People should be fair,” “I must have somebody to love me and help me,” “I must be perfect,” “I must not sin,” “I must be a good Christian.”

Low frustration tolerance—“I cannot stand when people criticize me,” “I cannot stand to be alone,” “I cannot stand when people are angry with me,” “I cannot stand the thought that God is angry with me.”

Awfulizing—“If I am not perfect, I will not be loved and that is awful,” “It is awful to upset people around you,” “It is awful to upset God,” “It is awful to sin.”

Self-downing—“I am an incompetent, ugly and unlovable person,” “I am a sinner,” “I am not a good Christian.”

Other-downing—“People are mean and unjust,” “People are not good Christians.”

Core religious assumptions:

• believing she must be virtuous to deserve God’s love and help;
• believing in good and bad spiritual entities that can interfere with people’s lives (physically and spiritually);

• believing people belonging to the religious group she is part of having a moral obligation to help her, accept her, love her and grant her their time and attention;

• being convinced she is entitled to a priest’s/pastor’s/spiritual leader’s love and unconditional support (much like the relationship between parent-child);

• associating sin with immediate punishment and rejection by God.

The typical situations when Maria’s beliefs are activated include challenging moments when she is facing activities she has never done before and negative evaluations from the others are possible (like moving to a new house or using new procedures at work). Also, her low frustration tolerance is most evident when people do not grant her the attention and the support, she demands from them. Another difficult situation for Maria is when, after losing her temper, she notices people are upset with her and less willing to interact with her when she experiences guilt and remorse. The possibility of losing her job because of aggressive behavior toward the clients is the main event that precipitated the development of panic attacks. Maria’s depression and sadness are mainly connected to her lack of ability to cope with the requirements of healthy human interaction.

While growing up, Maria learned she could always be abandoned by those she loved. Her father left the house when she was very young and made no attempts to restore any relationship with his children. Her mother was herself pretty unstable emotionally and refused to open up to her children, maybe for fear of getting herself hurt. Also, she held the belief a good education is incompatible with expressing affection and was exaggeratedly critical of any mistake her daughter made. Because her brother had better performances in school, he was always the mother’s favorite, who repeatedly pointed out how reliable he was as compared to Maria. Also, her grandmother believed the same and acted the same. As a consequence, Maria grew to believe that “They all abandon me because I am not lovable” (acceptance beliefs) and “I am inadequate” (adequacy beliefs). On the other hand, her mother constantly supported the idea of justice over forgiveness. Thus, Maria holds now very strongly the idea that “everybody should treat me fairly and respectfully, because I do the same for them” and “My brother and my mother should help me as I help them” (justice beliefs). At the same time, she hates dependency and believes that “being sick equals being weak and offending others” and that she “should always be in control” (responsibility and control beliefs).

Maria discovered religion on her own, as an adult, being both attracted to and intrigued by the idea of an almighty God that loves and accepts imperfect human beings and was willing to sacrifice his only son for them. While she is very enthusiastic about the idea of unconditional love, Maria is also unable to fully understand and apply this idea to life and human interaction.

As a method of diagnosis, we used interview, observation, and self-monitoring. So far we avoided administering tests or other questionnaires, which she associates with a “formal diagnosis” and therefore something to be ashamed of. Maria is aware of her social difficulties and motivated to change something in her life.

A comprehensive conceptualization—integrating cognitive distortions, selective religious beliefs, and poorly defined religious values to explain emotional and behavioral consequences.
Maria’s core beliefs about acceptance and adequacy, justice, control, and responsibility, created in her insecure relationship with her mother and grandmother, are activated mostly in unstructured situations. The various unrealistic demands she has of herself and other people are often unmet and contribute to her poor self-image as inadequate and unlovable. The major lack of social and communication skills (due to prolonged social isolation) contributes negatively to her attempt to integrate socially as an adult. Her low frustration tolerance of the other persons’ unjust behavior triggers aggressiveness, which she later regrets; as a consequence, her negative self-image is being reinforced. Panic attacks are mainly related to her catastrophic evaluation of physiological symptoms in terms of weakness and inadequacy. Her lack of ability in properly handling difficult interpersonal interactions leads also to feelings of depression and sadness. In an attempt to cope and adjust, Maria turns to religion, conceptualized mostly as a parallel world where her worldview, expectations, and behaviors are supposed to work. Although she understands relatively well the tenets of Christianity, she arbitrarily selects and rigidly interprets those ideas and guidelines that serve her needs and alleviate her emotional pain. She uses religion in such a utilitarian manner without acknowledging or understanding the underlying problems.

5.3.3 Treatment—integrating the psychological intervention and the client’s religious life

Understanding that Maria’s worldview is organized around religious beliefs and practices, a main overarching objective of the psychotherapeutic intervention is to determine how her manner of belief impacts her social, relational, and occupational functioning. The truth of Christian ideas and tenets is acknowledged, while the therapist’s efforts are directed at pointing out contradictions in Maria’s thoughts, attitudes, and beliefs. The main concern is helping Maria articulate a comprehensive and coherent life philosophy that is equally true to Christian values and rational, realistic, and helpful.

The mutually agreed-upon list of problems including—(1) deficient social and communication skills, (2) deficient emotional regulation skills, (3) feelings of depression and guilt, (4) panic attacks and agoraphobic avoidance (mostly related to work), (5) binge eating, (6) socially unacceptable behavior/aggressive behavior (e.g., Throwing her and her brother’s things away because they were inhabited by evil spirits), and (7) deficient conflict management skills.

Among the most important treatment goals were—(1) building social and communication skills, (2) building emotion regulation skills, (3) reducing dysfunctional negative emotions (e.g., depression, guilt), (4) reducing panic attacks and agoraphobic avoidance, (5) eliminating binge eating and restructuring the eating behavior, (6) reducing socially unacceptable behavior and developing adaptive behaviors, and (7) building conflict management skills.

In planning Maria’s treatment, we have selected treatment packages suitable for her complaints and adjusted the techniques and strategies included to make use of her religious beliefs and practices.

• For panic attacks, we used a treatment package containing: cognitive restructuring techniques (Socratic dialog—pragmatic and empirical disputations) to reduce catastrophic interpretation and evaluation of her physiological symptoms, and a distraction technique to help her manage her distress when in the triggering situation (mostly before going to work). A significant beneficial effect was obtained after the cognitive restructuring of her beliefs that: “Having physical symptoms
meant I am weak”, and “I must be perfect, otherwise I cannot stand it”. Systematic desensitization was also used to eliminate her agoraphobic avoidance.

- For improving her deficient social and communication skills, we used assertiveness training and social skill training.

- Her binge eating reduced considerably after starting to restructure the LFT (low frustration tolerance). No extra techniques were necessary; some overeating is still present in response to stressful situations. More effort is put into planning her eating habits.

- REBT (cognitive restructuring, rational-emotive imagery, role-play, modeling, and behavioral experiments) was also used to restructure irrational beliefs and other distorted cognitions underlying panic, depression, and guilt and to help her learn unconditional self-acceptance. Also, a broader understanding of emotion regulation strategies was promoted based on the ABC model.

- Behavioral analysis was used to develop an understanding of the causes of maladaptive behaviors and role-play and behavioral experiments help organize adaptive behaviors and build conflict management skills.

The therapeutic relationship was generally good with a few exceptions. First, Maria tried to manipulate the therapist into changing the agenda too often, by presenting different “emergencies” that had to be dealt with. Since this frequently happened at homework checkup time, the therapist decided to address Maria’s need for control and decision over the content, duration, and purpose of each task. After some guidelines were established that provided Maria with control over homework, the situation improved.

Several techniques and strategies were used to help achieve the therapeutic objectives.

- Cognitive restructuring—challenging and restructuring maladaptive beliefs—core beliefs, automatic thoughts, and irrational beliefs using Bible verses. For instance, to dispute God’s conditional love and acceptance, Maria was asked to meditate on and explain verses like Romans 5:8 “But God commendeth his love toward us, in that, while we were yet sinners, Christ died for us”—pointing out the difference between a sinful behavior and a sinful, unworthy person. Also, when approaching core beliefs like abandonment and emotional deprivation, some verses can help partly cover the unmet childhood need: Romans 8:38–39 “For I am persuaded, that neither death, nor life, nor angels, nor principalities, nor powers, nor things present, nor things to come/Nor height, nor depth, nor any other creature, shall be able to separate us from the love of God, which is in Christ Jesus our Lord (Holy Bible, KJV).

- Behavioral experiments—shame–attacking exercises, in which Maria chose to engage publicly in shameful behavior, were used to (1) expose her to criticism and (2) build tolerance for social rejection. Further discussion about the human value beyond social recognition also revolved around Bible verses. Fasting, as a religious behavior, was used as a means to consolidate frustration tolerance, experience and understand the distress and help control binge eating as a form of coping.
• Prayer and meditation on God’s word were employed (1) to help articulate Maria’s religious worldview, (2) as a vehicle for remembering and rehearsing useful ways of thinking and behaving, and (3) rehearse and consolidate rational beliefs.

• Rational-emotive imagery was used for changing emotions and coping with distress. Vivid images, including walking and talking with Jesus helped restructure cognitions and rehearse adaptive behaviors. Major distortions in Maria’s fantasies were used to identify irrational beliefs (e.g., Jesus would tell me to go away because I am weak”). This technique also helped create detailed scenarios of rational thoughts and adaptive behaviors that Maria was able to rehearse. Some of the early maladaptive schemas were approached by having Maria imagine Jesus responding to her mother’s actions when Maria was a baby.

• Modeling and skill training helped in acquiring and using new social and communication skills and managing conflict. Maria observed people she appreciated (e.g., spiritual leaders) handle social interactions and conflict and took notes about their responses. Later on, she took on the role of a teacher for younger people in her prayer group, to demonstrate proper social skills (like Jesus did for us).

All techniques and strategies used were introduced taking into consideration Maria’s need to be successful and her difficulties in managing failure. They were initially discussed and demonstrated and rehearsed with the therapist until Maria was confident, she can be successful on her own.

The main obstacle was Maria’s resistance to structured homework and a structured approach to therapy. She always preferred to have some control over the strategy used and work in therapy (while supervised and helped by her therapist) and kept coming up with reasons to justify why she could not do the homework. Fragmenting tasks, reducing their difficulty and extent, and reinforcing even the slightest success, combined with carefully selected choices offered to her to validate her need for control helped, but this was an ongoing problem.

The intervention was extended over 40 sessions, once a week for 50 minutes. The main results concern the complete remission of panic attacks and avoidance. Maria is now able to go to work and has not had a panic attack for more than 6 months. Also, she has experienced less and less depression and there is an important reduction in binge eating (although she still overeats). After Maria stopped throwing things away her relationship with her brothers improved significantly, helped by the newly acquired communication skills.

Her religious worldview is more articulated than before and she is able to recognize the instances when her immediate needs take precedence over her relationship with God and over broader religious principles.

On the other hand, she still has quite severe feelings of sadness and depression, low unconditional self-acceptance, and has not succeeded in making new social relations.

In conclusion, in Maria’s case, it was vital that the psychological intervention integrated the REBT intervention strategies with her Christian beliefs and practices since Maria’s worldview was built around her religious life. This was an organic development given that the REBT’s central assumptions and the philosophy behind the client’s religious system were already highly compatible. Moreover, it was obvious from the beginning that a lot of religious components were overlooked by our client and many of them were badly distorted and misrepresented. Under these circumstances, it was relatively easy to correct them while
restructuring irrational beliefs. Also, Maria was very responsive to discussing and analyzing religious material; this enabled us to formulate rational alternatives extracted from religious writings, as well as from the oral religious tradition. Maria’s case aptly illustrated the many ways in which REBT can incorporate religious beliefs and practices, thus advocating for the harmonious relationship between Christian values and REBT.
References


[7] Nisbett RE, Wilson TD. Telling more than we can know: Verbal reports on, 1977


[17] Lazarus AA, Ellis A. Can rational emotive behavior therapy (REBT) be effectively used with people who have devout beliefs in god and religion. In: Carlson J, Knaus W, editors. 2014. pp. 269-279


