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RATIONAL EMOTIVE BEHAVIOUR THERAPY FEATURES ON INTRINSICALLY RELIGIOUSLY ORIENTED PEOPLE

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Abstract
The interest in studying the implications of religion on mental health has increased lately, but the complexity of this relationship is not sufficiently elucidated. The purpose of this comparative study is to investigate the effectiveness of two versions of REBT in relieving emotional distress of intrinsically motivated religious people: 8 sessions of standard REBT intervention and 8 sessions of religiously oriented REBT intervention. A group of 52 students of Emmanuel Christian University of Oradea received 3 weeks of REBT intervention as follows: 3 weeks of standard REBT (n = 19), 3 weeks of religiously oriented REBT (n = 18) and a control group without therapeutic intervention (n = 15). Study results show similar efficacy of standard REBT and religiously oriented REBT in relieving emotional distress. Irrational cognitions underlying depressive and anxiety symptoms, as well as those of anger and stress have been modified as a result of our proposed interventions. Given the implications of religion in relation to mental health professionals should pay more attention to spiritual / religious resources of their customers and to offer psychotherapeutic methods which act to incorporate these resources into psychotherapy.

Keywords: intrinsic religiosity, irrational cognitions, emotional distress, psychotherapy

Introduction

In the specialty literature we have little information about the group activities based on REBT theory and practice. At the same time, there are few

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studies that refer to combination of REBT theory with religious practices and ideas on young people (pupils, students). It is worth mentioning that the religious phenomenon is part of the personality attitude formations which are crystallised only at certain levels of maturity. During adolescence an increase of childhood religious concerns is noticed (Levenson, Aldwin, & D'Mello, 2005). Spilka, Hood, Hunsberger, and Gorsuch, 2003 (as cited in Paloutzian & Park, 2005) identified the highest frequency of religious behaviour (Bible reading, church attendance, prayer practice) around the age of 30. The respondents of this study reported higher levels of religiosity around the age of 20 years, a phenomenon reduced the age of 40 years. This study invalidates the general common information that religiosity would increase with age.

Religiosity can also be defined in terms of underlying reasons for the religiously led behaviour (Ysseldyk, Matheson, & Anisman, 2011). A variety of factors entail people to act. Motivation is the extent to which a persistent effort is directed to an effect (Bonchiş, 2006). The source of human motivation can be placed inside or outside the person, but Radu (1991) believes that the source of action must be sought rather in the interaction between the individual and the environment. When the motivation source is located inside the individual, we talk about intrinsic motivation and when motivation source is outside we talk about extrinsic motivation. As specialty literature listed multiple forms of religiosity with their implications, we are interested in Allport and Ross (1967) distinction brought about in 1967 in terms of religious orientation, distinguishing between intrinsic religious and extrinsic religious orientation. The term *religious orientation* is a multidimensional construct. Religious orientation is the general bias of the individual towards acting in terms of religion to achieve some purpose. These purposes are not oriented towards the individual, but are rather spiritual goals (Pargament, Orsen, Reilly, Falgout, Ensing, & Haitsma, 1992).

Intrinsic religious orientation refers to a general bias of the person towards thinking and acting in accordance with religious principles, which are considered the primary reasons of existence, religion providing a framework to interpret reality data (Parck, Cohen, & Herb, 1990). Intrinsic religious orientation is defined as an internal dimension / construct that goes beyond economic and social needs, this definition making reference to what we call spirituality. Intrinsically oriented religious people have religion as a central principle in their lives building their existence from its view. They are seeking

to incorporate religion into all aspects of their lives (Barrett & Roesch, 2009). Extrinsic religious orientation involves an instrumental approach of the religious phenomenon, the person being motivated by acquiring comfort and adherence to social conventions (Donahue, 1985). *Intrinsic / extrinsic* concepts are closely related to motivation theories and to general motivation cognitive theories. Seen in terms of cognitive theories motivation is a cognitive representation of future states. Studies conducted on young people (students) show a better adjustment of intrinsically religiously oriented students, optimism, positive self-appreciation, internal locus of control, a better perception of self efficacy, better social skills and fewer antisocial behaviours (Kneipp, Kelly, & Dubois, 2011). Intrinsic religious orientation advantages were pointed out by Bergin, Masters, and Richards (1987) who have suggested that religious intrinsicness is positively related to traits such as sociability, responsibility, social maturity, ability to create a favourable impression, intellectual efficiency. In the same study, extrinsic religious orientation was negatively associated with sociability, responsibility and tolerance, the ability to create a favourable impression, intellectual efficiency, qualities that underlie a status.

Rigorous scientific approaches that explain the effects of religion on mental health are quite recent. Although there are many views that highlight the potential of religion on mental health, at the present time this relationship is not fully studied and elucidated. There is no question of therapeutic protocols and guidelines of good practice in this field yet, given the insufficient study of religious phenomenon in relation to health and mental illness. Although frequently met, the religious phenomenon is not universal and it involves many subjective transcultural and transpersonal aspects. The issue of positive or negative impact of religiosity on mental health still remains; intervention programs that include religious elements were not sufficiently scientifically validated and there is not objective enough methodology to study the relationship between religion and mental health or illness because of these multifaceted phenomena.

Objectives

The objectives of this research aim at studying the relationship between religiosity and mental health in terms of cognitive-behavioural model, specifically relying on the ideas and principles of REBT in conjunction with

elements of Christianity. We aim to highlight the effectiveness of REBT on religious participants, combining the therapeutic principles of standard REBT with scriptural techniques. We study the religious phenomenon based on intrinsic and extrinsic religious orientation dichotomy, which was discussed above. Present research is based on a mixed experimental design; participants were randomly placed in one of the experimental groups: participants who attended group therapy activities based on the standard REBT principles, subjects who attended therapeutic group activities based on REBT principles in combination with religious elements and a control group, where we did not intervene. Measurements were conducted ex-ante and ex-post. The present study was conducted during April / May 2011, being a preliminary stage of participants' term assessment (exams session) with the purpose of the preventing emergence of distress.

We aim to highlight aspects of the mental health and religious relationship on the Romanian population, given the particularities of the religious phenomenon depending on cultural context. In Romania we have few studies in this direction of research.

By this research we intend to make a contribution to the impact of standard REBT and with religious elements on relieving distress.

Method

Participants

The participants in this study are Emanuel University of Oradea Christian students of the average age of 20.63 years (SD=1.06). Emanuel University of Oradea Admission is subject to candidates' official membership in a church. This membership is possible due to the personal decision to join the protestant doctrine. The total number of participants was 52 (N=52), distributed by gender as follows: 4 male and 48 female participants. Participants are in the 1st and 2nd year of the study, in the social work specialization. All students were intrinsically religiously oriented. Detection of religious motivation of the participants was done with Allport-Ross religious orientation Scale; median scores on each of the two subscales (method Hood, 1970 as cited in Donahue, 1985) was calculated. Participants above the median values in intrinsic religiosity and below the median values in extrinsic

religiosity as were considered intrinsic religiously oriented participants. Participants above the median values in extrinsic religiosity and below the median values in intrinsic religiosity as were considered extrinsic religiously oriented participants. The median value in our sample for intrinsic religiosity subscale was 41.00 and for extrinsic religiosity scale was 21.50. All participants are high school graduates. 37 (35.6%) of the participants belong to the Baptist doctrine, 14 participants (13.5%) belong to Pentecostal doctrine and one participant (1%) belongs to the Christian by gospel doctrine. Participants in the study are not married. The sample of participants who received standard REBT intervention included a number of 19 students, the sample of participants who benefited from REBT with religious elements included a number of 18 students, and the control group included 15 students. All participants were assessed before and at the end of the study, in ex-ante and ex-post conditions. Participation in the study was done on a voluntary basis.

Instruments and working techniques

Ross Allport Scale measures religious orientation, intrinsic vs. extrinsic; it is a self-report scale, made of 21 items; the first nine items correspond to intrinsic religious orientation subscale, the last 11 items correspond to extrinsic religious orientation subscale. Internal consistency of items for Intrinsic Alpha Cronbach subscale is .80, and for Extrinsic Alpha Cronbach scale is .70 (Hill & Hood, 1999). The scale allows discrimination between intrinsic and extrinsic religiously oriented people, between indiscriminate proreligious and indiscriminate antireligious people.

Beck Depression Scale (BDI) (Beck, Ward, Mendelson, & Mock, Erbaugh, 1961) is an instrument for measuring symptoms of depression in adults, comprising 21 items. Alpha Cronbach internal consistency is .81 for nonpsychiatric population and the test-retest validity is between r=.60 and r=.90). It was also reported good discriminative validity between psychiatric and nonpsychiatric population from the scale. The Romanian population has very good psychometric properties (Alpha Cronbach coefficient=.84), being sensitive to clinical change (David, Szentagotai, Lupu, & Cosman, 2008).

Automatic thoughts questionnaire (ATQ) (Hollon & Kendall, 1980) includes 30 items to assess the frequency of occurrence of thoughts relevant to dysfunctional thinking, with good psychometric properties (Szentagotai & Freeman, 2007). A high ATQ score indicates a high level of dysfunctional

automatic and irrational thoughts, and a low ATQ score indicates a low level of dysfunctional automatic and irrational thoughts.

Emotional distress profile (EDP) is a scale comprising 26 items that measure dysfunctional negative emotions and functional negative emotions from the "fear" and "sadness / depression" categories. The scale was proposed by Opriş and Macavei (David, 2006), with good psychometric properties for the Romanian population.

General Attitudes and Beliefs Scale-Short Form (GABS-SF) (Lindner, Kirkby, Wertheim, & Birch, 1999). Short form GABS is a Likert type scale consisting of 26 items that measure cognitive processes (e.g., "must", catastrophic overall assessment, low tolerance to frustration). Items refer both to rational irrational cognitions. Three scores can be calculated as a result of the scale: 1) a score of irrational beliefs, 2) a rational belief score and 3) a total score of irrational beliefs (composed of irrational beliefs score plus the reversed rational beliefs score). High scores indicate high levels of rational or irrational beliefs. Good psychometric properties of the scale have been reported in the literature (Lindner et al., 1999). The scale has good psychometric properties for the people of Romania as well (Alpha Cronbach score = .81).

Anger as status or as trait scale (Spielberger, 1983). It is an instrument with 30 items that measure anger as emotional state varying in intensity as well as the anger as tension, annoyance, irritation. Anger as a trait refers to how often the respondent feels angry over time. A person who is characterized by anger that trait will be tempted to perceive more situations as triggers of anger. The distinction between anger and hostility can be drawn. The instruments were built based on rigorous psychometric procedures, including the construction of long and short forms that strongly correlated with scores ranging from .95 for anger as trait to .99 for anger as a state.

Treatments

Therapeutic activities were organized in biweekly sessions and designed for lasting about 1.30 hours. Overall, each of the two groups received 8 sessions, the first and last meeting being aimed to pre-test respectively to post-test. The tests were conducted by a social worker, based on an initial training, who coordinated the pre-testing and post-testing voluntarily. The decision to elect six intervention sessions was based on studying the therapeutic success recorded by earlier researches with the same number of meetings

(Johnson & Riddley, 1992). The researcher was the leader of each group where therapeutical intervention was undertaken.

Construction of therapeutic groups respected the recommendations proposed by David (2006) (number of participants, characteristics of participants in the intervention group, the specific of the group).

a. Standard Rational Emotive and Behaviour Therapy experimental condition

Therapeutic activities were based on the *Guide and Rational and Behavioural Emotive Psychotherapy Clinical Protocol* proposed by David (2007). After the participants signed the informed consent, their confidentiality being guaranteed, ABCDE model (cognitive conceptualization) was discussed; goals of therapeutic activities were discussed with students. Therapeutic activities focused on the disputed irrational cognitions. The presence of these cognitions was questioned by direct questions addressed to the student, such as: "Is it intolerable that you have to study more hours a day?", "Must you get a 10?". Cognitive restructuring were also the purpose of homework, the participants being encouraged to read standardized rational statements focused on improving dysfunctional thoughts. These statements have been called "psychological pills". The instructions for homework were: "read the following statements whenever you feel intense, negative, annoying emotions". These psychological pills, proposed by David (2007) aim to relieve anger, depression and fear by changing irrational thoughts. Also, participants were encouraged to read between sessions informative materials from *Rational Emotive and Behaviour Therapy Guide* proposed by Dryden and DiGiuseppe (2003).

b. Rational Emotive and Behavioural Therapy experimental condition with scriptural techniques

Therapeutic activities conducted in this experimental condition observed the instructions given in the *Guide and Rational and Behavioural Emotive Psychotherapy Clinical Protocol* proposed by David (2007), to which scriptural elements as biblical texts reading and as rational prayer learning were added. The sacred texts were chosen for disputing irrational cognitions; in the Bible there are texts that can be applied to specific irrational cognitions. The pattern of rational prayer, based on ABC model, proposed by Ellis in the conceptualization of customer issues, was discussed in the theoretical framework of this paper. Research to date has highlighted the positive impact

of prayer and of sacred texts in cognitive restructuring (Tan, 2007). Participants read statements with rational content in the so-called "psychological pills", which relieve their distress by combining REBT principles with principles of Christian doctrine from Biblical texts. Between sessions participants were encouraged to read the Bible verses which would dispute their irrational cognitions, using the same instructions as for the previous group.

In both experimental conditions monitoring data sheet were used of ABCD cognitive model (David, 2007). These were introduced to facilitate ABCD model learning and to facilitate its practice outside the context of the intervention group.

Results and interpretation

Data were processed using SPSS program. Next we present the statistical results obtained in ex-ante and ex-post stages.

We verified sample homogeneity in ex-ante stage in order to eliminate errors due to sampling, using univariate analysis of variance.

Table 1. Average, standard deviations and univariate analysis of variance for automatic thoughts, rationality and irrationality in ex-ante stage

Measured variable	Group	N	m	SD	F	Sig.
Automatic thoughts	REBT std.	19	30.84	6.80	2.52	.09
	REBT relig.	18	31.22	5.82		
	Control	15	20.73	6.13		
Irrationality GABS	REBT std.	19	17.05	3.02	2.20	.12
	REBT relig.	18	16.72	1.87		
	Control	15	15.33	2.31		
Rationality GABS	REBT std.	19	14.10	2.99	.05	.95
	REBT relig.	18	13.88	2.98		
	Control	15	14.20	2.80		

The average recorded by participants included in the three experimental groups for automatic thoughts and variables rationality/ irrationality have similar values. Also, the analysis of the above table indicates that there are no significant differences in terms of automatic thoughts and rationality/ irrationality between participants of three experimental groups in ex-ante stage.

Thresholds of significance associated to $F_{omnibus}$ test indicate groups' homogeneity.

Next we checked the effectiveness of interventions proposed by us in ex-post stage for the three experimental groups. Effect size and statistical power were calculated using G*Power program.

Table 2. Average, standard deviations and univariate analysis of variance for automatic thoughts, rationality and irrationality in ex-post stage

Measured variable	Group	N	m	SD	F	Sig.	E.S.	S.P.
Automatic thoughts	REBT std.	19	22.57	4.22	3.27	.04	.365	.951
	REBT relig.	18	21.22	3.40				
	Control	15	25.46	6.63				
Irationality GABS	REBT std.	19	9.94	2.09	5.78	.00	.485	.998
	REBT relig.	18	11.11	2.24				
	Control	15	12.93	3.30				
Rationality GABS	REBT std.	19	15.15	2.19	3.89	.02	.398	.979
	REBT relig.	18	15.55	2.33				
	Control	15	13.33	2.71				

Note: *Effect size (f): 0.1=low, 0.25= average, 0.4= high (Cohen); E.S. = Effect size; S.P. = Statistical power

In ex-post the values of the average of the two groups of students under therapeutic intervention were relatively close, differing significantly from the control group average. There is a general trend that the averages be slightly lower in the group of religious students who received REBT with religious elements intervention.

The value $F(2; 49)=3.271$, $p<.05$ obtained for automatic thoughts indicates statistically significant differences in the ex-post phase. Statistical power of 0951 is considered high. To investigate the location of these differences we used the post-hoc tests. Relating the results to the control group we obtained no significant differences between the group that received standard REBT (Gabriel=-2.88, p=.23); still we obtained significant differences for REBT group with religious elements (Gabriel=-4.24, p>.04). There is a tendency that relating to religious participants REBT with religious elements intervention to be recommended; this is due to the significantly different

changes compared to the control group achieved in the improvement of automatic thoughts, which was not observed in the group that received standard REBT.

Concerning *irrationality* item, therapeutic intervention was effective in relieving it (F(2; 49)=5.78, p=.01). The calculated statistical power of 0.998 indicates a high value. To see how differences occur between samples taken by us in study, we used the post hoc procedures. Results of comparisons between participants who received standard REBT and control group (Gabriel=-2.98, p=.00) indicate significant differences between the two samples. Comparing the results of the group with REBT with religious elements intervention to the control group (Gabriel=-1.82, p>.13) we obtained significant differences.

Cognitive behavioural interventions proposed by us were effective in terms of increasing rationality of religious people (F(2; 49)=3.89, p>.02). Christian philosophy is consistent with the meanings that the notion of rationality has in the view of REBT. Statistical power of 0.979 indicates a high value. We proceeded to specific highlight of differences between the three samples subsequent to the intervention of post-hoc using the procedures. The results indicate no significant differences in increasing rationality on the group with standard REBT intervention compared to control group (Gabriel=1.82, p>.09). People who have benefited from REBT with religious elements have achieved significant increases in size compared to control group results (Gabriel=2.22, p>.03). Our proposed interventions have led to an increase in rationality at religious students, with a higher efficacy of religiously oriented REBT. It is possible that religiously oriented REBT to be the gold standard in increasing rationality of beneficiaries of this type of intervention; the concept of, "rationality" is the attribute of this approach. Post hoc comparisons between the two groups with intervention revealed no significant differences for automatic thoughts (Gabriel=1.35, p=.77), for irrationality item (Gabriel=1.16, p>.42) and for rationality item (Gabriel=.9, p>.94).

Table 3. Average, standard deviations and univariate analysis of variance for irrational cognitions in ex-ante stage

Measured variable	Group	N	m	SD	F	Sig.
Overall assessment of self-worth	REBT std.	19	10.47	2.98	.59	.55
	REBT relig.	18	10.38	2.83		
	Control	15	9.53	2.09		

Table 3. Average, standard deviations and univariate analysis of variance for irrational cognitions in ex-ante stage - *continued*

Measured variable	Group	N	m	SD	F	Sig.
Need for achievement	REBT std.	19	13.52	3.58	3.13	.052
	REBT relig.	18	12.72	2.86		
	Control	15	11.06	1.53		
Need for approval	REBT std.	19	8.36	1.77	.59	.55
	REBT relig.	18	9.22	2.39		
	Control	15	8.66	2.60		
Need for comfort	REBT std.	19	13.42	2.91	3.13	.052
	REBT relig.	18	11.55	2.97		
	Control	15	11.06	2.96		
Absolutist requirement of justice	REBT std.	19	13.15	2.69	2.93	.06
	REBT relig.	18	13.50	3.07		
	Control	15	11.40	1.84		
Overall assessment of other	REBT std.	19	7.73	1.82	.54	.58
	REBT relig.	18	8.38	1.91		
	Control	15	7.73	2.73		

The average recorded on participants included in the three experimental groups for irrational cognitions had similar values. At the same time, our analysis of the above table indicates that there are no significant differences in terms of irrational cognitions between participants from the three experimental groups, thus highlighting the homogeneity of groups.

Table 4. Average, standard deviations and univariate analysis of variance for irrational cognitions in ex-post stage

Measured variable	Group	N	m	SD	F	Sig.	E.S.	S.P.
Overall assessment of self-worth	REBT std.	19	6.73	1.75	13.13	.00	.732	.999
	REBT relig.	18	7.83	2.38				
	Control	15	10.33	1.98				
Need for achievement	REBT std.	19	8.36	2.29	8.51	.00	.589	.998
	REBT relig.	18	7.44	1.97				
	Control	15	10.53	2.26				
Need for approval	REBT std.	19	5.05	2.06	17.92	.00	.855	1
	REBT relig.	18	5.38	2.40				
	Control	15	9.40	2.41				

Table 4. Average, standard deviations and univariate analysis of variance for irrational cognitions in ex-post stage - *continued*

Measured variable	Group	N	m	SD	F	Sig.	E.S.	S.P.
Need for comfort	REBT std.	19	7.05	1.80	20.85	.00	.921	.1
	REBT relig.	18	6.11	1.60				
	Control	15	10.66	2.87				
Absolutist requirement of justice	REBT std.	19	7.26	1.82	14.70	.00	.774	.999
	REBT relig.	18	7.16	1.85				
	Control	15	10.80	2.80				
Overall assessment of other	REBT std.	19	5.57	2.14	8.43	.00	.586	.998
	REBT relig.	18	6.05	2.07				
	Control	15	8.66	2.71				

Note: *Effect size (f): 0.1=low, 0.25= average, 0.4= high (Cohen); E.S. = Effect size; S.P. = Statistical power

According to REBT principles, irrational cognitions are the cause of psycho-emotional distress. On the other hand scriptural texts promote the concept of "metanoia", which means change of mind. Irrational cognitions have changed as a result of our proposed interventions.

The values obtained for "overall assessment of self-worth" ($F(2; 49)=13.13$, $p=.00$) indicate the effectiveness of interventions in changing this cognition, with statistically significant differences between the three samples in the ex-post stage. Statistical power of .999 is considered to be high. To investigate the location of these differences we used the post-hoc tests. The results of participants who received standard REBT (Gabriel=-3.59, p=.00) and of those who have benefited from REBT with religious elements (Gabriel=-2.50, p>.00) are significantly different from those of participants in group of control.

The cognition "need for achievement" has changed significantly as a result of the new interventions proposed ($F(2; 49)=8.51$, $p=.00$). Statistical power of 0998 is considered to be high. To locate the differences obtained, we used the post-hoc tests. The results of participants who received standard REBT (Gabriel=-2.16, p>.01) and of those who received religiously oriented REBT (Gabriel=-3.08, p>.00) are significantly different from control group participants.

The cognition "need for approval" has changed significantly as a result of our proposed interventions ($F(2; 49)=17.92$, $p=.00$), the values obtained

indicating the existence of significant differences between the three samples in the ex-post stage. Statistical power of 1 is considered to be high. Next, to locate the differences we obtained we resorted to post-hoc tests. The results of participants who received standard REBT (Gabriel=-4.34, p=.00) and participants who have benefited from REBT with scriptural elements (Gabriel=-4.01, p>.00) are significantly different from those of participants in group of control.

The values obtained for "need of comfort" (F(2; 49)=20.85, p=.00) indicate the effectiveness of interventions in changing this cognition, with statistically significant differences between the three samples in the ex-post stage. Statistical power of 1 is considered to be high. To investigate the location of these differences we used the post-hoc tests. The comparisons of results between participants in the control group and those in the group who received standard REBT (Gabriel=-3.61, p>.00) and religiously oriented REBT (Gabriel=-4.55, p>.00) indicate significant differences.

The cognition "absolutist requirement of justice" has changed significantly as a result of our proposed interventions (F(2; 49)=14.70, p=.00), the values obtained indicating the existence of significant differences between the three samples in the ex-post stage. Statistical power of 0.499 is considered to be high. Next, to locate the differences obtained we resorted to post-hoc tests. The results of participants who received standard REBT (Gabriel=-3.53, p=.00) and REBT with scriptural elements (Gabriel=-3.63, p=.00) are significantly different from control group participants.

The cognition "overall assessment of other" has changed significantly as a result of our proposed interventions (F(2; 49)=8.43, p=.00), the values obtained indicating the existence of significant differences between the three samples in the ex-post phase. Statistical power of 0.998 is considered to be high. Next, to locate the differences obtained we resorted to post-hoc test. The results of participants who received standard REBT (Gabriel=-3.08, p<.00) and REBT with scriptural elements (Gabriel=-2.61, p=.00) are significantly different from the results in the control group.

Comparing the results of participants who received the standard REBT to those who benefited from religiously oriented REBT no significant differences are obtained regarding automatic thoughts (Gabriel=1.09, p>.29); for the cognition "need for achievement" (Gabriel=-.92, p>.48); for the cognition "need for approval" (Gabriel=-.33, p>.95); for the cognition "need of

comfort" (Gabriel=-.94, p>.44); for the cognition "absolutist requirement of justice" (Gabriel=-.09, p>.99); for the cognition "overall assessment of other" (Gabriel=-.47, p>.89).

Table 5. Average, standard deviations and univariate analysis of affective variance in ex-ante stage

Measured variable	Group	N	m	SD	F	Sig.
Depression	REBT std.	19	13.10	3.22	2.93	.06
	REBT relig.	18	13.33	2.58		
	Control	15	11.20	2.14		
Anxiety state	REBT std.	19	27.63	7.79	.14	.86
	REBT relig.	18	26.94	6.11		
	Control	15	26.00	4.53		
Anxiety trait	REBT std.	19	29.15	7.98	.69	.50
	REBT relig.	18	26.77	4.64		
	Control	15	28.26	5.00		
Affective distress	REBT std.	19	53.84	12.41	1.81	.17
	REBT relig.	18	52.61	12.48		
	Control	15	46.73	7.88		
Functional sadness	REBT std.	19	12.84	3.13	3.16	.051
	REBT relig.	18	12.94	2.50		
	Control	15	10.80	2.36		
Functional fear	REBT std.	19	12.73	2.28	2.96	.06
	REBT relig.	18	12.38	2.17		
	Control	15	11.00	1.92		
Dysfunctional sadness	REBT std.	19	16.31	3.78	.44	.64
	REBT relig.	18	15.33	2.93		
	Control	15	15.60	2.94		
Dysfunctional fear	REBT std.	19	13.78	3.27	2.02	.14
	REBT relig.	18	13.27	2.53		
	Control	15	11.86	2.50		
Stress	REBT std.	19	69.73	14.24	.82	.44
	REBT relig.	18	66.00	13.86		
	Control	15	72.60	16.66		
Anger	REBT std.	19	99.04	12.56	.74	.48
	REBT relig.	18	100.77	14.28		
	Control	15	105.46	14.84		

Average recorded by participants included in the three experimental groups for affective variables (distress) studied by us have similar values. The thresholds of significance associated to the test indicate groups homogeneity in

terms of the variables studied. From the above table analysis we conclude that there are no significant differences in terms of distress (depression, anxiety, self-perceived stress, anger, distress (functional and dysfunctional fear and anger) between the participants in the three experimental groups.

Table 6. Average, standard deviations and univariate analysis of affective variance in ex-post stage

Measured variable	Group	N	m	SD	F	Sig.	E.S.	S.P.
Depression	REBT std.	19	8.00	2.56	8.70	.00	.596	.466
	REBT relig.	18	7.38	1.78				
	Control	15	10.60	2.52				
Anxiety state	REBT std.	19	22.42	4.41	3.68	.03	.387	.874
	REBT relig.	18	22.44	4.81				
	Control	15	26.80	6.59				
Anxiety trait	REBT std.	19	24.36	5.10	6.24	.00	.505	.987
	REBT relig.	18	22.61	4.14				
	Control	15	28.53	5.38				
Affective distress	REBT std.	19	37.78	8.59	11.93	.00	.697	.987
	REBT relig.	18	34.83	4.65				
	Control	15	46.53	7.25				
Functional sadness	REBT std.	19	9.00	1.89	4.87	.01	.445	.953
	REBTrelig.	18	8.22	4.76				
	Control	15	10.46	2.21				
Functional fear	REBT std.	19	9.78	2.69	3.71	.03	.389	.877
	REBT relig.	18	9.27	1.96				
	Control	15	11.33	1.79				
Dysfunctional sadness	REBT std.	19	10.63	2.94	25.71	.00	1.02	1
	REBT relig.	18	9.38	2.09				
	Control	15	15.86	3.04				
Dysfunctional fear	REBT std.	19	7.89	2.20	21.32	.00	.932	.1
	REBT relig.	18	7.38	1.19				
	Control	15	11.53	2.32				
Stress	REBT std.	19	57.68	16.73	15.31	.00	.790	.999
	REBT relig.	18	49.88	12.18				
	Control	15	76.60	12.36				
Anger	REBT std.	19	92.10	10.86	3.51	.03	.378	.856
	REBT relig.	18	91.00	12.70				
	Control	15	102.2	16.30				

Note: *Effect size (f): 0.1=low, 0.25= average, 0.4= high (Cohen); E.S. = Effect size; S.P.= Statistical power

REBT type interventions resulted in lowering depressive symptoms measured with the BDI. Participants in our sample, intrinsically motivated religious students, had the pre-test depression level commensurate with subclinical depression. The averages recorded on participants from the two experimental groups on which therapeutic intervention was undertaken were relatively close. Recorded values ($F(2; 49)=8.70$, $p=.00$) indicate the effectiveness of interventions in relieving depressive symptoms. Statistical power of 0.466 shows a moderate value. Participants who received standard REBT (Gabriel=2.60, $p=.00$) and religiously oriented REBT (Gabriel=-3.21, $p=.00$) obtained significantly lower results compared to the control group.

Anxiety as state and as trait has changed significantly as a result of our proposed interventions. Standard REBT and religiously oriented REBT interventions led to relieving anxiety as a state $F(2; 49)=3.68$, $p>.03$) and as trait $F(2; 49)=6.24$, $p=.00$). If the variation of anxiety as state can be determined by other factors as well, given the natural mobility of affective processes, anxiety as trait involves more stability, its variation being determined by specific interventions in improving dysfunctional negative emotions of anxious type. 0.874 and 0.987 values indicate high statistical power for both cases. For a specific analysis of the differences obtained in terms of anxiety as a state and as a trait in the context of the three samples we used the post hoc procedures. Comparing the results of the group that received standard REBT with the results of the control group we noticed that there are not significant differences relating to anxiety as a state (Gabriel=-4.37, $p>.05$), but we have significant differences when we talk about anxiety as trait (Gabriel=-4.16, $p>.04$). Compared to the control group, the results of participants who received REBT with scriptural elements show no differences relating to anxiety as a state (Gabriel=-4.35, $p>.06$), but there are significant differences when we refer to anxiety as trait (Gabriel=-1.70, $p=.00$). When comparing the results between the two samples on which standard REBT and religiously oriented REBT therapeutic intervention was undertaken no significant differences in anxiety as a state (Gabriel=1.72, $p=.1$) or in anxiety as a trait (Gabriel=1.60, $p=.62$) were obtained.

Emotional distress has changed significantly as a result of our interventions ($F(2; 49)=11.93$, $p=.00$). Statistical power of 0.987 indicates a high value. The results of comparison between the samples of participants who

received standard REBT (Gabriel=8.74, p= 00) and religiously oriented REBT (Gabriel=-11.70, p=.00) and the control group indicate significant differences.

Standard and religiously oriented REBT interventions were efficient in changing functional and dysfunctional negative emotions. Our proposed interventions led to changes in functional sadness (F(2; 49)=4.87, p=.01) and functional fear (F(2; 49)=3.71, p>.03). Statistical power of 0.953 for functional sadness and 0.877 for functional fear indicate high values. To specifically locate the differences recorded between the groups of participants we used the post-hoc procedures. Comparing the results of the group that received standard REBT intervention with the control group we obtained no significant differences (Gabriel=-1.46, p=.12) for functional sadness and functional fear (Gabriel=-1.54, p>.14). Results of the group that benefited from religiously oriented REBT (Gabriel=-2.24, p=.01) were significantly different compared with those of the control group for functional sadness and functional fear (Gabriel=-2.05, p>.03). In terms of comparing the results of the two groups on which therapeutic intervention was undertaken there are no significant differences in what concerns functional sadness (Gabriel=-.77, p=.58) and functional fear (Gabriel=-.51, p=.86).

Our proposed interventions have led to changes in dysfunctional negative emotions such as dysfunctional sadness (likely to transform relatively easy into depression) (F(2; 49)=25.71, p=.00) and dysfunctional fear (F(2; 49)=21.32, p=.00). Statistical power of 1 for dysfunctional fear and of 1 for dysfunctional sadness indicate high values.

Comparisons between the beneficiaries of standard REBT intervention and control group indicate significant differences regarding dysfunctional sadness (Gabriel=-5.23, p=.00) and regarding dysfunctional fear (Games-Howell=-3.63, p=.00). Comparisons between the beneficiaries of religiously oriented REBT and control group show significant differences for dysfunctional sadness (Gabriel=-6.47, p=.01) and for dysfunctional fear (Gabriel=-4.14, p=.00). Comparing the results of the two groups where therapeutic intervention was undertaken do not show significant differences in terms of dysfunctional sadness (Gabriel=-.77, p=.58) and dysfunctional fear (Gabriel=-.50, p>.66).

Self-perceived stress level changed significantly as a result of cognitive behavioural interventions of REBT type (F(2; 49)=15.31, p=.00). Statistical power of 0.999 indicates a high value. To specifically analyze changes occurred

in terms of stress relief we resorted to post-hoc comparisons. The results of comparison between the control group and those who received standard REBT (Gabriel=-18.91, p=.00) and religiously oriented REBT (Gabriel=-26.71, p=.00) indicate significant differences. Religiously oriented REBT interventions have a similar impact by comparison with the control group.

As a result of the interventions applied by us, the anger of people who benefited from the intervention was significantly reduced compared to those from the control group F(2; 59)=3.51, p>.03. Statistical power of 0.749 indicates a high value. Wanting to see how the three groups differ, we used the post-hoc methods. There are no significant changes in terms of anger among participants who followed standard REBT (Gabriel=-10.16, p>.08) and religiously oriented REBT (Gabriel=11.26, p>.05) and participants in the control group. There is a tendency towards a better relieving of anger of those who received group therapy on the religiously oriented REBT protocol compared to the other group on which therapeutic intervention was undertaken.

Comparisons between the results of the two groups with intervention by the two methods show no significant differences between the two groups for: depression (Gabriel=-.61, p>.80); for global distress (Gabriel=-2.95, p>.49); for self-perceived stress (Gabriel=-7.79, p>.26); for anger (Gabriel=-1.10, p>.99).

To test the effectiveness of our interventions we used the pre-test – post-test pairs comparison between the control group, the group of participants who received standard REBT and the group of participants who received religiously oriented REBT. Next we present the results of pre-test – post-test comparisons regarding depression, anxiety, distress, stress and anger.

Table 7. Average, standard deviations and t test values for pair samples regarding the therapeutical effect on depression

Group	Stage	N	m	SD	t	Sig.	E.S.	S.P.
Standard REBT	Pre-test	19	13.10	3.22	4.91	.00	1.73	.999
	Post-test		8.00	2.56				
Religious REBT	Pre-test	18	13.33	2.58	11.55	.00	.882	1
	Post-test		7.38	1.78				
Control	Pre-test	15	11.20	2.14	1.05	.30		
	Post-test		10.60	2.52				

Note: *Effect size (f): 0.1=low, 0.25= average, 0.4= high (Cohen); E.S. = Effect size; S.P. = Statistical power

Inspecting the above table we see that the averages decreased significantly in post-test stage compared to pre-test stage. Calculated effect sizes indicate higher effects and the statistical power values are increased.

Table 8. Average, standard deviations and t test values for pair samples regarding the therapeutical effect on anxiety as state

Group	Stage	N	m	SD	t	Sig.	E.S.	S.P.
Standard REBT	Pre-test	19	27.63	7.79	5.54	.00	.770	1
	Post-test		22.42	4.41				
Religious REBT	Pre-test	18	26.94	6.11	6.21	.00	.807	1
	Post-test		22.44	4.81				
Control	Pre-test	15	26.46	4.53	-.35	.72		
	Post-test		26.80	6.59				

Note: *Effect size (f): 0.1=low, 0.25= average, 0.4= high (Cohen); E.S. = Effect size; S.P. = Statistical power

The above table allows us to observe significant changes in the averages of pre-test stage compared to post-test stage, these having similar values for the two groups in which therapeutic intervention occurred.

Table 9. Average, standard deviations and t test values for pair samples regarding the therapeutical effect on anxiety as a trait

Group	Stage	N	m	SD	t	Sig.	E.S.	S.P.
Standard REBT	Pre-test	19	29.15	7.98	5.52	.00	.684	1
	Post-test		24.36	5.10				
Religious REBT	Pre-test	18	26.77	4.64	14.15	.00	.943	1
	Post-test		22.61	4.14				
Control	Pre-test	15	28.26	5.00	-.69	.49		
	Post-test		28.53	5.38				

Note: *Effect size (f): 0.1=low, 0.25= average, 0.4= high (Cohen); E.S. = Effect size; S.P. = Statistical power

Table 9 allows us to observe significant changes in the averages of pre-test stage compared to post-test stage, these having similar values for the two groups in which therapeutic intervention occurred.

Table 10. Average, standard deviations and t test values for pair samples regarding the therapeutical effect on overall distress

Group	Stage	N	m	SD	t	Sig.	E.S.	S.P.
Standard REBT	Pre-test	19	53.84	12.41	5.17	.00	1.45	1
	Post-test		37.78	8.59				
Religious REBT	Pre-test	18	52.61	12.48	5.32	.00	1.62	1
	Post-test		34.83	4.65				
control	Pre-test	15	46.73	7.88	-.69	.49		
	Post-test		46.53	7.25				

Note: *Effect size (f): 0.1=low, 0.25= average, 0.4= high (Cohen); E.S. = Effect size; S.P. = Statistical power

Total distress significantly changed as a result of our interventions in both of the experimental groups with intervention being recorded similar changes in the values of overall distress. Overall distress values remain unchanged in the control group, no form of therapy occurred.

Table 11. Average, standard deviations and t test values for pair samples regarding the therapeutical effect on anger

Group	Stage	N	m	SD	t	Sig.	E.S.	S.P.
Standard REBT	Pre-test	19	99.94	12.56	5.44	.00	.664	.999
	Post-test		92.10	10.86				
Religious REBT	Pre-test	18	100.77	14.28	8.08	.00	.720	1
	Post-test		91.00	12.70				
Control	Pre-test	15	105.46	14.84	3.27	.06		
	Post-test		102.26	16.30				

Note: *Effect size (f): 0.1=low, 0.25= average, 0.4= high (Cohen); E.S. = Effect size; S.P. = Statistical power

Regarding the level of anger, we see that it changed in post-test stage compared to pre-test stage. Averages are relatively close in the two stages.

Table 12. Average, standard deviations and t test values for pair samples regarding the therapeutical effect on self perceived stress

Group	Stage	N	m	SD	t	Sig.	E.S.	S.P.
Standard REBT	Pre-test	19	69.73	14.24	4.16	.00	.770	1
	Post-test		57.68	16.73				
Religious REBT	Pre-test	18	66.00	13.86	4.44	.00	1.23	1
	Post-test		49.88	12.18				

Table 12. Average, standard deviations and t test values for pair samples regarding the therapeutical effect on self perceived stress - *continued*

Group	Stage	N	m	SD	t	Sig.	E.S.	S.P.
Control	Pre-test	15	72.60	16.66	-1.66	.11		
	Post-test		76.60	12.36				

Note: *Effect size (f): 0.1=low, 0.25= average, 0.4= high (Cohen); E.S. = Effect size; S.P. = Statistical power

Self-perceived stress values changed significantly in the groups where therapeutic intervention occurred, the intervention being effective in relieving stress. In the control group, where no therapeutic intervention was undertaken, average values are relatively close. Effect sizes and statistical power indicators have high values.

Conclusions

Numerous studies support the increased compatibility between the ideas and practice of REBT and religious beliefs in general, particularly the Judeo-Christian tradition (Ellis, 2000; Robb, 2002; Garzon, 2005; Johnson, 2008). In the last twenty years the interest in studying the impact of religion on mental and physical health has increased, given the numerous observations of religious people's daily lives and inferences of their religious behaviour in their lives. Religious beliefs were associated with lower levels of depression (Koenig, Hays, George, Blazer, Larson, & Landerman, 1997), with lower rates of violent behaviour (Dye & Eckhardt, 2000), with the idea of social support (McIntosh, Silver, & Wortman, 1993), with happiness (Lewis, Maltby, & Day, 2005). The subject of religion has aroused much controversy among the scientific community, justified by the uncertainties concerning the assessment and measurement of the religious phenomenon, the multiple dimensions of the concept of religiosity, low prevalence of specialists to deal with this area and scepticism of scientists regarding this subject.

The present study aligns in the last two decades' tendency of intensifying the religious phenomenon in conjunction with ideas of cognitive-behavioural therapy for improving mental health related issues. There are many studies that have used their cognitive behavioural approach religious ideas and beliefs; the cognitive behavioural intervention based on ideas of Aaron Beck (Robertson, Smith, Ray, & Jones, 2009) by comparison to Rational Emotive

and Behaviour Therapy is better validated. Albert Ellis founded the study of religious beliefs potentials in the context of REBT, this field remaining open to research.

In this study we aimed to highlight the impact of standard and combined with religious elements REBT in relieving distress of students during the term evaluation period. We are interested in analyzing the influence that standard REBT vs. religiously oriented REBT has in relieving distress, operationalized by depression and anxiety-type symptoms, functional and dysfunctional sadness and fear, self-perceived stress, anger. In Romania, as far as we know, the present study is the first of this type.

15% - 20% of young people experience at least one depressive episode before 18 years, which is associated with an increased risk of recurrence in adulthood (Costello, Foley, & Angold, 2006). Depressive experience in adolescence is associated with school failure, interpersonal problems, substance abuse and suicide; depression treatment costs are very high. Intrinsic religiosity is a protective factor against depression experimented in the context of negative life events (James & Wells, 2003; Posser, Banister, Pickering, Martin, Garber, & Hautzinger, 2011). In regard to relieving depressive symptoms, the statistical results allow us to support similar efficacy of standard cognitive behavioural and religiously oriented interventions (REBT) on intrinsically religiously motivated participants. These results are consistent with those of other studies that have shown efficacy of religious beliefs in improving depressive symptomatology, the call to religion being parts of the participants' coping mechanisms (Kilbourne, Cummings, & Levine, 2009). In the biblical context depression is presented in the context of hope, so it is possible that the sacred texts to address the component of despair associated with depression (Brandt & Skiner, 2008). Prayer and reading of sacred texts can offer hope and comfort, reinforcing the belief that the person is not alone in facing problems. Beyond connecting with the transcendent and beyond the comfort given by the perception of support from a supreme being, religion is a source of social support. In the study of Kilbourne, Cummings, and Levine (2009), social support was moderately associated with psychological distress but was not a sufficient protective factor against depression. Watlington and Murphy (2006) showed that social support given by the religious communities was associated with lower rates of depressive symptoms, but it would not mediate the association between religious involvement and the

negative effects of posttraumatic stress and depressive symptoms. During adolescence, the religious factor exerts a role of moderator of the relationship between stress, in negative life events, and emerging of depressive pathology (Posser et al., 2011).

Self perceived stress was modified following the classical REBT interventions and those with religious elements. The overall test shows the effectiveness of interventions in relieving the stress. It is known that people, when confronted with stressful life events, rely on their own system of beliefs, including religious beliefs, to understand and cope the situation (Pargament, 1997). The religious system is a person's orientation system in difficult circumstances. Religious coping is associated with favourable responses resulting from exposure to stressful situations (Smith, McCullough, & Pool, 2003). Participants' answers to self perceived stress scale were similar in the two intervention groups. There is a trend that intrinsically religiously oriented participants who have benefited from REBT interventions with scriptural elements have lower values on the self perceived stress scale. Both therapies have demonstrated efficacy in relieving stress. Intrinsic religiosity involves living the religious phenomenon, acting from within of the religious principles, which can become a style of approaching the problem changing the individual's view from the perception of the threat to the perception of challenge. Religiosity may influence not only the way of interpreting life events, but also selection strategies for understanding and managing those events. Religious coping moderates the relationship between the perception of stress and psychological well-being, so that the high levels of religiosity are associated with low levels of distress (Lee, 2007).

Anxiety of intrinsically religiously oriented students was modified, resulting in changes in anxiety as state and in anxiety as trait, the global tests showing this. Post hoc comparisons show changes in anxiety as trait, but not in anxiety as a state. These results should be interpreted with caution, given that the anxiety as state component is more likely to change compared to the anxiety as trait. It is possible that uncontrollable effects to intervene to influence the results: the imminence of school evaluations during the intervention period may have led to high scores of anxiety as a state, while changes in the anxiety as trait to be maintained, as they are not influenced by the immediate circumstances related to school evaluation. Changes of anxiety as a trait appear to be slightly more consistent for students who have benefited

from religiously oriented REBT, which is consistent with other studies that identified superior efficacy of religiously adapted psychotherapy compared to supportive psychotherapy in generalized anxiety (Koszycki, Raab, Aldosary, & Bradwejn, 2010).

The level of anger experienced a significant change as a result of the interventions proposed, as highlighted by the global test. Participants who received religiously oriented REBT showed significantly lower levels of anger than the control group. This situation was not found in the case of comparisons between the intervention group that received standard REBT. Relieving anger is based on, according to Ellis's views (1994), disputing rigid and absolutist cognitions that encourage violence and interact with the ability to negotiate, to reach a compromise. People easily turn their desires in absolute requirements, and these underlie neurotic attitudes, leading to interpersonal conflict. In the present research we achieved significant changes in terms of absolute cognitions ("absolutist requirement of justice"), a result of both types of interventions proposed by us. The results are similar both for the group that received standard REBT and for those who followed REBT with religious elements. Closely connected to this cognition in determining violent behaviour is the low tolerance to frustration cognition. Many authors considered the link between LFT and the conflict attitude and behaviour (Ellis, 1994). REBT focuses mainly on improving this cognition, while the biblical texts discourage violent behaviour and attitudes of revenge.

Interventions proposed by us targeted the reduction of distress level of students who were in the run-up of term evaluations, by adjusting cognitions about stressful events they experiment. Level cognitive changes were possible using both methods therapeutic, leading to lower distress. The use of prayer and reading the sacred texts in the psychotherapeutic process leads to improved client outcomes; it facilitates the therapeutic relationship and improves the quality of customers' life (Weld & Eriksen, 2007). Rational prayer and reading the sacred texts can be techniques of disputing irrational cognitions, along with statements from "psychological pills with religious content". These fold better on the customers' repertoire of knowledge, are part of their resources that are activated and structured in the therapeutic process, giving them a purpose within therapy and involving the client's increased responsibility for the therapeutic act. Exclusion of spiritual and emotional resources of clients, their ignorance or non-valuing, can negatively affect the therapeutic results, the

therapeutic relationship and the therapeutic process. Religious clients' preferences are in favour of including of their spirituality in the therapeutic process (Tan, 2007). Rose, Westfeld, and Ansley (2008) launched the idea of the possibility that the religiosity / spirituality level of a person to be related with preference for the inclusion of spiritual elements in the psychotherapeutic process. Such intrinsically religiously oriented people can fall into the category of people with high level of religiosity / spirituality. Preferences of religious customers of including religious elements in therapy are accompanied by the search of specialists who would harness their spiritual / religious side, while avoiding secular approaches. Thus, we conclude that REBT with religious elements approaches are preferred by religious customers compared to secular approaches.

As drawbacks of the present study we mention the relatively small number of participants. We also note that the number of samples is close to the total number of students in the 1st and the 2nd year of study in social work specialization. The generalization of study results may require a higher number of participants. Moreover, the study was conducted on protestant students, thus limiting the generalization of results. Gender distribution of participants is highly uneven, most participants being of female sex. The present research was carried out on theological university students, therapeutic interventions were undertaken simultaneously, which could lead to the dissemination of information between experimental groups. Besides the effect of information diffusion, it is possible that we deal with errors caused by the effect of compensation (the compensatory effort that the control group members may have, feeling frustrated that they are not part of the experimental group: Radu, 1993). We can also experience errors caused by the effect repeated testing, taking into account the fact that we used the same measuring instruments. The measurements used were only of self-report type, an overestimation of the results and an association of the factors taken into study being possible. The study was conducted by only one researcher who carried out the interventions in the both experimental groups. The absence of interaction between the researcher and beneficiaries of therapeutic interventions would be advisable, by resorting to neutral people in the intervention stage.

We can conclude that Rational Emotive and Behaviour Therapy is valid to relieve distress, the standard and religious orientation of therapy leading to similar effects when participants are religious. According to previous research

in the field, the religious orientation of REBT is preferred by religious customers. Integrating scriptural elements in REBT context is possible and beneficial in relieving distress on religious participants.

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