Johnson, W. B., DeVries, R., Ridley, C. R. Pettorini, D., & Peterson, D. R. (1994). The comparative efficacy of Christian and secular rational-emotive therapy with Christian clients. *Journal of Psychology and Theology, 22,* 130–140.
Johnson, W. B., & Ridley, C. F. (1992). Brief Christian and non-Christian rational-emotive therapy with depressed Christian clients: An exploratory study. *Counseling and Values, 36,* 220–229.
Keller, R. R. (2000). Religious diversity in North America. In P. S. Richards & A. E. Bergin (Eds.), *Handbook of psychotherapy and religious diversity* (pp. 27–55). Washington, DC: American Psychological Association.
Kelly, G. (1955). *The psychology of personal constructs.* New York: Norton.
Malouff, J. M., & Schutte, N. S. (1986). Development and validation of a measure of irrational belief. *Journal of Consulting and Clinical Psychology, 54,* 860–862.
Malouff, J. M., Valdenegro, J., & Schutte, N. S. (1987). Further validation of a measure of irrational belief. *Journal of Rational Emotive Therapy, 5,* 189–193.
Neimeyer, R. A. (1995). An appraisal of constructivist psychotherapies: Contexts and challenges. In M. J. Mahoney (Ed.), *Cognitive and constructive psychotherapies: Theory, research, and practice.* New York: Springer.
Nielsen, S. L. (1994). Religion and Rational-Emotive Behavior Therapy: Don't throw the therapeutic baby out with the holy water. *Journal of Psychology and Christianity, 13,* 312–322.
Nielsen, S. L., & Ellis, A. E. (1994). A discussion with Albert Ellis: Reason, emotion and religion. *Journal of Psychology and Christianity, 13,* 327–341.
Pecheur, D. R., & Edwards, K. J. (1984). A comparison of secular and religious versions of cognitive therapy with depressed Christian college students. *Journal of Psychology and Theology, 12,* 45–54.
Piaget, J. (1954). *The construction of reality in the child.* New York: Basic Books.
Propst, L. R. (1980). The comparative efficacy of religious and nonreligious imagery for the treatment of mild depression in religious individuals. *Cognitive Therapy and Research, 4,* 167–178.
Propst, L. R. (1996). Cognitive-behavioral therapy and the religious person. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 391–407). Washington, DC: American Psychological Association.
Propst, L. R., Ostrom, R., Watkins, P., Dean, T., & Mashburn, D. (1992). Comparative efficacy of religious and nonreligious cognitive-behavioral therapy for the treatment of clinical depression in religious individuals. *Journal of Consulting and Clinical Psychology, 60,* 94–103.
Richards, P. S., & Bergin, A. E. (1997). *A spiritual strategy for counseling and psychotherapy.* Washington, DC: American Psychological Association.
Richards, P. S., & Bergin, A. E. (2000). Toward religious and spiritual competency for mental health professionals. In P. S. Richards & A. E. Bergin (Eds.), *Handbook of psychotherapy and religious diversity* (pp. 3–26). Washington, DC: American Psychological Association.
Robin, M. W., & DiGiuseppe, R. (1997). "Shoya moya ik baraba": Using REBT with culturally diverse clients. In J. Yankura & W. Dryden (Eds.), *Special applications of REBT: A therapist's casebook* (pp. 39–67). New York: Springer.
Schafranske, E. P. (1996). Introduction: Foundation for the consideration of religion in the clinical practice of psychology. In E. P. Shafranske (Ed.) *Religion and the clinical practice of psychology* (pp. 1–17). Washington, DC: American Psychological Association.
Walen, S. R., DiGiuseppe, R., & Dryden, W. (1992). *A practitioner's guide to Rational-Emotive Therapy* (2nd ed.). New York: Oxford University Press.
Williams, J., Watts, F., McLeod, C., & Matthews, A. (1988). *Cognitive psychology and the emotional disorders.* New York: Wiley.

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To Dispute or Not to Dispute: Ethical REBT With Religious Clients

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Disputation of irrational beliefs is the most commonly utilized therapeutic strategy among therapists practicing from a Rational Emotive Behavior Therapy (REBT) framework. Very little attention has been given to the unique ethical concerns that arise when REBT practitioners treat devoutly religious clients or clients presenting with uniquely religious problems. Ignoring client religious variables altogether or directly challenging and disputing specific religious beliefs both appear ethically problematic. This article offers a summary of the changing perspective on the compatibility of REBT and religion and an exploration of the ethics of disputing with religious clients. Finally, the author offers a preliminary model for both general and specialized use of disputational techniques with religious clients.

RENEE is a college sophomore at a small Christian university. She is transported voluntarily to a local mental health clinic for emergency triage due to concerns on the part of peers that she is acutely suicidal. She is escorted by her roommate and a university administrator. An REBT practitioner is assigned to the case and begins a formal intake session. Renee is a slight, conservatively dressed young woman with long hair and minimal attention to fashion or grooming. She is obviously distraught. She has been sobbing recently and there are bags under her eyes. Renee admits to some suicidal ideation, though there is no plan or immediate intent. She

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describes feeling hopeless, "lost," and "fallen." The therapist learns that Renee's acute symptoms have persisted for approximately 3 days, and that the onset of her distress coincides directly with her first experience of sexual intercourse. This occurred while on a date with a college peer she has dated for 1 year. Although she describes the sexual experience as consensual, she believes firmly that she has committed a serious sin by engaging in premarital sexual relations. The therapist asks more about her beliefs in this area and Renee tearfully quotes several biblical passages warning that sin leads to death and that "lusting in the flesh" is evidence of disobedience and lack of spiritual discipline. When the therapist asks her more about this, Renee pulls a well-worn Bible from her handbag, opens it to 1 Corinthians (6:18–20), and proceeds to read this passage while sobbing: "Shun immorality. Every other sin which a man commits is outside the body; but the immoral man sins against his own body. Do you not know that your body is a temple of the Holy Spirit within you, which you have from God? You are not your own; You were bought with a price. So glorify God in your body." She then reads several passages indicating that sexual relations outside of marriage are clearly immoral. Renee describes her own church as extremely strict when it comes to sins of this sort, and she anticipates being ostracized from the church community. At the same time, she feels compelled to disclose this event to her pastor immediately. She also anguishes at the shame and humiliation this will certainly cause her family. She says, "God asked so little of me, and I failed at loving him more than myself. I have become a harlot. My sin is like a millstone around my neck."

"It [RET] is one of the few systems of psychotherapy that will truly have no truck whatever with any kind of miraculous cause or cure, any kind of God or Devil, or any kind of sacredness."
(Ellis, 1973, p. 16)

How "should" the REBT therapist approach Renee? It seems this client's depressive symptoms are rooted in her thinking *about* her sexual behavior. Although a careful intake assessment, including a rule-out of biologic and additional environmental factors, is certainly warranted, the REBT practitioner may quickly confirm that Renee's depressive upset is directly linked to her demanding and evaluative beliefs about her behavior in this instance as well as more pervasive irrational philosophies. In addition, Renee's religious beliefs appear directly linked to her emotional upset. Specifically, if Renee did not believe she had sinned grievously and if she did not believe she would be negatively evaluated by a divine power, it is unlikely she would be suicidal. In fact, were Renee not religious, it is conceivable that she would have only positive emotional reactions to her recent sexual encounter. As the REBT therapist prepares to intervene, it is likely that he or she will begin disputing Renee's primary irrational beliefs (Ellis, 1973; Ellis & Dryden, 1997; Walen, DiGiuseppe, & Dryden, 1992). Would not the most elegant solution to Renee's distress be a direct challenge to Renee's religious beliefs? Her religious beliefs appear to be causing her emotional distress and preventing a more adaptive reaction to recent events. Could it be that direct disputation of her belief that sex outside of marriage is a grievous and damnable sin is the most parsimonious therapeutic solution? Finally, would such an REBT intervention be ethical?

In this article, I will briefly consider the compatibility of REBT and religious belief. In spite of Ellis's early opposition to all religious belief, REBT appears particularly well suited to a theistic worldview. I will then consider the foundational REBT intervention, disputation of irrational beliefs, and the ethical dilemmas that may arise when applying this technique to explicitly religious clients. Finally, I will present a preliminary model for identifying unethical and ethical use of disputation with religious clients. I will conclude that REBT may be an exceptionally useful treatment modality for religious clients and that with appropriate cross-cultural attitudes and skills, it can be delivered ethically and effectively by many REBT practitioners.

On the Compatibility of REBT and Religiousness

Those cognitive-behavioral psychotherapists unfamiliar with the recent shift in thinking about religion on the part of Albert Ellis (Ellis, 1992, 1994) may wonder how a rational-emotive approach could ever embrace client religiousness. Early in his development of rational-emotive psychology and therapy, Ellis was uniformly opposed to any notion of a positive or "healthy" manifestation of religious belief and behavior (Ellis, 1960, 1971, 1973). During this time frame, Ellis boldly claimed that religious belief was essentially synonymous with emotional disturbance and that there was a direct and linear relationship between degree of orthodoxy (religious commitment) and disturbance (Ellis, 1971). Ellis noted, "When and if humans fully accept the reality that there is no supernatural 'force' in the universe that gives a damn about them or ever will, they will then be truly humanistic" (1973, p. 16), and "It [RET] is one of the few systems of psychotherapy that will truly have no truck whatever with any kind of miraculous cause or cure, any kind of God or Devil, or any kind of sacredness" (1973, p. 16).

In the 1980s, Ellis modified his universal rejection of all religiousness as pathologic and acknowledged that some religious belief may not cause emotional distur-

bance (Ellis, 1980, 1983). Calling himself a "probabilistic atheist," he contrasted "mild" religiousness (moderate, liberal, or nonorthodox belief) with orthodox, pious, and devout religiosity (Ellis, 1980). In various writings, Ellis suggested that devout religiousness was often correlated with the following characteristics and symptoms: low self-esteem, dependency, masochism, intolerance, rigidity, narcissism, hostility, compulsivity, paranoia, depression, self-hate, powerlessness, grandiosity, bigotry, suicidal terrorism, and lying (Johnson, 1994).

More recently, however, Albert Ellis has altered his perspective on religion and mental health. He has acknowledged that many religious people (including some psychotherapists) appear both open-minded and emotionally well-adjusted (Ellis, 1992, 1994). He has pointed out some substantial compatibilities between rational-emotive principles and many of the tenants of Judeo-Christian religions (Ellis, 1994). Ellis has endorsed the therapeutic benefits of Scripture and some Christian doctrines, such as grace. He has even spoken favorably of Biblical Scripture: "The Judeo-Christian Bible is a self-help book that has probably enabled more people to make more extensive and intensive personality and behavioral changes than all professional therapists combined" (Ellis, 1993, p. 336). Most recently, Albert Ellis translated some of the primary tenants of REBT into what he refers to as the "God-oriented" language of Christian clients and acknowledged striking congruence between REBT and Christian doctrine (Ellis, 2000).

The evolving perspective of Albert Ellis on the compatibility of religiousness and REBT has been welcomed by both theorists and practitioners (DiGiuseppe, Robin, & Dryden, 1990; Nielsen, 1994; Sharkey, 1981) who view REBT as compatible with most religions and, in some cases, more effective than other approaches in handling uniquely religious problems. However, it is also true that REBT's fundamental theory of psychopathology, psychotherapy, and behavior change is distinct from Ellis's personal philosophy and even the rational-emotive assumptions rooted in stoic philosophies (DiGiuseppe et al.). The therapeutic techniques of REBT appear to be remarkably value-neutral and therefore potentially useful with clients from a wide range of religious worldviews (Sharkey).

Why is REBT likely to be an effective, even "elegant," psychotherapy for religious clients? There are several reasons, both theoretical and applied. First, REBT is a belief-focused treatment (Nielsen, 1994). REBT focuses on clients' foundational or core beliefs about themselves, others, and events in the world around them. Although REBT embraces a range of cognitive, emotional, and behavioral interventions, the preferred goal of detecting and helping the client to change core irrational beliefs will likely undergird most REBT interventions (Ellis & Dryden, 1997; Walen et al., 1992). Clients from many religious traditions (Nielsen, 1994; Nielsen, Johnson, & Ridley, 2000) will often be familiar and comfortable with belief-oriented language.

Additional congruencies between REBT and religious faith include REBT's existential/philosophical nature and its psychoeducational emphasis (Nielsen et al., 2000). Many organized religions strongly endorse philosophies of free will, hard work, and the need to modify wrong belief. Further, many religious clients will be highly receptive to the REBT tenant that faulty belief and conviction may lead to cognitive, emotional, and behavioral manifestations of disorder (Ellis, 1994; Ellis & Dryden, 1997). Similar to many religious rituals and practices, REBT emphasizes an educational and demonstration-focused method for helping clients learn to examine, evaluate, and change their own demanding and evaluative beliefs (Walen et al., 1992).

Beyond mere philosophic congruence, however, Albert Ellis's softening stance on religion may also be traced to empirical evidence that religious commitment is not inimical to mental health and that, in most cases, religiousness is positively correlated with physical and emotional well being (Bergin, 1983; Gartner, Larson, & Allen, 1991; Sharkey & Malony, 1986). In addition, preliminary outcome research suggests that religiously accommodated cognitive-behavioral psychotherapies (CBT and REBT), when applied to religious clients, are as or more effective than standard cognitive-behavioral protocols (Worthington, Kurusu, McCullough, & Sandage, 1996). Two outcome studies that employed both Christian and standard versions of REBT with explicitly religious clients found that both approaches were highly efficacious in reducing depression, automatic negative thoughts, and general symptom distress (Johnson, DeVries, Ridley, Pettorini, & Peterson, 1994; Johnson & Ridley, 1992).

> "The Judeo-Christian Bible is a self-help book that has probably enabled more people to make more extensive and intensive personality and behavioral changes than all professional therapists combined."
> (Ellis, 1993, p. 336)

Beyond these important theoretical sources of congruence between REBT and religious faith, several authors have addressed the application of REBT to religious clients (DiGiuseppe et al., 1990; Johnson & Nielsen, 1998; Nielsen, 1994). Of course, the primary REBT treatment intervention is the cognitive disputation. Although many REBT practitioners have advo-

cated application of this technique to religious clients' general and uniquely religious beliefs (DiGiuseppe et al.; Robb, 1993; Young, 1984), there has been very little consideration of the ethical issues at hand when a psychotherapist "disputes" personally or clinically salient client religious beliefs.

Rational-Emotive Disputation With Religious Clients: Ethical Concerns

Albert Ellis has long held that the core of psychological disturbance is the tendency of human beings to make devout, absolutistic evaluations of themselves, others, and perceived events in their lives (Ellis & Dryden, 1997). Evaluative and demanding beliefs are considered *irrational* in REBT terms because they usually obstruct people in their pursuit of desired goals. Beliefs are considered irrational if they are (a) logically inconsistent, (b) inconsistent with empirical reality, (c) absolutistic and dogmatic, (d) prone to elicit disturbed emotions, and (e) likely to block goal attainment (Ellis & Dryden; Walen et al., 1992). There are also two subtypes of irrational thinking. *Irrational evaluative beliefs* are the most common target of intervention and are typically absolutistic and demanding assessments of clients about themselves and their circumstances. Evaluative beliefs most commonly include demandingness, low frustration tolerance, human worth ratings, and awfulizing (Walen et al.). *Core irrational beliefs* are more fundamental and pervasive beliefs that clients often adopt as unarticulated life philosophies. Examples of core irrational beliefs with relevance to the case of Renee are as follows: *I must be loved and approved of by every significant person in my life and if I am not, it is awful. I am not worthwhile unless I am thoroughly competent, adequate, and achieving at all times. When people behave badly or unfairly, they should be blamed, reprimanded, and punished; they are bad or rotten individuals.*

> Why is REBT likely to be an effective, even "elegant," psychotherapy for religious clients? Most importantly, REBT is a belief-focused treatment. . . .

In addition to these core irrational beliefs, it is reasonable to hypothesize the existence of several evaluative irrational beliefs that are directly linked to Renee's upset. Further, it is likely that these beliefs are both general and uniquely religious in content. These beliefs may fall into categories of *demandingness* (I should not have slept with my boyfriend and I ought to have obeyed God's laws regarding sexual purity before marriage), *awfulizing* (It is horrific that I have committed this gravest of sins. Nothing in the world could possibly be more catastrophic or disappointing to God), *human worth rating* (My behavior proves that I am evil to the core. Losing my virginity is the same as losing my value in God's eyes), and *low frustration tolerance* (I can't stand living with the knowledge that I have sinned so grievously).

How, then, will the REBT therapist approach intervening to change these irrational beliefs? The most common technique employed by REBT psychotherapists to confront and change irrational beliefs is a cognitive intervention known as *disputation of irrational beliefs.* Disputation is a debate or challenge (usually logical or empirical) to the patient's irrational belief system. Walen et al. (1992) have described the intent of disputation:

> Its basic goal is to help the patient internalize a new philosophy . . . this basic goal is known in RET as the *elegant solution.* [Disputation], therefore, consists of two basic stages. The patient is helped to: 1. Examine and challenge his or her present mode of thinking. 2. Develop new, more functional modes of thinking. (p. 154)

Although disputation is generally considered the heart of REBT, little attention has been given to the unique ethical concerns that arise when disputing or challenging beliefs that have theistic or religious content. Historically, Albert Ellis was quite open about his willingness to talk clients out of their religious beliefs if those beliefs (in Ellis's view) impede emotional adjustment (as defined in terms of rational-emotive psychology; Ellis, 1971). Although Ellis has certainly changed his perspective here, other REBT therapists have suggested an equally pragmatic and irreverent approach to religious beliefs. For example, Young (1984) advocated that REBT therapists be "clever" in cloaking the principles of REBT in the religious language of the client. Young suggested lying to clients about one's religious affiliation: "If you are backed into a corner and nothing less than a straight 'yes' or 'no' answer is acceptable, I strongly recommend you lie and tell the client you are a firm believer" (p. 127). He also recommended contradicting clients' religious beliefs by reinterpreting or even fabricating Scriptures from the client's faith: "I am not interested in whether or not I am biblically accurate, nor am I the least bit interested in checking up and finding out if what I have to say or even what the client has to say is actually found in the Bible" (p. 129).

It appears that the REBT therapist will necessarily face a dilemma in handling cases such as Renee's. Should the therapist avoid the religious material present in the case altogether? Should specific religious beliefs be targeted for disputation in hopes of reducing emotional upset and, in this case, suicide risk? In my view, both courses of action present ethical concerns.

Ignoring Clinically Salient Religious Material

Let us suppose that the REBT therapist in the case at hand ignores Renee's religious affiliation, her concern with the eternal consequences of her sexual behavior, and her concerns regarding the response of her religious community. In this case, the therapist might merely dispute the most generic forms of Renee's primary irrational beliefs using logical, empirical, pragmatic, or even humorous disputes (e.g., "Where is the evidence that you must be perfect?" "How does it follow that because you have had sexual relations, that you yourself are damnable?" "How is suffering now helping you?" "Wouldn't it be worse if you'd had sex with several men?"). The problem with this approach, of course, is that Renee's faith-based worldview may indeed endorse the notion that human beings are damnable for sinful thought and behavior. She may also point out biblical passages that reinforce the significance of God's favor and the biblical law of sowing and reaping. For these reasons, ignoring the client's religious surround is unlikely to be helpful. Worse yet, this approach may violate professional guidelines (American Psychological Association, 1993).

Ignoring important client data or significant activating events and consequences merely because they are religious in nature raises concerns about whether the client is receiving competent intervention (Bergin, 1980; Richards & Bergin, 1997). It is common for religious clients to resist and drop out of therapy when their faith is discounted by mental health professionals. Failure to assess and overtly address the client's religious concerns is equivalent to entirely ignoring a client's race, ethnicity, or gender when these variables have obvious bearing on treatment (American Psychological Association, 1993). If the REBT therapist ignores Renee's religious identity and her specific religious concerns, the therapist is probably practicing below the standard of competence with religious clients and is likely to reduce the probability of an effective intervention.

Disputing the Content of Religious Beliefs

Now, let us suppose that the REBT therapist in this case chooses the root of direct disputation of Renee's religious beliefs. He or she might choose disputations such as the following:

> "Where is the evidence that any God exists? Prove to me that any supernatural being cares one bit what you choose to do! It seems to me that believing your body is a 'temple' to some other being is helping you to feel miserable. I guess you'll have to choose between killing yourself or accepting the fact that sexual relations between consenting adults are normal and healthy—regardless of what your religion teaches."

There are several ethical problems inherent in the practice of disputing a client's religious beliefs. Most importantly, the American Psychological Association's Code of Ethics and Specialty Guidelines for providers to diverse populations (American Psychological Association, 1992, 1993) require that psychologists respect human differences (including religious differences). The Specialty Guidelines specifically state, "Psychologists respect client's religious and/or spiritual beliefs and values, including attributions and taboos since they affect worldview, psychological functioning, and expressions of distress" (1993, p. 46). Related to this is an ethical concern about treating explicitly religious clients without having developed appropriate competence via education, training, supervision, and consultation.

In the majority of cases, an REBT therapist who directly challenged the content of a client's religious belief would probably be practicing unethically (Bergin, 1991; DiGiuseppe et al., 1990; Johnson & Nielsen, 1998; Nielsen, 1994). Certainly, it is hard to imagine demonstrating respect for client religious beliefs and practices while simultaneously working to have the client relinquish those beliefs. Because it is impossible to rule out the truth or falseness of religious beliefs (Meissner, 1996), and because the REBT disputational process relies primarily on empirical and logical criteria of rationality and irrationality, disputing religious belief content appears unproductive at best and grossly unethical at worst.

> . . . Clients from many religious traditions will often be familiar and comfortable with belief-oriented language.

Although utilizing the disputation technique with religious clients raises significant ethical concerns, it is also true that REBT therapists often face devoutly religious clients in their clinical practices. Further, these clients may present with disturbances tied directly to their theistic beliefs or their religious practices. How is the REBT therapist to respond? How should the REBT therapist in the case presented at the start of this article respond? How can Renee's evaluative and core irrational beliefs be addressed in order to achieve the most "elegant" and effective outcome? In the final section of this article, I will describe what I view to be an ethical approach to the client described in this case.

Ethical Disputation With Religious Clients

Can the competent REBT therapist effectively and ethically employ disputational strategies with overtly religious clients and client issues? I believe the answer is yes. However, in order to do so, it is critical that the clinician

carefully evaluate his or her own level of competence with the general religion and specific religious concerns in question. Reasonably skilled REBT practitioners can ethically utilize what I will refer to as *general disputation,* while those with specialized training in the treatment of religious clients and specific knowledge of their clients' religious tenants and practices may practice what I refer to as *advanced (specialized) disputation.*

General Disputation With Religious Clients

When the REBT client presents with personally salient religiousness (Johnson & Nielsen, 1998), he or she will hold firmly to religious beliefs and will often show evidence of devotion to specific doctrine and practice. Although many clients evidence personally salient religiousness, far fewer demonstrate *clinically salient* religiousness (Johnson & Nielsen). When religion is clinically salient, maximal treatment outcome will require the provider to address client religiousness in some manner. At the lowest level, the level of general disputation, the therapist will demonstrate respect for the client's religious commitments while searching for ways to dispute the client's evaluative irrational beliefs—even when those evaluations have religious components.

> Ignoring important client data or significant activating events and consequences, merely because they are religious in nature, raises concerns about whether the client is receiving competent intervention. . . .

In general disputation, the REBT therapist conveys respect for the client's religious views and initiates a collaborative approach (McMinn & Lebold, 1989) to understanding how these beliefs factor (or not) in the client's disturbance. When religious beliefs are unfamiliar, the clinician asks the client for additional information and collaborates with other members of the client's religious community as indicated (American Psychological Association, 1993). One form of such collaboration is interaction with the clergy person involved with the client (McMinn, Chaddock, Edwards, Lim, & Campbell, 1998). Of course, this would only occur with the client's permission.

As the therapist begins to assess, clarify, and dispute the religious client's essential irrational beliefs, attention is given to avoiding any disputation of the actual *content* of religious beliefs. Adopting Bergin's (1980) notion of theistic realism, the therapist honors the client's views about God, the relationship of human beings to God, and even the possibility that spiritual factors influence behavior. Instead of arguing or disputing these core religious beliefs, general disputation will focus on the evaluative and demanding quality of the beliefs expressed by the client. The question for the therapist is, "How does this client's *style* of thinking about God and his or her religion make him or her distressed?"

Turning to the case of Renee, the REBT therapist practicing general disputation would respectfully listen to her beliefs about immorality, sin, and biblical proscriptions against sex before marriage. The therapist would acknowledge that Renee's faith is clearly important to her and would avoid any attempt at questioning the veracity of these biblically driven beliefs. He or she might additionally express a willingness to speak with Renee's pastor if she thought this might be helpful.

Because REBT therapists generally begin the disputational process early in treatment (usually in the first session), the therapist would be identifying the *must*urbatory and demanding components to Renee's current system of thought. These would be appropriate targets for intervention. Returning to the evaluative irrational beliefs hypothesized for Renee earlier in this article, the therapist might begin by disputing the irrational demand that she absolutely *should* not have had sex with her boyfriend. The therapist might say,

> "I understand that the Bible asks you to work very hard at leading a moral life, including avoidance of sexual relations when you are not married; however, I don't quite understand how insisting that you 'absolutely must not have done what you did' is going to help at this point. It seems that God created you with free will to choose how you think and act. In this case, you choose to do something you're now sorry about; don't you also have free will to choose to make up for that, seek forgiveness, etc.?"

The therapist might also address Renee's self-damnation (*human-worth rating*) with a logical disputation that presents discrepant information from within Renee's own faith system:

> "You know, I understand after listening to you that God may not be pleased with your decision to sleep with your boyfriend, but I'm a little surprised that you think this mistake makes you 'evil' and 'worthless' in God's eyes. Now, I don't know too much about Christianity, but I had always thought that Jesus died on the cross for our sins and that, in God's eyes, most people sin now and then. Is that right? So wouldn't it be more accurate to say that you're a person who did a thing you're not happy about, but who is still invited to be forgiven?"

Renee's tendency to *awfulize* her situation might be addressed with a disputation such as the following:

"It certainly does sound very disappointing and sad to have done something you'd hoped to avoid doing, but I'm not sure I understand how you've decided sleeping with your boyfriend is absolutely the 'worst' and 'most awful' thing a Christian person could do. If I understand you correctly, then enjoying a physical relationship with your boyfriend was not just immoral, it was far more evil and awful than molesting children or murdering your family."

Finally, the REBT clinician might attempt a humorous disputation of Renee's low frustration tolerance surrounding her recent behavior: "I guess maybe you are right, maybe you really 'can't stand' knowing what you have done. In fact, knowing that you have sinned, like many other people, might cause you to implode or explode or at least burst into flames." Of course, humorous interventions must be used very carefully and only after some judgment on the part of the therapist that the client is responsive to and likely to be helped by humor.

Advanced (Specialized) Disputation With Religious Clients

In some cases, delivering the more general approach to disputation with religious clients may be less effective than an approach that directly seeks to challenge and modify those elements of religious beliefs that are incongruent with the client's own stated faith and religious practice. This specialized intervention poses more substantial risk of ethical wrong-doing and, possibly, harm to the client (Johnson & Nielsen, 1998). Nonetheless, when REBT therapists obtain the necessary training in treating religious clients and prerequisite familiarity with the client's own faith community, it is possible that REBT may incorporate careful disputation of idiosyncratic, incongruent, and destructive religious beliefs.

Prior to disputing religious beliefs, the REBT therapist with expertise in religious issues might consider a careful assessment of the client's specific religiousness (Johnson & Nielsen, 1998; Shafranske & Malony, 1996). For example, is the client primarily intrinsic (internal, mature) or extrinsic (instrumental, utilitarian) in his or her approach to experiencing and expressing religion (Bergin, 1983)? Is the client high or low on indicators of religious well-being (perceived relationship with God) and existential well-being (sense of life purpose and satisfaction)? To what extent do they engage in adaptive and effective religious coping and problem solving? Does the client frequently find him- or herself in conflict with others, society, and the church as a result of religious belief and expression? Finally, to what extent is the client's cognitive style defined as dichotomous or black-and-white? Various authors have suggested that rigidity of this sort is correlated with personal and religious conflict (Meissner, 1996). An assessment of this dimension may offer the clinician clues as to whether to address the client's more pervasive approach to evaluating events or focal religious views themselves.

Following an assessment of the client's unique religious beliefs, community doctrine, and religious functioning, the REBT therapist with appropriate training and expertise with clients from this community, as well as strong familiarity with the client's religion, may consider specific REBT interventions tailored to client religiousness—including disputation of beliefs. Although the therapist would avoid direct refutation of core or foundational religious dogma, clients very often present with idiosyncratic or distorted understandings of doctrine, Scripture, or religious practice. For example, Christian clients are notorious for holding fast to beliefs such as "If I sin, God does not love me" or "Because I am a Christian, I should be perfect." Beliefs of this nature cannot generally be supported by Scripture and there are numerous biblical contradictions to these statements that the religiously savvy REBT therapist might employ.

Most often, incomplete or inaccurate interpretations of Scripture are caused by what DiGiuseppe et al. (1990) refer to as selective abstraction: "People do not become disturbed because of their belief in religion: rather, their disturbance is related to their tendency to selectively abstract certain elements of their religion to the exclusion of attending to others" (p. 358). So, for example, the angry male client who insists that his wife must obey him in all matters, all the time, may reference a Scripture such as Ephesians 5:22, "Wives, be subject to your husbands, as to the Lord," while ignoring verses like Ephesians 5:22, "Husbands, love your wives, as Christ loved the church and gave himself up for her."

> ... Simultaneously, however, an REBT therapist who directly challenged the content of a client's religious belief would probably be practicing unethically.

Turning now to the case of Renee, there is some evidence in Renee's presentation that she has engaged in selective abstraction of the Christian Scriptures and otherwise distorted components of Christian doctrine. An REBT therapist with sophistication in this area and knowledge of Christian doctrine might therefore engage Renee in more elegant disputations that attempt to correct doctrinal and/or scriptural misunderstandings. For example, when Renee describes herself as "fallen" and "lost" spiritually as a result of her sinful act, the therapist might ask where exactly it is written in the Bible that an episode of sexual immorality

means one is lost or fallen. He or she might then counter (disputational counterchallenge) with biblical passages that emphasize grace and forgiveness (e.g., I John 1:19: "If we confess our sins, he is faithful and just and will forgive our sins and cleanse us from all unrighteousness"; Romans 8:1: "There is therefore no condemnation for those who are in Christ Jesus"). Adopting a Socratic ("Columbo") style, the REBT therapist might ask Renee, "So, if Jesus made it very clear in the Bible that all sins will be forgiven if you seek forgiveness and believe in him, how is it then that you, Renee, can say you are 'fallen?' I'm confused . . ."

> As the therapist begins to assess, clarify, and dispute the religious client's essential irrational beliefs, attention is given to avoiding any disputation of the actual *content* of religious beliefs.

Renee may well persist in believing that her sin, because of its sexual nature, is worse than the sins of most others in her community. The therapist might again use conflicting evidence from the Scriptures to rupture this belief and create a therapeutic sense of dissonance for Renee. "Well, I understand that you believe this kind of transgression is especially damnable and that you are somehow worse than others as a result, but the Bible says that 'all have sinned and fall short of the glory of God [Romans 3:23].' It seems God doesn't think any of us are that special just because of the 'way' we sin!" Finally, if Renee were to persist in her depression as a result of the belief that she must pay penance or earn back God's favor, the REBT therapist might respond,

> "Well, that's an interesting idea, but I wonder where it says in the Bible that to be forgiven, you must first earn forgiveness through some punishment, hard work, etc.? In fact, I know the Bible does talk about why and how we come by God's grace. Ephesians 2:8 says, 'For by grace you have been saved through faith; and this is not your own doing, it is the gift of God.' I don't know about you, but it doesn't sound to me like God is asking for you to *do* anything but believe in him and be forgiven."

Summary

Disputing irrational beliefs is a well-established and frequently employed component of REBT. REBT is distinct in its concerted and active-directive emphasis on identifying and disputing client beliefs that create disturbance and undermine health. When disputational techniques are applied to explicitly religious clients, questions arise regarding the extent to which a client's religious beliefs can be challenged (American Psychological Association, 1992, 1993). Two approaches to religious clients—(a) ignoring client religiousness altogether, or (b) directly disputing the content of client religious beliefs—appear prone to create doubts about ethical and professional practice on the part of the REBT clinician. Alternatively, REBT therapists may actively dispute the irrational nature of client beliefs, while remaining respectful of belief content. Those with specialized training in psychotherapy with religious clients generally, and those with a strong understanding of the client's religious community, might also engage in higher-order disputation designed to correct selective abstractions or distortions of religious doctrine and Scripture.

References

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47,* 1597–1611.

American Psychological Association. (1993). Guidelines for providers of psychological services to ethnic, linguistic and culturally diverse populations. *American Psychologist, 48,* 45–48.

Bergin, A. E. (1980). Psychotherapy and religious values. *Journal of Consulting and Clinical Psychology, 48,* 95–105.

Bergin, A. E. (1983). Religiosity and mental health: A critical reevaluation and meta-analysis. *Professional Psychology: Research and Practice, 14,* 170–184.

Bergin, A. E. (1991). Values and religious issues in psychotherapy and mental health. *American Psychologist, 46,* 394–403.

DiGiuseppe, R. A., Robin, M. W., & Dryden, W. (1990). On the compatibility of rational-emotive therapy and Judeo-Christian philosophy: A focus on clinical strategies. *Journal of Cognitive Psychotherapy: An International Quarterly, 4,* 355–368.

Ellis, A. (1960). There is no place for the concept of sin in psychotherapy. *Journal of Counseling Psychology, 7,* 188–192.

Ellis, A. (1971). *The case against religion: A psychotherapist's view.* New York: Institute for Rational Living.

Ellis, A. (1973). *Humanistic psychotherapy: A rational-emotive approach.* New York: Institute for Rational Living.

Ellis, A. (1980). Psychotherapy and atheistic values: A response to A. E. Bergin's "Psychotherapy and religious values." *Journal of Consulting and Clinical Psychology, 48,* 635–639.

Ellis, A. (1983). *The case against religiosity.* New York: Institute for Rational-Emotive Therapy.

Ellis, A. (1992). My current views on rational-emotive therapy and religiousness. *Journal of Rational-Emotive and Cognitive-Behavior Therapy, 10,* 37–40.

Ellis, A. (1993). The advantages and disadvantages of self-help therapy materials. *Professional Psychology: Research and Practice, 24,* 335–339.

Ellis, A. (1994). My response to "Don't Throw the Therapeutic Baby Out With the Holy Water": Helpful and hurtful elements of religion. *Journal of Psychology and Christianity, 13,* 323–326.

Ellis, A. (2000). Can Rational Emotive Behavior Therapy (REBT) be effectively used with people who have devout beliefs in God and religion? *Professional Psychology: Research and Practice, 31,* 29–33.

Ellis, A., & Dryden, W. (1997). *The practice of rational-emotive therapy* (2nd ed.). New York: Springer.

Gartner, J., Larson, D. B., & Allen, G. D. (1991). Religious commitment and mental health: A review of the empirical literature. *Journal of Psychology and Theology, 19,* 6–25.

Johnson, W. B. (1994). Albert Ellis and the religionists: A history of the dialogue. *Journal of Psychology and Christianity, 13,* 301–311.

Johnson, W. B., DeVries, R., Ridley, C. R., Pettorini, D., & Peterson, D. (1994). The comparative efficacy of Christian and secular rational-emotive therapy with Christian clients. *Journal of Psychology and Theology, 22,* 130–140.

Johnson, W. B., & Nielsen, S. L. (1998). Rational emotive assessment with religious clients. *Journal of Rational-Emotive and Cognitive-Behavioral Therapy, 16,* 101–123.

Johnson, W. B., & Ridley, C. R. (1992). Brief Christian and non-Christian rational-emotive therapy with depressed Christian clients: An exploratory study. *Counseling and Values, 36,* 220–229.

McMinn, M. R., Chaddock, T. P., Edwards, L. C., Lim, B. R. K. B., & Campbell, C. D. (1998). Psychologists collaborating with clergy. *Professional Psychology, 29,* 564–570.

McMinn, M. R., & Lebold, C. J. (1989). Collaborative efforts in cognitive therapy with religious clients. *Journal of Psychology and Theology, 17,* 101–109.

Meissner, W. W. (1996). The pathology of beliefs and the beliefs of pathology. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 241–267). Washington, DC: American Psychological Association.

Nielsen, S. L. (1994). Rational-emotive therapy and religion: Don't throw the therapeutic baby out with the holy water! *Journal of Psychology and Christianity, 13,* 312–322.

Nielsen, S. L., Johnson, W. B., & Ridley, C. R. (2000). Religiously-sensitive Rational Emotive Behavior Therapy: Theory, techniques, and brief excerpts from a case. *Professional Psychology: Research and Practice, 31,* 21-28.

Richards, P. S., & Bergin, A. E. (1997). *A spiritual strategy for counseling and psychotherapy.* Washington, DC: American Psychological Association.

Robb, H. B. (1993). Using RET to reduce psychological dysfunction associated with supernatural belief systems. *Journal of Cognitive Psychotherapy: An International Quarterly, 7,* 281–289.

Shafranske, E. P., & Malony, H. N. (1996). Religion and the clinical practice of psychology: A case for inclusion. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 561–586). Washington, DC: American Psychological Association.

Sharkey, P. W. (1981). Something irrational about rational-emotive psychology. *Psychotherapy: Theory, Research and Practice, 18,* 150–154.

Sharkey, P. W., & Malony, H. N. (1986). Religiosity and emotional disturbance: A test of Ellis's thesis in his own counseling center. *Psychotherapy, 23,* 640–641.

Walen, S. R., DiGiuseppe, R., & Dryden, W. (1992). *A practitioner's guide to rational-emotive therapy* (2nd ed.). New York: Oxford University Press.

Worthington, E. L., Kurusu, T. A., McCullough, M. E., & Sandage, S. J. (1996). Empirical research on religion and psychotherapeutic processes and outcomes: A 10-year review and research prospectus. *Psychological Bulletin, 119,* 448–487.

Young, H. (1984). Practicing RET with bible-belt Christians. *British Journal of Cognitive Psychotherapy, 2,* 60–76.

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