



The Application of Maultsby's Rational Behavior Therapy in Psychosis – A Case Report

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Abstract

The purpose of this paper is to present the applicability of Rational Behavior Therapy (RBT) for a patient with psychosis. RBT is a form of cognitive-behavioral therapy developed by an American psychiatrist, Maxie C. Maultsby, Jr. RBT teaches rational self-counseling to achieve emotive and behavioral goals, reduce distress and the symptoms of the disease, improve functioning, improve treatment adherence, and prevent relapse. The challenges in applying cognitive behavior therapy in psychosis are described. We report the case of a 17-year-old patient who had been recently diagnosed with schizophrenia according to ICD-10 criteria, presenting with recurrent psychotic symptoms and suicidal ideation. Over 1.5 years, the patient was treated in an outpatient setting with antipsychotic medications and, intermittently, with RBT-based psychotherapy (by the first author). The therapy process was interrupted periodically due to temporary improvements in the patient's status, non-adherence, or relapses, including one episode requiring hospitalization. Nevertheless, the treatment eventually resulted in a long-lasting remission. We present examples of the RBT techniques used in this therapeutic process and highlight this treatment modality's unique features which support patients utilizing rational self-counseling skills to become more independent in coping with their problems. We emphasize that patients with a mental illness like schizophrenia or bipolar disorder also suffer from learned emotional disturbances that are amenable to treatment with cognitive-behavior therapies like RBT. In conclusion, we submit that with its self-counseling properties, RBT offers non-intrusive ways of helping people experiencing psychotic symptoms as part of their diagnosis and in prodromal or non-diagnostic states.

Keywords Rational Behavior Therapy (RBT) · Psychosis · Schizophrenia · Bipolar disorder · Prodromal · Self-counseling

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Introduction

Psychosis is a state of mind characterized by the loss of objective and accurate reality perception. While the emotional feelings and behaviors of a person with psychosis may be considered by others as irrational, they often are logical to the subjectively *perceived reality*, and the person finds them fully *rational*. Individuals with psychosis experience unusual beliefs, sounds, images, and other perceptual disturbances. Recovery from psychosis is possible once the patient can critically and accurately judge a real situation and is able to look at her/his own experiences from the psychotic period using a new, healthy perspective.

In some disorders such as schizophrenia, psychotic symptoms may persist chronically despite pharmacologic treatment. Treatment-resistant schizophrenia is much more prevalent than previously thought. It also has serious co-morbidity and mortality and poses a significant burden on the individual, the family, and society (Seppälä et al., 2016). Even if such a patient is in remission and free from positive psychotic symptoms (e.g., delusions and hallucinations), she/he may still remember previous experiences, and frequently will present with post-psychotic depression and continuous negative symptoms (e.g., blunted affect, lack of initiative and spontaneity, poor motivation to undertake normal activities, apathy, anhedonia), or have persistent cognitive deficits.

For a long time, psychotherapy in psychosis was completely neglected or considered a treatment option with little relevance. This has changed with the development and progress of cognitive-behavior therapies and their introduction to the treatment of patients with mental disorders. As a result, CBT combined with administration of antipsychotic medications is currently a recommended therapy for psychosis and is included in the UK guidelines of the National Institute for Health and Care Excellence (Turkington et al., Wright et al. 2013, Burns et al., 2014, Kuipers, Kendall, Udechuku, Slade, & Birchwood, 2014, NICE, 2014).

Rational Behavior Therapy (RBT) is a form of cognitive-behavior therapy developed by Maxie Maultsby, Jr. (Maultsby, Wirga et al., 2020; Wirga, DeBernardi, & Wirga, 2019), an American psychiatrist who, during the late 1960s and the early 1970s, cooperated closely with Albert Ellis, the creator of the Rational Emotive Therapy (RET). After adding some of Maultsby's techniques, Ellis renamed his therapy "Rational Emotive Behavior Therapy" (REBT) (Ellis, 1994).¹ Ellis seems to be the first one who used CBT techniques with patients with psychosis; REBT has an established value in this area (Trower & Jones, 2019). Maultsby's RBT is designed to overcome self-defeating thoughts through Rational Self-Analysis (RSA) of one's perceptions, cognitions, emotional feelings, and behaviors. The therapy enables the patient to distinguish clearly between healthy (rational) and unhealthy (irrational) ways of thinking. RBT is aimed at re-learning and practicing new cognitions associated with improved emotional health, comfort, and self-control. RBT was the first program of psychotherapy to be based on human brain neurophysiology and can

¹ A more detailed description of RBT was recently published (Wirga et al., 2020) and its comparison to REBT and CT are the subjects of a separate article in preparation.

be applied regardless of one's origin, culture, language, or religion. An important advantage of RBT stems from the fact that it motivates patients to apply rational self-counseling to themselves, thus enabling them to develop the ability of self-help in effectively dealing with unhealthy thoughts, emotional feelings, and behaviors as soon as they emerge.

In Poland, RBT has been taught since 1990. The therapy has been primarily adopted in psycho-oncology, as it constitutes the basis for therapeutic interventions for cancer patients in Simontonian Therapy (from the name of its creator, radiation oncologist Dr. O. Carl Simonton) (Zielazny et al., 2016). It has also been applied in other, often underserved populations including mentally healthy people with physical disabilities, to reduce the stress of daily living (Sierant et al., 2016). RBT was originally developed for patients with mental disorders and is also suitable for managing emotional and behavioral symptoms for patients with psychosis (Kafwa, 2011).

Psychosis—in particular, an active psychotic episode—represents an extreme example of irrational beliefs. Implementation of any cognitive-behavior therapy in individuals with this condition requires clinical skill, experience, an open mind, and creative attitude. Chronic or recurrent forms of delusions and hallucinations, the presence of negative and post-psychotic depressive symptoms, and common but heterogeneous cognitive deficits often displayed in schizophrenia make the therapy of psychosis particularly challenging (Dorofeikova et al., 2018; Fioravanti et al., 2012; Tripathi et al., 2018).

Case study

Marc was a 17 year-old high-school student raised by an upper-middle-class family of practicing Catholics living in the suburbs of a large Polish city. Marc started psychotherapy after being discharged from an inpatient psychiatric hospital unit. It was his second psychotherapy attempt after a 6-month-long course prior to his first psychiatric hospitalization. Marc had been recently diagnosed with schizophrenia according to the International Classification of Diseases (ICD-10) and had started pharmacotherapy with antipsychotic medication.

At the beginning of the psychotherapy, Marc experienced both positive and negative symptoms. He heard voices that criticized him and sometimes even commanded him to commit suicide. He also had delusions, believing that he was the main character in a staged show in which people around him were impostors trying to hide the ruse. This is often called *The Truman Show delusion* after the movie titled “The Truman Show” (Gold & Gold, 2012). Marc had an impression of constantly being monitored by hidden cameras, even at his own home. His negative symptoms were associated with a blunted affect, “mind emptiness” that replaced earlier “racing thoughts,” difficulties in motivating himself to undertake actions, and loss of pleasure from performing his favorite activities such as practicing sports. Most of the time his mood was low, and he occasionally had suicidal ideation. Furthermore, Marc suffered from a cognitive dysfunction involving attention, concentration, and learning.

For Marc, the onset of his illness was a devastating experience. Before developing symptoms of schizophrenia, he used to be a sociable person, often seen as a leader among his peers. At the beginning of psychotherapy, he described his friends as the ones who “now rule in the club.” Marc avoided social interactions and spent most of his time in bed. Only occasionally would he make an effort to meet one of his acquaintances or to talk to them on the phone. In his opinion, this only worsened the situation as he was no longer an interactive and talkative person. Sometimes he had ideas of reference—an impression that his friends were assessing him negatively, talking about him, and laughing at him behind his back. He believed that his friends were disappointed due to canceled meetings or silent phone calls with him. He still had a strong desire to be a part of the group, and the fear that it was no longer possible resulted in increased suicidal ideation.

Marc’s parents requested that he attend church every Sunday. That was sometimes his only motivation to go outside, even despite the anxiety and exhaustion caused by the delusion of being monitored by cameras. The diagnosis of schizophrenia was unacceptable for Marc, and he had difficulties sharing information about his disease with others. Also, Marc’s parents could not accept his diagnosis but still supported him in contact with the therapist (AK), especially during exacerbations. The psychiatrist in charge motivated Marc to regularly see his therapist, who helped Marc formulate the principal goal of psychotherapy being a reduction of Marc’s suicidal ideation and improvement of his social functioning to be able to go to school.

Marc’s therapy was based on RBT and continued for more than 1.5 years. His therapeutic sessions with AK were scheduled once per week. Marc would periodically interrupt his treatments, including pharmacotherapy, so, effectively, he participated in therapy in two- to four-month-long stretches. This was usually due to the intermittent improvement of his condition—complete remission of symptoms lasting approximately one month—or because of psychotic relapses due to non-adherence, including one episode so severe that he required re-hospitalization due to florid positive symptoms and suicidal ideation. During the periods of psychotherapy, Marc also saw a psychiatrist and received antipsychotic medications initially olanzapine and perazine. Following a re-hospitalization, he tried clozapine and valproic acid. A few months of therapy after his last relapse, Marc finally achieved complete remission and later was able to pass the final high school exams, thus opening opportunities for higher education. At that time, he decided to terminate the therapy and left the Child and Adolescent Psychiatry Clinic.

Application of the RBT Techniques During the Course of Marc’s Therapy

ABCD of Emotions

In this model, originally formulated by Albert Ellis and later modified by Maultsby, patients are taught that their emotional response to a given situation is caused by their thoughts, beliefs, and attitudes (Maultsby, 1984; Wirga et al., 2020; Wirga & DeBernardi, 2002). In this model, A (activating event) represents the situation to

which the person is responding; B (beliefs) represents cognitions about the situation; C (consequences of B) represents the emotional feelings; and D (doing) represents the resulting physical behaviors.

By applying the ABCD of emotions, the therapist was able to help Marc identify associations between his thoughts, feelings, and avoidant behaviors in social situations. One such activating situation (A) occurred when a high-school classmate invited Marc for a birthday party. Marc thought (B) about himself as "the person who fails in social situations," and this thought was associated with a growing feeling of anxiety (C). Using a subjective units of distress scale from 0 (no anxiety) to 10 (the highest level), Marc evaluated his anxiety as 10, accompanied by unpleasant body sensations (dry mouth, body tension). As a result, Marc did not attend the party (D). Further exploration of the ABCD model showed that the change of the situation caused by Marc's behavior (A2: avoidance) stimulated thoughts (B2) that he should stay at home and "should not fail" in the social situation, caused relief (C2), and reinforced avoidance of the action by "doing nothing" (D2). However, the new situation (A3: staying at home doing nothing) evoked a sense (B3) of social rejection and feeling worthless—both currently and in the future—which eventually contributed to suicidal ideation and self-blame (B4).

Using the ABCD model, Marc was able to formulate emotional goals that he would like to have in future similar situations (e.g., "less anxiety" and "diminished anger"), as well as future behavioral goals (e.g., "go to the next party"). The patient and therapist then planned additional supportive activities to increase the likelihood of success. As a result, Marc went to another party with a friend with whom he felt comfortable. On their way to the party, they had a conversation on a neutral topic that had been pre-planned with the therapist. Marc managed to stay at the party for two hours and had conversations with other friends. Although he was exhausted from coping with his anxiety and not fully satisfied with the event's outcome, he managed to maintain the healthy belief "I coped with this effectively," and no longer had suicidal thoughts.

The Five Questions for Healthy Thinking

Since cognitions drive emotional feelings, it is important to be able to assess which are healthy and rational and which are not. The unique feature of RBT is its clear definition of determining what is healthy by simply applying of the Five Rules for Healthy Thinking (5RHT). This allows patients to assess their thinking for themselves.

In RBT, rational cognitions obey at least three of the 5RHT. To make it easier for patients to use them, the rules are often presented in question form as Five Questions for Healthy Thinking (5QHT):

1. Is this thought based on obvious facts?
2. Does this thought best help me to protect my life and health?
3. Does this thought best help me achieve my short- or long-term goals?

4. Does this thought best help me avoid or handle most unwanted conflicts with others?
5. Does this thought best help me to feel the way I want to feel without abusing alcohol or other substances?

Additional qualifiers of healthy thoughts and beliefs.

- They obey at least three of the five rules.
- All of the rules are equally important.
- What is healthy thinking for me does not have to be healthy for another person.
- What is healthy for me today does not have to be healthy for me at other times.
- Some rules may not be applicable in certain situations, but healthy thinking still would obey at least three of the remaining four rules.

Working with Marc's cognitions often involved a rational discussion of his delusions, which he considered as factual. Consequently, his answer to the first of the 5QHT (if this belief was based on facts) was usually inconclusive. His therapist taught Marc to debate his own beliefs rationally and to provide existing evidence and fact-based arguments. For example, Marc believed that he was being monitored by cameras installed at his home. Although he genuinely believed that he had been constantly observed by the cameras, he was not able to provide any evidence for such devices being installed by his parents. Additionally, despite many attempts, he had never found any camera installed at home. Even so, he was convinced that his parents must have known about the cameras and used them to control his behavior.

Nevertheless, he never admitted that his belief was not based on an obvious fact, but rather concluded that there was a 10% probability that the cameras did not exist. He also admitted that the idea of believing he was continuously being monitored was not necessarily best for his life and health (QHT2), as it generated a high level of stress. He also realized that healthy people do not have such thoughts. As a result, Marc achieved his short-term and long-term goals (QHT3), such as spending a lovely evening at home or talking to his family members. Conversely, the irrational thought of being observed only caused him to avoid contact with his parents and increase his suspicions and confrontations rather than building a better relationship with them and reduce conflict (QHT4). It was clear that the concept of being monitored did not help him to feel the way he wanted to feel (QHT5).

The second part of QHT5—the ability to cope better without alcohol and drugs—did not apply to Marc as he did not drink alcohol or abuse drugs.

In addition to assessing the health value of disturbing beliefs, the particular value of the 5RHT is in the clear direction it gives patients in formulating healthy beliefs. This can be seen in the RSA technique described below.

Rational Self-Analysis (RSA)²

Homework is essential for effective cognitive-behavior therapy (Burns & Nolen-Hoeksema, 1991; Burns & Spangler, 2000; Kazantzis et al., 2016; Maultsby, 1971), and similarly indispensable in therapy for psychosis (Smith & Pell, 2003). The purpose of a written RSA as a *permanent* homework in RBT is to help explore the cognitive basis for one's own emotional feelings and behaviors in emotional ABCD format, and then transform these cognitions into healthy ones. RSA allows for the formulation of healthy emotional and behavioral goals. Most importantly, it provides a structure for a rational self-debate to create a healthy, rational, alternative ABCD leading to an immediate decrease in emotional distress. The advantage of the RSA stems from its practicality—it can be done any time—with the involvement of a therapist being needed only initially when learning this technique, for immediate practical experience and therapeutic feedback. The only accessories used during the RSA are a sheet of paper and a pen or pencil (online forms are also available). The RSA is comprised of two columns: the “initial” ABCD is placed on the left column and the rational debate (an alternative healthy ABCD) on the right.

The healthy right column of the RSA is filled out in a different order than the left column of the original ABCD. The healthy emotional (section HC) and behavioral (section HD) goals are filled out first, followed by the “camera check” of perceptions (HA). The camera check asks the patient to imagine the same situation (A), but from the perspective of a video camera dispassionately recording only what actually happened. This enables the patient to distinguish between the situations that really took place and her/his subjective interpretation thereof. The final and most important section of the RSA is the self-debate of irrational thoughts (section B), which is done by checking how many “yes” answers they would give to the Five Questions for Healthy Thinking (5QHT). Unhealthy, irrational thoughts, by definition, don't give more than two “yes” answers and often yield zero “yes” answers. In this final step, alternative thoughts satisfying criteria of healthy thinking (i.e., at least three “yes” answers to 5QHT), while also being accepted by the patient, are formulated in the section HB.

One of Marc's RSAs is presented below. Due to his delusions, the term “camera check” was not used but instead only a “test of perceptions.”

Rational Emotive Imagery (REI)

Life doesn't give enough opportunities to practice new healthy thoughts, emotional feelings, and behaviors. When it does, people are usually not prepared for it and consequently act in their old, habitual ways. RBT employs mental rehearsal techniques to help the patients practice in their minds as much as they want,

² More detailed description (Wirga et al., 2020).

supplementing experiences occurring in real life. REI is an often-used technique within the realm of imagery rescripting and has an established value in CBT in psychosis (Trower & Jones, 2019).

At the time of the RSA, Marc was still unable to accept that his delusions of cameras monitoring him had, in fact, never existed. He did benefit from mentally rehearsing the healthy thoughts that he had written in section HB of his RSA, and from imagining his goals of healthy emotional feelings and actions. With practice, his thoughts became more rational. Prior to imagining a given situation with new beliefs and emotional feelings, in order to relax Marc used the Instant Stress Relief Technique (which Maultsby originally called “Instant Better Feeling Maneuver”), a simple exercise of slow diaphragmatic breathing.

Emotional re-learning and cognitive-emotive dissonance³

In RBT, all patients are taught that when they start to practice—even just mental practice—new behaviors that are in conflict with old habits, it immediately causes the unpleasant visceral sensation that this new cognition or behavior feels *weird*, *awkward*, *unnatural* or *wrong*. Educating about this phenomenon, known in RBT as cognitive-emotive dissonance, is important because people tend to stop thoughts and actions that feel *wrong* even if they are objectively healthy, often discontinuing the practice essential to solidifying their new behaviors. Marc’s therapist prepared him for this with the example of what it would be like to drive for the first time in left-hand-side traffic. Marc, who grew up driving on the right, could easily imagine himself feeling *weird* in the British traffic. He realized that the British do not have different brains. Hence there was nothing inherently *unnatural* about driving on the left-hand side, and that the ease of doing what we associate with feeling *natural* and *right* reflects a well-established habit. When asked if it would always feel *wrong* to drive on the left-hand side, Marc quickly recognized that if he practiced new skills long enough, soon driving in the UK would feel as *right* as driving in his home country.

Marc was instructed to apply emotional re-learning and the idea of cognitive-emotive dissonance in his psychotherapy assignments. He realized that his new healthy beliefs in section HB and emotional and behavioral goals in sections HD were, in fact, opposite to his habits, so acting on them (or just doing their REI) may elicit the visceral sensations related to cognitive-emotive dissonance. Moreover, he recognized that these goals may feel *wrong* while being objectively healthy and *right* for him (as he decided with 5RHT). He was encouraged to give himself the same advice he had for the driver, namely to ignore the feeling *wrong* and to practice in his imagination/REI and in real life what he had written on the right side of his RSA. Marc realized that many people give up on new behaviors, even if it is the only chance for them to improve their lives because the old habits feel *right*

³ It is a reference to Maultsby’s Psychosomatic Learning Theory (also called Rational-Behavioral Learning Theory) which emphasized that the process of changing emotional habits is the same as changing physical behavior habits. It is explained in more detail elsewhere (Maultsby Jr, 1984; Wirga et al., 2020).

and familiarly comfortable while keeping them stuck in the ruts of unhealthy habits. He was reassured that with practice, the new behaviors eventually would become as comfortable and feel as *right* and *natural* as the old ones. If patients are not prepared for the cognitive-emotive dissonance, they usually don't adopt the behaviors associated with feeling *wrong*. They give up on practicing the new cognitive, emotive, and behavioral goals.

In Marc's case, a thorough explanation of this process was fundamental and required multiple revisits, particularly when he was engaging in the practice of new behaviors that challenged his strong social anxiety. Exposure is the only definitive treatment for such anxiety. Marc's success required gradual exposure in his imagination and in real life. Having a "safe friend"—someone with whom he felt comfortable and could engage in small talk on the way to a party—would keep him from focusing on his social anxiety and provoking unhealthy beliefs, thus allowing easier entry into the social scene.

Healthy Semantics

Semantic techniques have a long tradition in cognitive behavior therapies starting with Albert Ellis, who in turn credited Alfred Korzybski (Ellis, 1994; Korzybski, 1935). RBT therapists pay particular attention to habitually-used words; they promote healthy semantics to replace habitually-used words expressing irrational, non-factual attitudes (often reflecting demandingness, awfulizing, self-/other-worth ratings, or low frustration tolerance as well as many cognitive distortions), with healthy ones, and in doing so, reducing emotional distress (Wirga et al., 2020).

In Marc's case, the focus was on his habitual use of the word "should." His attempts to go to school were not successful even though he maintained a belief that he "should" do so. He realized that he bristled when others were telling him what he "should" do and, similarly, "I should go to school" elicited his rebellion against acting towards his goals. With his therapist, Marc explored the beliefs behind his unwillingness to attend school: too much effort required, meeting people with whom he did not feel comfortable because they might not accept his appearance, his short attention span, a fear of being laughed at by his classmates. Therapists also focused on his motivations to attend: involvement in the same activities as his peers rather than being isolated, making significant progress toward success, continuing his education, passing the final high school exams. This evaluation enabled Marc to replace the unhealthy semantic, "I should go to school," with the healthy one of, "I want to continue school education because...."

Another of Marc's unhealthy semantic habits was calling himself a "loser." During the periods of psychotic symptom exacerbation, he could even hear voices referring to him by "loser." In therapy, Marc realized that the meaning of "loser" was not factual in his case. He finally admitted that referring to himself with this self-downing term violated all 5QHT and contributed to his depressed mood. This in turn impeded him in achieving his rational objectives or feeling the emotions he really wanted to feel. Finally, Marc discovered that the term "loser" could be replaced with "beginner," a term better suited to a person starting to implement substantial

changes into their radical unconditional self-acceptance and not yet having reached the level of “master.” His previous experiences with a sport in which he progressed from a beginner to an advanced level were helpful in this transition.

General Principles of Applying RBT in Psychosis

The case presented above gives a good overview of the process of RBT in the treatment of a patient with psychosis. During our residency training, Dr. Maultsby asked us (AW and MW) to conduct group and individual RBT with severely, chronically mentally ill patients. These patients predominantly carried the diagnosis of schizophrenia or schizoaffective disorder. Despite vigorous treatment with neuroleptic, mood-stabilizing, and other psychotropic medications, they continued to experience persistent delusions, hallucinations, mood swings, negative symptoms, and marked cognitive deficits. Applying RBT to patients with psychosis was new to us, particularly as initially it seemed to contradict what the RBT manual specifically said: RBT is indicated for people with learned behavioral and emotional problems. Psychosis is a non-learned problem (Maultsby Jr, 1984). It is important to note that people with non-learned problems like schizophrenia or bipolar disorder are not exempt from learning unhealthy emotional and behavioral habits. As a matter of fact, because of their underlying mental illness, they usually are exposed to more experiences predisposing them to the acquisition of more unhealthy emotional habits than an average person. Still, these habits are amenable to treatment with RBT. Moreover, it turns out that the content of delusions and hallucinations reflects the person’s biography, their views of the world, of their own nature, and of their future, therefore it also, to a certain degree, is learned (Longden et al., 2012). It became clear to us that if one listened to the psychotic content and explored the related beliefs that appeared hidden, many possibilities for effective cognitive interventions would open (Romme & Morris, 2013).

While establishing non-judgmental therapeutic rapport, the therapy is guided by the patient’s short- and long-term goals in the most important areas of their lives before even introducing the ABCDs, 5QHT, and other concepts and techniques. For some patients with psychosis, the insight that their hallucinations and delusions are creations of their own minds reflecting their thoughts and beliefs is liberating. They come to understand that their minds create a “virtual reality” (which at some point may have been protective) that is not factual, nor adaptive anymore, and the level to which they believe in this virtual reality correlates with the severity of their current disturbance. At the same time, learning the ABCDs of emotions can be empowering with the realization that they are not at the mercy of the situation (A), and from their thoughts, beliefs, and attitudes (B) arise all their emotional feelings (C) and physical actions (D). Knowing and practicing their ABCDs helps patients choose to “ignore” hallucinations, create distance from delusions, and develop the skills to do a reality check of perceptions.

In RBT, we treat hallucinations like an A, or “activating event.” We also ask about the quality and the content of these hallucinations (the discussion of

differential diagnosis is beyond the scope of this article, but it is an essential process in itself), and at the same time establish therapeutic rapport with the patient. Then we explore the patient's beliefs about these hallucinations. For instance, in the case of command auditory hallucinations prompting the patient to hurt herself/himself or others, the patient's beliefs in her/his abilities to resist the voices vs. being powerless over them may impact the probability of the patient taking dangerous action on these auditory commands. In this process, we found it useful for patients to fill out the Beliefs about Voices Questionnaire-Revised (BAVQ-R) (Chadwick et al., 2000; Chadwick & Birchwood, 1995; Paul Chadwick & Birchwood, 1994).

For patients with predominant delusions (fixed false beliefs), it is paramount to first establish a compassionate and nonjudgmental therapeutic rapport, as the patients may be suspicious, guarded, and unwilling to reveal their delusional beliefs. Therefore, we don't rigidly keep the session to the typical (for RBT) 30 min (Maultsby, 1984, pp 104, 105, 128). Sometimes it may be too much for the patient to tolerate interpersonal interaction, while at other times we don't want to cut short a flow of deepened inquiry and the opportunity for exploration of her/his beliefs. The authors believe that some psychotic symptoms were, to a degree, protective at some point for the patient. Unfortunately, these patients' delusional beliefs were often questioned and contradicted by laypeople or unskilled but well-intentioned professionals. At times, their delusions were discredited or even ridiculed. After such experiences, patients' suspiciousness is further reinforced, and paranoid beliefs become entrenched as they learn to guard their delusions even more and grow reluctant to share them.

We have found that teaching the basics of Healthy Semantics (i.e., how words like "have to," "should," "must," "unfair," etc., influence how people feel) from a handout that is illustrated with cartoons (Maultsby, Wirga, & DeBernardi, 2021) is a non-threatening and engaging way of establishing rapport with patients, and helps them learn the relationship between their cognitions and affect. In a group setting, patients begin to correct each other's unhealthy semantics, and the therapist models how to do so in a non-challenging, kind, gentle, and often playful way. The use of Healthy Semantics may extend beyond the group and help in establishing a healthier milieu such as in an Intensive Outpatient Program, Partial Hospitalization Program, or in a board-and-care home where the patients may reside.

Once rapport is formed and over the course of several individual sessions, with the help of the therapist the patient makes a list of all her/his delusions. Then she/he ranks the delusions from the strongest-held belief to the weakest, rated as a percentage of how "true" this belief is for the patient and how strongly they believe it is real. Once the hierarchy is established, the patient and therapist begin applying the Five Questions for Healthy Thinking (5QHT) to the weakest of delusions. i.e., What is the evidence supporting this belief (QHT1); how this belief protects her/his life and health (QHT2); how this belief helps in achieving her/his goals (QHT3); how it affects her/his relationships with others (QHT4); and how it makes them feel (QHT5). It may take several sessions for the patient to realize that this belief—the weakest delusion—doesn't obey at least three of the 5QHT and therefore is unhealthy. The therapist then helps them formulate a healthy belief incompatible

with this weakest delusion and obeying at least three of the 5QHT. Consequently, the therapist assigns the patient a mental practice (as described above in Rational Emotive Imagery/REI) of rehearsing this new healthy thought. Rehearsing is accomplished by repeating the new healthy thought in the patient's mind for a minimum of half a minute at least three times daily, and every time the delusion comes up in her/his consciousness.

The therapist then introduces the formal practice of RSA/REI (as described above) and encourages the patient to apply it to his/her next weakest delusional belief, and so on. Through generalization, it sometimes occurs that some of the previously strongly-held delusions lose the strength of their conviction or dissipate entirely, even before the patient has addressed them. The process of establishing initial emotional goals in HC is similar to gradually moving from weakest delusions to the strongest. Particularly with patients tormented by intense negative emotions, it is crucial that the initial emotional goals in HC are believable to the patient; for example, if they wrote "despair and fright" in C, they may write "less depressed and less anxious" in HC rather than "happy and confident." From there, the patient may work along the emotional continuum towards neutral emotions like "accepting and calm." Eventually, if motivated, they can work towards positive emotions. The ultimate proof of the validity of healthy beliefs, as well as healthy emotional and behavioral goals, is consistently acting on them even if this may feel *wrong* or *unnatural* (cognitive emotive dissonance) or evoke irrational fear (like during exposure) (Maultsby et al., 2021).

Discussion

A common question regarding RBT is whether it is safe to let emotionally disturbed people counsel themselves. This question seems to be particularly relevant in individuals with psychosis who may present with extremely irrational cognitions. The answer is "yes," because we cannot stop the patients from counseling themselves anyway, as we cannot stop internal dialogue from one's mind. As long as the train of thought of a person with psychosis is coherent and goal-directed, her/his emotional feelings are usually logical to her/his sincere beliefs. The RBT therapist's role is to show the patient the relationship between the content of her/his thoughts with their feelings and actions in order to make them more rational and factual. The patient who learned to correctly complete the Rational Self-Analysis (RSA) is capable of self-counseling outside of the formal therapy sessions with the therapist and can intensify the therapeutic effect by combining it with the REI with real-life practice.

Undoubtedly, due to a particular spectrum of symptoms, the therapy of a patient with psychosis poses distinctive challenges. Successful application of RBT techniques depends on the patient's condition at the time of the therapy. This involves not only the impact of positive symptoms, but also the presence of potential negative symptoms, thought process disorders, and cognitive dysfunction. In the case of Marc, the thought disorders referred primarily to the content rather than to the process (Berna et al., 2016); as he was free of symptoms such as incoherence, derailments or loose associations, severe poverty of thought, clanging, perseverations, and

paraphasias (Andreasen, 1979). A patient who is a candidate for RBT, and therefore rational self-counseling, needs to be able to express her/his thoughts and emotional feelings. Similar to other therapies, RBT is more challenging in the patients who present with more severe symptoms and have difficulties in maintaining rapport with the therapist. Some techniques need to be modified in order to be better adjusted for the symptoms presented by a given patient. In Marc's case, such a modification was necessary, for example, in the case of the RSA "camera check." Our experiences suggest that such a "test of perceptions" can be helpful in individuals with psychoses, especially with self-referent patients.

RBT in psychoses extends beyond the symptoms typical for the psychotic diagnoses; it may help with depressive and anxiety symptoms, address interpersonal issues and unhealthy habits, as well as decrease the distress of daily life. One distinct advantage of this therapy stems from its emphasis on the development and mastery of self-counseling skills. This way, RBT's transdiagnostic features can be useful in prodromal states and in persons who present with some symptoms but do not meet the diagnostic criteria for a specific mental illness (Romme & Morris, 2013). Thanks to its rational self-counseling, RBT may also be applicable to individuals who experience unusual inner speech sensations (Alderson-Day & Fernyhough, 2015; Romme et al., 2009) but do not consent to standard psychiatric care. An example of such an approach is the Hearing Voices Movement. In this population, RBT empowers the individual with a non-intrusive focus on self-exploration and self-debate within the agreed-upon parameters of the 5RHT. RBT goes beyond the usual emotional goals of typical cognitive therapy approaches such as reduction of distress or anxiety and depression related to hallucinations and delusions. RBT helps address personal short-term and long-term goals (RHT3), interpersonal issues (RHT4), as well as overall health in general (RHT2). The patient who masters self-counseling may perceive himself/herself as a more independent partner in the therapeutic relationship, better adhere to the treatment plan, have less mood swings, and handle stress and interpersonal conflict more effectively. It may also diminish the intermediate- to long-term risk of a recurrence since the patient can apply rational self-counseling, (Table 1) even years after the end of the formal therapy, as an effective relapse prevention and self-rescue tool.

The data presented here have several significant limitations. In the case presented, no evidence in the form of questionnaires, surveys, or checklists was included to objectively measure improving symptomatology (except for typical for RBT in-session subjective units of distress). We were also unable to demonstrate if the remission of psychotic symptoms was due to recently introduced clozapine (in combination with valproate) that had not been tried before. Furthermore, Marc aged out of the Child and Adolescent Psychiatry Clinic and was lost to follow up so we have no information as to whether the patient continued to apply any of the RBT self-counseling skills and if they had any lasting beneficial effect. The most important limitation is that there is no systematic research of the of RBT's efficacy, specifically in the treatment of psychosis. We would strongly recommend that such research is undertaken to further the field in the form of single-case design or pre-, post-, and follow-up randomized controlled design. Despite these limitations, this article offers a unique insight into Maultsby's approach to the treatment of psychosis in

Table 1 Rational Self- Analysis (RSA) of Marc in one of the social situations

A. Activating situation	Healthy A. Test of perceptions
I was at church with my parents. The mass lasted for almost two hours. That was so difficult to cope with! A man sitting next to us was looking at me the entire time and talking to the woman who was with him. I felt like running away	Most of the time, I was sitting with my eyes directed at the ceiling. I was not observing that man and woman all the time. Every time I looked at them, the man was looking back at me There is no such feeling “like running away” but just an urge to leave because of my negative thoughts causing anxiety
B. Beliefs	Healthy beliefs
B1. When I am surrounded by many people, it always happens that at least one of them constantly looks at me	HB1. I am not able to verify all the time whether the people are looking at me or not
B2. The person who keeps looking at me all the time reads my mind. He may know about my illness. He is talking about it with a woman	HB2. This man may not be reading my mind, and may be talking to the woman about something else (10% likelihood)
B3. There might be cameras around watching me; someone may be interested in recording me	HB3. I have not seen any cameras at the church, so there might not be any cameras (10% probability). Even if there were cameras, there would be no problem because it was a public space and my behavior was appropriate for such. Therefore, there is no rational reason to be so anxious about being recorded
B4. I need to control myself to avoid doing something stupid while somebody is watching me and recording my behavior with the cameras	HB4. I came here to pray, not to be anxious about doing something and controlling myself. Everyone does something stupid from time to time and I am no different
C. Emotional feelings	HC. Healthy emotional feelings
Anxiety (10 of 10) in that situation Body sensations: muscle tension, pain	Less anxiety. More calm and relaxed. Body sensations: only slight muscle tension, no pain
During the therapy session: anxiety (7 of 10) when remembering the situation and talking about it	After the session: anxiety (4 of 10)
D. Physical actions	HD. Healthy physical actions
Frozen. Unable to do anything. I am not telling my parents that I need to go. I cannot stop looking at the ceiling	Participating in the service and looking at the altar (without staring at the ceiling). I can always leave but that will only reinforce my negative thinking and avoidant behavior

this step-by-step example. The authors believe that RBT can complement any other CBT approach with its strong self-counseling features and its truly transdiagnostic applicability, including psychotic disorders and prodromal states (Wirga et al., 2020; Wirga, DeBernardi, Wirga, et al., 2019).

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Declarations

Conflict of interest The authors declare that they have no conflict of interest.

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