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Homework Use in Cognitive Therapy for Psychosis: A Case Formulation Approach

Neil A. Rector, *Centre for Addiction and Mental Health, University of Toronto*

Based upon empirically supported cognitive-behavioral treatment approaches, this paper aims to outline the use of homework to enhance the therapeutic relationship, patient motivation, and skills for managing delusions, hallucinations, and negative symptoms. The nature and timing of homework is outlined for the different phases of treatment. Frequent barriers that emerge during the setting and reviewing of homework are described, followed by strategies to enhance motivation and homework compliance. The paper concludes with a demonstration of how homework is optimized within a case formulation approach for persistent symptoms of psychosis.

Numerous randomized controlled trial studies have demonstrated the efficacy of cognitive behavioral therapy (CBT) for psychosis (Gould, Mueser, Bolton, Mays, & Goff, 2001; Pilling et al., 2002; Rector & Beck, 2001; Tarrier & Wykes, 2004). In response to this accumulating evidence, CBT is now a recommended component of evidence-based care in the National Institute for Clinical Excellence (NICE, 2003), American Psychiatric Association (APA, 2004) and the schizophrenia patient outcomes research team (PORT; Lehman & Steinwachs, 1998) practice guidelines for patients with schizophrenia. CBT for psychosis draws on the conceptualization and intervention strategies previously developed in CBT for depression (Beck, Rush, Shaw, & Emery, 1979) and anxiety (Beck, Emery, & Greenberg, 1985) but is tailored to address the unique cognitive and behavioral factors associated with delusions, hallucinations, and negative symptoms. Treatment also aims to target some of the secondary consequences of the disorder, such as functional impairments, stigma, rejection, and loss, within a comprehensive stress-vulnerability model (Beck & Rector, 2000, 2005; Chadwick, Birchwood, & Trower, 1996; Fowler, Garety, & Kuipers, 1995; Gumley & Schwannauer, 2006; Kingdon & Turkington, 2005; Nelson, 2005; Rector & Beck, 2002; Tarrier, 1992; Tarrier & Haddock, 2002; Warman & Beck, 2003).

The comprehensive goals of CBT include: (a) the establishment of a strong therapeutic alliance, completing an assessment, and developing a case formulation; (b) providing psychoeducation about the nature of psychosis within a biopsychosocial model with the goal of reducing stigma and normalizing these experiences; (c) delivering cognitive and behavioral interventions for delusions, hallucinations, and the social, emotional, and behavioral disengagement that characterizes the negative symptoms; (d) targeting comorbid affective states such as anxiety and depression; and (e) reducing relapse and helping the patient stay well.

The treatment manuals (cf. Nelson, 2005) noted above and case studies in the CBT treatment of psychosis (Kingdon & Turkington, 2002; Morrison, 2002) demonstrate that irrespective of symptom presentation, assigning, reviewing, and consolidating feedback from homework is an integral component of the therapeutic process. The basic tenet that between-session activities facilitate consolidation and generalization of skills practiced in sessions is important to the fundamental goals of CBT: normalizing and reducing stigma associated with symptoms; and helping patients to learn to identify and reframe delusional beliefs, question the content and the secondary delusional beliefs pertaining to voices, reduce negative expectancies regarding social and emotional engagement, and improve functional outcomes. The aims of this article are to provide an overview of common homework assignments that may be most helpful at different phases of treatment, strategies to identify and reduce

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the common barriers to successful homework completion, and to illustrate the use of homework in the CBT for psychosis through case illustration.

The Nature and Timing of Homework in CBT for Psychosis

Table 1 provides an overview of common homework options for different phases of treatment. The early phase of treatment is aimed at developing the therapeutic alliance through empathy, warmth, and honesty. Through gentle questioning and guided discovery, the therapist instills a climate of openness and trust. Homework during this phase can focus on collecting more detailed information about the patient's day-to-day activities with mastery and pleasure ratings, general mood monitoring, and self-monitoring of the beliefs, feelings, and behaviors pertaining to the experience of specific symptoms. Introductory readings on cognitive therapy and handouts on specific symptoms (e.g., hearing voices) also help to socialize the patient to the cognitive model. Providing psychoeducation about the nature of personal vulnerability and the role of stress on the production of delusions, hallucinations, and social and emotional withdrawal is a key component to demonstrating the universality of the patient's experiences. Homework tasks to facilitate "normalizing" include preparing handouts on the common experience of many symptoms of psychosis, assigning readings of first-person accounts of psychosis (e.g., like those that appear frequently in *Schizophrenia Bulletin*), scheduling attendance at a group meeting, and accessing support through popular Web sites (e.g., the widely accessed Hearing Voices Network). Progress in the patient's understanding of the relation between thoughts, feelings, and behaviors and the underlying beliefs and assumptions that contribute to persistence of symptoms culminates in a case formulation, which provides an individualized blueprint for the timing of specific cognitive and behavioral strategies in session, as well as part of homework.

Specific cognitive and behavioral strategies are aimed at reducing the positive and negative symptoms. Once the therapist has a thorough understanding of the patient's delusional beliefs and the past and current events that are interpreted as supporting the belief, gentle questioning of the evidence is undertaken. The approach is collaborative and Socratic, and the therapist initially deals with the interpretations and explanations that are peripheral to the more central and highly charged beliefs. Patients are also taught to identify, question, and correct cognitive distortions and other information processing biases that facilitate misinterpretation of experiences. Homework includes providing a list of cognitive distortions and dysfunctional thought records (DTRs), initially to record thoughts, feelings, and emotions (3-column record). Eventually, practice with a full DTR that provides opportunity to identify distortions, evaluate evidence, and generate alternative balanced explanations. Behavioral experiments are an especially powerful tool to build alternative explanations for experiences. Similarly, voices are targeted through daily self-monitoring; behavioral distraction techniques (use of Walkmans, earplugs, etc.); and active cognitive restructuring strategies to change the distressing response to the voice content (e.g., "You're stupid"), the secondary delusional beliefs about the voices (e.g., "Deceased grandfather punishing me"), and, finally, the nondelusional core beliefs (e.g., "I'm stupid and inadequate") that underlie the voice content and beliefs about voices. Voice diaries and modified thought records to restructure responses to voices are pivotal to the treatment of voices. Reduction of the avoidance and safety behaviors associated with hearing voices are reduced through exposure strategies and behavioral experiments.

The characteristic features of the negative symptoms—low motivation, diminished energy, restrictions in emotional and verbal expressiveness, and social disengagement—have been construed as deficits that are not amenable to change with psychological interventions. Yet, we know that the negative symptoms wax and wane for the vast majority of patients who experience them. Internal and external triggers have been associated with their onset (e.g., hearing voices and hospitalization) and reduction (e.g., reduced hopelessness and acquisition of a part-time job). CBT can contribute to the reduction of negative symptoms by helping the patient learn to identify and reduce the triggers for their activation and/or develop strategies for the alleviation following onset. A cognitive set characterized by low expectancies for pleasure, success, acceptance, and anticipated lack of personal resources contribute to the persistence of negative symptoms and are targeted in CBT (Rector, Beck, & Stolar, 2005). Common strategies include the use of activity schedules, graded task assignments, assertiveness training, and thought records to target negative expectancies (Kingdon & Turkington, 2005; Rector & Beck, 2002). Much of the progress in reducing negative symptoms is achieved through the successful completion of homework tasks between sessions.

Following the targeting of dysfunctional attitudes and beliefs with standard CBT strategies such as DTRs and core belief records (J. Beck, 1995), the final goal is to consolidate treatment gains and provide strategies to reduce relapse. The goals are to help patients identify potential triggers for relapse, early signs of relapse, cognitive strategies to decastrophize the return

Table 1
Common homework options in CBT treatment of psychosis

Phase of treatment	Common homework options
Assessment and engagement	▪ Self-monitoring: ✓ Voices ✓ Delusions ✓ Negative symptoms ✓ Moods ▪ Bibliotherapy/resources: ✓ Introductory readings on Cognitive Therapy ✓ Specialized handouts on Cognitive Therapy for Psychosis ▪ Cognitive tasks: ✓ Start monitoring of automatic thoughts with 3-column DTR ▪ Behavioral tasks: ✓ List of goals for treatment ✓ Activity scheduling with pleasure/mastery ratings ✓ Assist in scheduling of doctor's appointment and medication adherence ✓ Start testing out correspondence between anticipated and actual pleasure ratings in life activities
Psychoeducation and normalizing	▪ Self-monitoring: ✓ Monitor symptoms with modified DTR ✓ List appraisals and interpretations of experience ▪ Bibliotherapy/resources: ✓ Prepare handouts for readings on normalizing of voices, delusions, and negative symptoms ✓ Assign readings of first-person accounts ✓ Provide information and plan for joining local support groups ✓ Provide information and facilitate access to popular websites for support such as Voice Hearers Groups ▪ Cognitive tasks: ✓ Prepare normalizing information on coping cards to be reviewed ▪ Behavioral tasks: ✓ Conduct survey to see what others think of their interpretations ✓ Test out whether experience (e.g., voice) fits in with new normalizing rationale
Cognitive-behavioral approaches for voices	▪ Self-monitoring: ✓ Daily voice diary ▪ Bibliotherapy/resources: ✓ Readings on cognitive therapy for voices ✓ Handouts on cognitive distortions ▪ Cognitive tasks: ✓ DTR for cognitive restructuring of voice content ✓ DTR for cognitive restructuring of the beliefs about voices ✓ DTR for cognitive restructuring of nondelusional beliefs that relate to voice content and belief about voices ▪ Behavioral tasks: ✓ Distraction strategies (e.g., earplugs/Walkman) ✓ Focusing strategies (e.g., relaxation) ✓ Exposure exercises to reduce avoidance and safety behaviors ✓ Survey methods – What do others think about your voices? ✓ Review taped sessions to determine if voices are present/absent to gauge internal or external generation of voice ✓ Use exposure to triggers to show that voices can be activated and deactivated with the patient's control
Cognitive-behavioral approaches for delusions	▪ Self-monitoring: ✓ Monitor delusional triggers ▪ Bibliotherapy/resources: ✓ Readings on identifying, testing and correcting cognitive distortions ✓ First-person accounts where self-directed CBT exposure was used ▪ Cognitive tasks: ✓ 3-column DTR to monitor situational triggers, moods, negative automatic thoughts supporting delusional interpretations

(continued on next page)

Table 1 (*continued*)

Phase of treatment	Common homework options
	✓ Full modified DTR to identify distortions, evaluate evidence, generate alternative balanced interpretations ✓ Pie charts ▪ Behavioral tasks: ✓ Exposure exercises to reduce avoidance and safety behaviors ✓ Use opportunity to test out alternative explanations for beliefs
Cognitive-behavioral approaches for negative symptoms	▪ Self-monitoring: ✓ Focused self-monitoring of periods of social and emotional withdrawal ▪ Bibliotherapy/resources: ✓ Cognitive therapy readings that are relevant to social and behavioral withdrawal ▪ Cognitive tasks: ✓ Use of standard DTRs to target negative expectancies ▪ Behavioral tasks: ✓ Creating a list of pleasurable activities ✓ Activity scheduling with anticipated pleasure ratings and post-activity pleasure ratings ✓ Activity scheduling with anticipated success ratings and post-activity success ratings ✓ Reducing secondary negatives symptoms to delusions and voices via exposure exercises ✓ Graded task assignments ✓ Assertiveness tasks ✓ Homework goals that include family members and caregivers (e.g., will have dinner with parents every night provided that we do not have to discuss my school plans) ✓ Testing out whether negative outlook (e.g., “I could never do that,” or “I'll sound stupid”) is supported by experience in a particular activity
Cognitive-behavioral approaches for nondelusional beliefs	▪ Self-monitoring: ✓ Standard DTRs ▪ Bibliotherapy/resources: ✓ Readings about core beliefs ▪ Cognitive tasks: ✓ Thought records ✓ Core belief records ▪ Behavioral tasks: ✓ Analyze behavioral patterns to impact on dysfunctional beliefs ✓ Positive environment logs ✓ Test out “old” and “new” beliefs
Relapse prevention	▪ Self-monitoring: ✓ Activity scheduling to maintain pleasure/mastery events during periods of setbacks ▪ Bibliotherapy/resources: ✓ Develop list of resources with phone numbers ▪ Cognitive tasks: ✓Use DTRs to combat “catastrophization” of early signs ▪ Behavioral tasks: ✓ List of individual stressors ✓ Create steps for relapse prevention ✓ Create list of early warning signs ✓ Establish experiments to test out beliefs

of mild, transient symptoms, and a coping plan that includes a detailed review of resources available for support. Homework strategies at this stage of treatment often include having the patient actively participate in the construction of lists corresponding to these goals.

Barriers to Homework Use in CBT for Psychosis and Strategies to Enhance Compliance

There is considerable variability in the quantity and quality of homework in the CBT treatment of psychosis, as there is the CBT treatment of nonpsychotic disorders

(Helbig & Fehm, 2004). There are a number of disorder-specific factors that may limit homework success if not adequately identified and addressed. Common factors that affect homework compliance in patients with psychosis include low motivation, trouble taking initiative, and lack of energy. In a survey of psychologists' use of homework with patients with schizophrenia, Deane, Glaser, Oades, and Kazantzis (2005) found that the top five ranked barriers, in order of importance, were: little motivation, ineffective decision-making, social withdrawal, distractibility, and difficulty initiating activities. In a study that focused on patients' experience and perspective of homework tasks in CBT (Dunn, Morrison, & Bentall, 2002), factors cited affecting homework compliance also included low motivation, putting off the assignment, and lack of effort. Importantly, these reported problems pertaining to low motivation, withdrawal, lack of effort, and troubles initiating activities, in part, mirror a core aspect of the disorder, namely, the negative symptoms. This corresponds to an earlier report that the presence of prominent negative symptoms, in particular, led to poor homework compliance (Hogg & Hall, 1992). However, recent progress in the conceptualization (Rector et al., 2005) and treatment of negative symptoms (Rector, Seeman, & Segal, 2003) demonstrates that patients improve in their motivation, reduce social withdrawal, and become more emotionally engaged in goal-directed activities when their negative social and performance attitudes are directly addressed during the planning and review stages of behavioral activation tasks. Performance-related items on the Dysfunctional Attitude Scale (DAS; Weissman & Beck, 1978), such as "If I fail at my work, then I am a failure as a person," "Taking even a small risk is foolish because the loss is likely to be a disaster," and "I should be upset if I make a mistake," have been found to be associated with social and emotional withdrawal in schizophrenia (Rector, 2004). These negative performance beliefs represent potential barriers to homework compliance, but can be directly targeted in treatment to enhance homework compliance. As outlined by J. Beck (1995) and Tompkins (2004), addressing dysfunctional performance beliefs and fear of failure are critical to improving homework compliance in CBT treatment. In the study by Helbig and Fehm (2004), the most frequently cited problem regarding homework assignments was "Patient doubts his/her ability to complete the task."

Strategies to improve homework compliance should be aimed at both the *assignment stage* and *review stage*. With respect to the former, small and manageable goals are set, including probing for anticipated success with the homework, working with distorted appraisals and beliefs around the task, and arriving at a perspective that makes homework a "no-lose" proposition in which the task is to try rather than to succeed itself (Tompkins, 2004). At the review stage, it is important to make sure that first off, all homework is actually reviewed. All efforts to complete homework are generously rewarded with praise and support. Further, cognitive distortions need to be addressed carefully during the review stage given that many patients tend to minimize their efforts, accomplishments, and pleasure taken in tasks (Rector et al., 2005). Finally, since it is important for patients not to experience performance pressure around their treatment, the therapist also agrees to be flexible, never pressuring, around homework assignments.

In addition to the factors listed thus far, there are also more disorder-specific factors that may reduce homework compliance, namely, the cognitive impairments of poor attention, organization strategies, and memorial functioning (e.g., Nuechterlein & Dawson, 1984). The study by Dunn and colleagues (2002) found that problems with cognitive functioning and poor insight, two factors that have been found to correlate significantly in psychosis, can make it difficult for patients to accurately recall, execute, and then remember the outcomes of homework assignments. To improve compliance in the face of these real limitations, therapists can aim to provide a very clear set of instructions for homework completion, with efforts to check in to make sure the patient understands the assignment, provide the patient with written or audiotaped summaries of homework instructions, outline when and where the task will be completed, provide reminder cues (e.g., sticky notes) to be posted in the patient's residence, limit requirement of extensive written summaries of homework, and, where feasible, include caregivers into the homework equation. Collectively, these strategies can be applied to the enhancement of homework at each phase of treatment, as outlined in Table 2.

Case Example

Elizabeth[1] was a 35-year-old single female living alone in a large urban city. She experienced her first psychotic break approximately 10 years earlier, with symptoms that included voices and delusions focusing on religious, grandiose, and persecutory themes. Despite adequate, if not optimal, pharmacotherapy over the past 10 years, she experienced persistent positive symptoms of psychosis, and worsening negative symptoms. In addition, she had

[1] In addition to name-change, some non-essential aspects of Elizabeth's clinical presentation and treatment have been modified to protect her anonymity.

Table 2
Enhancing compliance with specific homework tasks

Homework task	Factors to improve
Activity scheduling	▪ Model use of activity schedule in session with pleasure/mastery ratings assigned to recent activities ▪ Write down homework instructions pertaining to the schedule ▪ Address the patient's thoughts and feelings about completing the activity schedule ▪ Review the patient's thoughts and feelings about their perceived likelihood of success with the scheduled activity ▪ Address cognitive distortions in negative expectations, if shared ▪ Establish small goals initially
Self-monitoring	▪ Practice with the self-monitoring forms in session (e.g., review events in the past week that led to suspiciousness) ▪ Focus on specific behaviors relevant to focus of session (e.g., occurrence of voices, triggers for delusions, periods of withdrawal) ▪ Generate curiosity about what could be learned if self-monitoring was carried out (e.g., "Let's find out more about what exactly the voice says to you") ▪ Discuss distress that may occur during self-monitoring and review coping plan
Psychoeducation	▪ Develop coping cards with normalizing information in session ▪ Use materials that reflect a suitable difficulty level ▪ Be an active participant, get articles at the library, use computer for information websites together, get updated contact information of relevant self-help/community organizations ▪ Schedule reading times for normalizing materials
Cognitive restructuring	▪ Introduce and complete DTRs in session ▪ Provide readings that teach how to use thought records ▪ Plan for limiting writing requirements – use shorthand ▪ At planning stage, anticipate and reduce negative appraisals regarding performance with thought records ▪ Help establish safe and private setting where thought records can be completed ▪ Establish coping plan for upset, symptoms, etc., prompted by completing thought records

two major depressive episodes. The referral came approximately 6 months from her last relapse.

Reason for Referral

Elizabeth was referred by a community psychiatrist working with a specialty service for people with long-term psychiatric difficulties. She was referred for CBT to help treat her delusions and worsening negative symptoms. She had no past experience of psychotherapy or CBT in particular.

Current Treatments: Therapy as Usual

Previously, Elizabeth had been treated with a range of neuroleptic and antidepressant medications. At the time of referral, she was compliant with medication treatments of olanzapine (7.5 mg) and citalopram (50 mg). She was receiving case management, which included weekly meetings with a clinical nurse specialist and options for specialized day treatment services, which she attended irregularly.

Clinical Assessment

Elizabeth was assessed with the Structured Clinical Interview for Axis 1 Disorders (SCID-1/P version 2.0; First, Gibbon, Spitzer, & Williams, 1996) and, for symptoms of psychosis, with the Positive and Negative Syndrome Scale (PANSS; Kay, Fizbein, & Opler, 1987).

Summary of Assessment Results

DSM-IV

Multiaxial assessment

Axis I:	Schizoaffective Disorder, Depressive Type (295.70) Subclinical Social Phobia
Axis II:	Not assessed, deferred
Axis III:	Seasonal allergies, asthma
Axis IV:	Problems with primary support groups (i.e., parental strain) Problems related to social environment (i.e., loss of/absence of friendships) Economic (i.e., application for disability support)
Axis V:	GAF – 28

Standardized Assessment of Psychotic Symptoms

Elizabeth scored in the moderate-severe range on the symptom dimensions: delusions, conceptual disorganization, hallucinatory behavior, grandiosity, and in the moderate range on suspiciousness/persecution. On the negative symptom scale, she demonstrated severe blunted affect, emotional withdrawal, apathetic social withdrawal, and lack of spontaneity and flow of conversation. With respect to the general psychopathology scale, Elizabeth scored in the moderate-severe or higher range on feelings of guilt, unusual thought

content, poor attention, lack of judgment and insight, preoccupation with thoughts.

Relevant Background Information

Elizabeth grew up with her parents and two siblings. Both parents were described as hardworking, serious, and devout Catholics. Elizabeth felt considerable pressure from her parents to excel academically and to be "good." She was an excellent student and did well all through school and into academic years at the university. She described herself as "responsible" "compliant" and "always striving." However, she harbored resentment toward her parents. She often "pretended" to pray to God while in fact, she was intentionally thinking blasphemous thoughts and "praying to the devil" as a form of protest to her parents. She stated that as a young child she remembered already feeling "bad" that she was responsible for causing accidents because of her "games" with the devil. For instance, a religious leader was supposed to visit her city when she was 10 years of age and it was cancelled at the last moment. She thought her "prayer games" had led the religious leader to cancel the trip. In her teens, she reported feeling awkward, lonely, and sad, as her friends from school appeared to be having so much fun while her life was like being "locked in a prison." She also felt powerless to change her situation. She frequently daydreamed of being powerful and sought after by boys in response to actual feelings of being unwanted. She continued to excel academically, but remained socially isolated through to the end of high school and into her university years, where she accepted her parents' wish to remain at home.

Proximal Factors to Onset

In her final year of university, she reported feeling "exhausted" due to persistent academic pressure as well as perceived pressures to start dating. She finished her term and went on a vacation. While on vacation, she met a man and had unprotected intercourse the first night they met. She immediately thought she had "sinned" and was "going to Hell" for what she had done. She was also diagnosed with a sexually transmitted disease (STD) the week after returning home. She thought she had been "stained by the devil's hand" and the STD was a form of punishment from God. She became preoccupied with "atoning" through prayer day and night. She eventually interpreted her continued feelings of remorse as a sign that God had given up on her and she decided, "To turn her back on God." Over the next 6 months, she began to live somewhat recklessly, having multiple one-night stands and drinking excessively. A year later she met a man through her work, they began to date, and she fell in love. She did not disclose the events of the prior year to her new boyfriend and lived with considerable pressure to "pretend to be innocent." Months later, she decided to confide in him and he responded with rage and verbal abuse, calling her a "slut" and breaking off the relationship. Over the next week, she experienced a downward spiral of rumination about past events and feeling increasingly bad and evil.

Transition to Psychosis

Approximately 1 week later, Elizabeth experienced a voice that said "I know the real you," which she interpreted as the devil intercepting her prayers, and a second voice that said "slut," which she interpreted as her boyfriend. She had a visual hallucination of an angel floating over her bed, which she interpreted as a message that "God was present" and that he wanted her to resist and fight the "evil force." She continued to hear voices identified as God, the devil, and her boyfriend. She interpreted the voices as a battle between "good and evil" that would determine whether her life would become a "mission" in service of the Lord or the devil. She came to believe that she had "special powers" that could lead to the "saving" or "ruining" of the world. A voice told her to "go and await judgment," which resulted in seclusion and intensification of the voices. She believed that she had become "possessed" and that she was a "fallen angel" destined to do harm to other people. She was hospitalized following an appearance at a crowded venue urging everyone present to "save themselves." The police apprehended her and she was admitted.

Presenting Problems

Elizabeth presented to the first session stating, "I am not a good person," "I feel possessed," and "There's evil in me." She specifically indicated that she believed that she was a "fallen angel" (belief rating: 100%). She described feeling responsible that her prayers had "caused great suffering and death" throughout of the world. She listed a range of local, national, and international personalities whose deaths had been brought on by her prayers. She also described hearing voices of "God" and the "devil." In the past, though not in the last year, the voices would, at times, command her to "save" and "punish" people, respectively. At present, she would hear a voice, whom she believed was her boyfriend, uttering critical and demeaning statements. She also specifically reported believing that "The devil is using me to harm others" (belief rating: 80%). She also indicated that for years she had no motivation and was unable to take pleasure in anything she did. She described herself as a "complete failure." She also reported having problems with keeping "thoughts organized" and remembering things.

Goal List

Following the assessment phase, Elizabeth's homework was to create a list of goals for treatment. The goals on the list that she established included the following: develop more energy, be more interested in things, think less distressing thoughts, have peace in religion, not hear voices, contribute to society more.

Case Conceptualization

Elizabeth's delusional beliefs focused on religious themes involving religious persecution, grandiosity, and passivity (i.e., being controlled), as did the meanings attributed to the voices. As outlined in Figure 1, the development of the case conceptualization provides an understanding of the role of early life experiences, predelusional beliefs, and precipitating factors in the onset of Elizabeth's symptom difficulties. Important early experiences included growing up in a very strict Catholic family that valued self-discipline and piousness over fun and self-expression. She "escaped" this controlling environment through fantasy, becoming irreverent, feisty, and "blasphemous." She suffered guilt and remorse for defying her parents and God. Core beliefs focused on being "bad," "dishonest," "evil," and "unlovable." There were also other beliefs pertaining to being "awkward" and "powerless." Precipitating events included the one-night stand, subsequent promiscuity, and shame around "pretending to be good" with her new boyfriend. The proximal precipitating

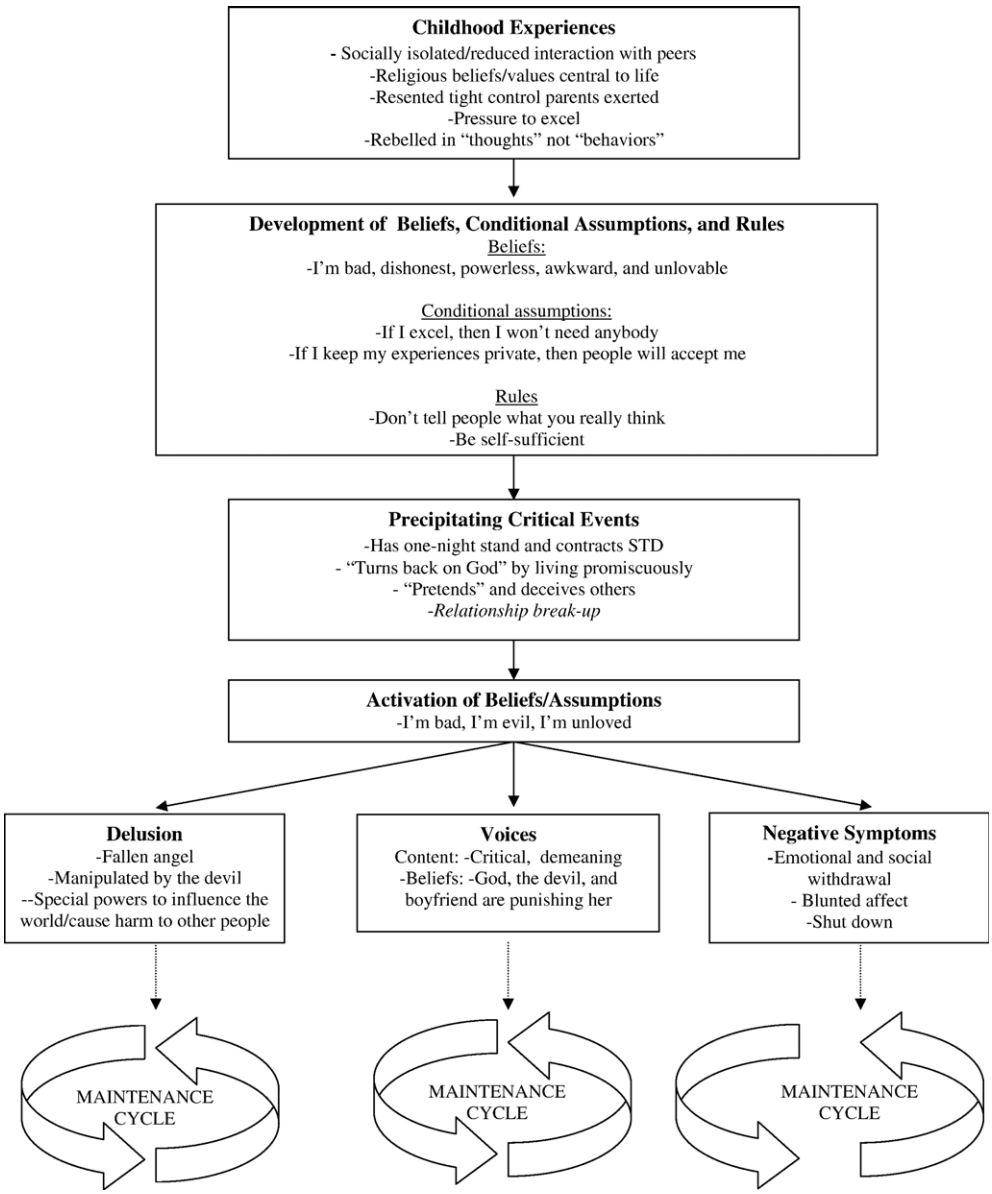

Figure 1. Case conceptualization.

event was the break-up with her boyfriend. In terms of understanding the evolution of Elizabeth's delusions and voices, it was hypothesized that the religious structure of the delusions was predicated on religious beliefs that she had held throughout her life. Following from previous formulations of grandiose beliefs (Beck & Rector, 2002, 2005), it was hypothesized that the grandiose nature of her delusional system was compensatory for underlying self-beliefs related to being bad, worthless, and powerless. Further, the passivity themes to the delusions further reflected a sense of recrimination for her past behaviour. The content of the voices appeared to reflect her own "hot" negative automatic thoughts that transitioned from first person, "I'm a slut," to second person, "You're a slut" (Beck & Rector, 2003). Once the delusional beliefs and voices were activated, a range of factors led to their persistence, including cognitive distortions and biases, attentional vigilance, and avoidant and safety behaviors. Neurobiological factors were further hypothesized to exacerbate these cognitive features (e.g., Kapur, 2003). Further, Elizabeth's pattern of negative symptoms were conceptualized within a cognitive framework (Rector et al., 2005) as, in part, stemming from her long-standing behavioral tendencies to be socially disengaged as well as a response to the thwarting of her career goals by the onset of psychosis itself, leading her to subsequently relinquish nearly all goal-directed behaviors and establish a more comfortable safety zone. Taken together, both her positive and negative symptoms were conceptualized as beliefs and behaviors initiated as a form of *self-protection* for her vulnerable self-esteem.

Selective Demonstration of Homework Exercises Across Elizabeth's Treatment

Assessment and Engagement

The background information and assessment results were collected across several sessions. The principal goal was to build rapport through accurate display of empathy, honesty and support. Elizabeth described her difficulties, both past and present, as well as the experiences that she thought contributed to her problems. As part of this early assessment and engagement phase, Elizabeth was introduced to the relationship between situational triggers, automatic thoughts, feelings, and behaviors, and her early homework assignments included one chapter from *Mind Over Mood* (Greenberger & Padesky, 1995) for each of the first 4 to 5 weeks of this phase. The review phase focused on Elizabeth's understanding of her readings. Since Elizabeth had listed that she would like to read more, homework was also framed as an opportunity for her to start scheduling more pleasurable activities. Elizabeth was also assigned to self-monitor her activities with an activity schedule with pleasure/mastery ratings. The review of this homework provided the opportunity to focus on her (negative) appraisals of her activities. During homework review, Elizabeth would attest to being a "loser" and a "failure" and a "hopeless case" as she reviewed her week's activities. This provided the context to begin to normalize some of the negative symptoms of psychosis and to highlight the role of negative appraisals in fueling downward momentum in her motivation. Homework corresponded to this goal by initially having Elizabeth monitor situations, moods, and negative automatic thoughts in a three-column DTR. Examples of her early homework demonstrated that she understood the purpose of the homework goal and successfully completed the columns, although she again minimized her efforts. The clinician used this as an opportunity to generously reward her efforts and to communicate the degree to which her homework represented excellent progress for the week. It also became another opportunity for the clinician to introduce the importance of cognitive distortions and their role in undermining her meaningful efforts in her treatment.

Closer inspection of her responses showed some limitations in her understanding of the difference between moods and behaviors, and there was only cursory mention of thoughts. The skills associated with practicing the three-column thought record were rehearsed in session. The content of these thought records also provided the first foray into the discussion of cognitive distortions pertaining to her automatic thoughts. Homework was set to include a list of common cognitive distortions to read and to check off beside her three-column DTR over the upcoming week. Elizabeth was also given the tape of the session to take home and review. The specific time and place where she could review the tape was discussed.

Early Focus on Negative Symptoms

In Elizabeth's treatment, there were four reasons why it was preferable to start with behavioral activation strategies pertaining to her negative symptoms as opposed to jumping right into targeting the delusions and the voices: (a) Elizabeth had designated her top two goals as developing more energy and taking a greater interest in things (i.e., negative symptom-related goals); (b) work on changing her delusional beliefs was going to require effort and energy (as outlined below) and adherence to homework assignments, which required practice with less threatening tasks; (c) her social, emotional, and behavioral disengagement was rarely triggered by the delusional beliefs or voices, and (d) importantly, the reduction of the negative aspects of her delusional belief system (e.g., fallen angel, controlled by devil, harming others) would potentially challenge other aspects of her belief system that contributed to positive self-esteem (e.g., special powers). As such, early sessions focused on identifying a range of previously enjoyed activities, which included

visiting with people at church, volunteering one night per week at local food bank, spending time with cousins, exercising, reading, using the computer, going to movies, and beginning to increase engagement in these activities. One central impediment to engaging in activities was that she had become accustomed to waking up between 1:00 and 2:00 p.m. and so an early homework goal was aimed at addressing this.

> THERAPIST: Today we've talked about some of the consequences of spending the day in bed and how that leaves you feeling unproductive and missing out on chances to do the things you'd like to do. How would you feel about practicing getting up at an earlier time this week?
> ELIZABETH: Okay, I could try that.
> Therapist: Great. So what steps will you have to take to get up an hour earlier?
> ELIZABETH: I will have to remember to set my alarm clock and I will have to remember to get up when it rings.
> THERAPIST: Let's write down those two steps just to be sure that you won't forget, okay set alarm clock, and how about we make a sticky note here to put beside your bed when the alarm rings. What should we write on the sticky note?
> ELIZABETH: "Get up now or you're going to lose another day."
> THERAPIST: Elizabeth, how do you feel right now as you just said that?
> ELIZABETH: Angry.
> THERAPIST: What is it that you were thinking just now as we were discussing the sticky note?
> ELIZABETH: How much of a loser I've become that I need help to learn how to wake up.
> THERAPIST: Elizabeth, if you were having the thoughts and feelings that you're having right now just as you were waking up, do you think you'd prefer to get up and start your day or go back to bed?
> ELIZABETH: Back to bed, for sure.

The remainder of the session focused on the role of appraisals and cognitive distortions in reducing motivation and the effort required for the goals she identified as important. It also provided the opportunity to normalize some of her negative symptoms with attention to the role of neuroleptic medications in producing fatigue and drowsiness. In fact, there were several indications that the medications were affecting her ability to awake, so the therapist called and spoke with the treating psychiatrist and the medications were reduced. In response to these efforts, Elizabeth began to start her day at 10:00 a.m. Homework continued to build on this success by further activity scheduling, assertiveness tasks (e.g., requesting that Mom stop calling so often to check up on her; to talk to her boss at the food bank around rescheduling her hours, etc.), and graded task assignments (e.g., completing disability paperwork). The targeting of the cognitive, social, and behavioral aspects of the negative symptoms continued throughout every session of treatment.

Psychoeducation and Normalizing

A major goal of CBT for psychosis is to help the patient understand his or her symptoms in a less stigmatizing and blaming way. Despite many years of difficulties, Elizabeth was unsure of her diagnosis. She knew that she had difficulties that required help and she was very compliant with her medications. Consistent with a case formulation perspective and the goals of normalizing psychosis (Kingdon & Turkington, 2005), the aim was to achieve an acceptable explanation for her different symptoms. Even though Elizabeth's delusions and hallucinations caused her great distress, there were a range of benefits afforded to her within this belief system, including feeling that she was powerful (instead of powerless) and special/wanted (instead of insignificant). It was essential to determine what Elizabeth would feel if these beliefs were successfully modified. The principal goal was to explore Elizabeth's understanding of her symptoms, all of the past and present experiences that seemed to support her beliefs about being a fallen angel and controlled by the devil, and the agency of her voices being the God and devil, so as to be able to arrive at a shared understanding of her problems that would (a) normalize some of these experiences and (b) reduce self-blame, (c) not necessarily remove some of the perceived benefits of the delusional system that bolstered self-esteem.

It is often the case that normalizing symptoms becomes the first step in providing an alternative, less threatening perspective regarding their occurrence. First, the clinician acknowledged that he was not an expert in understanding components of her faith but that he understood that her perceived importance of God, devil, Heaven, Hell, punishment, sin, etc., were actually key articles of her faith shared by millions of people and deserving great respect. Second, a normalizing perspective was shared on her distress around her experiences during the onset of symptoms (e.g., felt that she had acted in a way inconsistent with her faith and was deserving of punishment). Third, a normalizing perspective was offered around the sense that she attempted to make of previously unfamiliar experiences, such as hearing voices and the perceived interference of the devil. Fourth, normalizing of her negative symptoms was extended, with an emphasis on the adaptive features of disengaging in the face of anticipated social and performance threat.

The only homework new to this phase of treatment was that the therapist and Elizabeth took time at the end of

the session to write down some of the details shared in session for her to review between sessions. This phase of treatment concluded with a discussion of the nature of belief formation and how beliefs can be sometimes held with great emotional investment, even though they sometimes turn out to be false (e.g., example of her previous belief of Santa Claus).

A further consideration was whether her thoughts about doing harm to others could be normalized as ego-dystonic intrusions characteristic of obsessive-compulsive disorder (Morrison, 2005; Salkovskis, Forrester, Richards, & Morrison, 1998). However, Elizabeth's thoughts about causing harm were not ego-dystonic intrusions but ego-syntonic, intentionally generated prayers that selected individuals would get sick and/or die. Given this profile, an alternative belief was introduced for consideration: "You do have a special relationship with God that provides special powers through positive prayer, and there may be alternative reasons why you sometimes pray that others be harmed, although it is not due to the presence or control of the devil." The therapist asked: "How would you feel if there was some way you could come to believe that your prayers have not harmed others and that the devil is not capable of intercepting your prayers?" Elizabeth responded, "If I didn't do all that evil, then I'd be okay."

Targeting Delusions

The therapeutic approach involves a number of cognitive and behavioral strategies aimed at undermining the rigid conviction and centrality of the delusion(s). Once the therapist has a thorough understanding of the patient's delusional beliefs and the past and current events that are interpreted as supporting the belief, gentle questioning of the evidence is undertaken. In generating explanations for her beliefs about being a fallen angel and creating bad acts under the control of the devil, Elizabeth focused on the following experiences that seemed to confirm her beliefs:

- I sinned so badly in the past (reference to sexual promiscuity)
- I have prayed for people to die and they have died (named six people)
- I have prayed for people to get sick and they have gotten sick (name two people)
- Heard footsteps of devil at boyfriend's place
- Hear voices of devil
- I have sent people to Hell through prayer
- My prayers are intercepted by the devil
- I have been to Hell

As seen, Elizabeth's perceived reasons for believing her primary delusional belief about being a fallen angel and being controlled by the devil reflect secondary delusional beliefs about: (a) her "special powers" to harm others and (b) the devil intercepting her prayers, plus (c) misappraisals of experiences (e.g., hearing footsteps and going to Hell) and (d) life experiences that she deems to be sinful. Based on belief ratings, the last item, "In Hell," was believed the least and so cognitive restructuring started with this. In short, Elizabeth had had a panic attack and misinterpreted the normal symptoms of autonomic arousal, such as feeling hot and flushed, sweating, and tightening ("burning"), as signs that she was in Hell (belief before: 80%). The clinician provided an alternative perspective, sharing that the symptoms she described were typical of those in the midst of fear and panic, and provided further psychoeducation about the nature of the flight-or-flight response. Homework was set that included a handout on anxiety and panic. Reviewing the reading together in the next session, Elizabeth's belief rating regarding this piece of evidence had been reduced to 0.

This phase of treatment involved continued questioning of different sources of evidence for her delusional beliefs. It seemed that much of her interpretation of the evidence supporting her beliefs rested upon interpretation of religious scripture. It was apparent that any real change in Elizabeth's religious delusional beliefs would require the generation of alternative evidence from a respected and trusted religious authority. Elizabeth was able to identify a senior religious leader at her church whom she liked and trusted, and it was agreed that for the next phase of treatment we would conduct a number of experiments by writing down questions in session that we could take to a Catholic religious authority and receive feedback. An example of a behavioral experiment form included outlining the *perceived* fear ("The devil has intercepted my prayers and I am harming others"), the *feared consequence* ("The priest will tell me that I'm evil and going to hell"), *ways of testing the fear* ("Ask the priest the following questions: Is it possible for the devil to intercept my prayers? If I prayed for others to be harmed, would the devil carry out the prayers?) and *collect feedback* from the experiment. In Elizabeth's case, the priest became the critical source of alternative evidence for her beliefs as she was told: *Your prayers can be at times misguided but these types of prayers are of no real consequence. You should always trust in God's goodness and know that your prayers of goodness are the ones that count. There is no sin on your soul; God loves you and wants you to be happy.*

As treatment progressed, Elizabeth further examined the historical evidence for her beliefs and completed DTRs for newly emerging situations that triggered her delusional beliefs. For instance, reasons why people may have gotten sick or died were addressed across each of the eight individuals mentioned (e.g., most were already sick, were sick before she met them, had serious and chronic

life-threatening diseases, nearly all were elderly). Another homework assignment aimed at generating alternative evidence included the use of pie charts, particularly for situations where Elizabeth felt responsible for another person's illness/death because she *failed to pray* for them (i.e., acts of omission leading to harm). At the end of this phase of treatment, her belief rating in being a fallen angel had dropped to 20%, with worsening on days where she felt more distressed. Her belief that she had caused others in the past to be sick was also greatly reduced to 10% to 20%. She was also able to use DTRs in the moment to reduce catastrophizing and delusional cycles.

Targeting Voices

At the time of treatment, Elizabeth was not hearing voices identified as emanating from God or the devil, but she did continue to hear a voice, identified as her past boyfriend, that made critical and demeaning comments. The first step included efforts to normalize the experience of hearing voices (e.g., voices are reported in 5% to 25% of population; the effects of stress, bereavement, solitary conferment, sleep deprivation, etc., may contribute to hearing voices). As part of homework Elizabeth was introduced to a voices monitoring form that included the opportunity to review: What she was doing when the voices started, what the voices said, the loudness of the voice, her level of distress, and her selected strategies to cope with the voices. Triggers frequently included reminders of her boyfriend (e.g., thinking of him, seeing old photos), sexual themes (sexual scenes in a movie, stories about deceit), or religious cues on the theme of sin. She interpreted the voice as a form of punishment and typically responded with feelings of guilt and shame. Following the assessment phase, the therapist employed gentle questioning to elicit alternative perspectives on both the voice content and the beliefs held about the voices.

Depending on the patient, it may be more effective to start by focusing on the *beliefs* about the voices. With other patients it may be better to first target the *voice content*. Elizabeth had experienced reductions in her beliefs about being a fallen angel and under the control of the devil, so the initial focus was to build on this success by generating alternative explanations for her past beliefs around this voice content. Her belief that it was the devil speaking to her came from two fundamental sources of evidence: (a) the experienced panic attack when she first heard the voice, leading to the belief that she must be in Hell, and (b) the perceived power of the devil to intercept and control her thoughts. Considering the previous evidence gathered from her priest and from her thought records, she was able to quickly reduce her belief. It was decided not to target the past belief regarding God speaking with her given that this contributed to positive affective states and enhanced self-worth (Chadwick & Birchwood, 1994; Morrison & Renton, 2001).

In an attempt to generate an alternative perspective on the voice of her ex-boyfriend, we focused on the effects of stress, sleep deprivation, isolation, the power of suggestion (e.g., boyfriend told her she would hear his wrath 24 hours per day), bereavement over loss of romantic relationship, as well as research demonstrating the extent to which thoughts can be externalized to be experienced as a voice (see Beck & Rector, 2003 for review) on voice onset. The content of the voice, "liar," "slut," "whore," and "evil," was taken as the principal evidence that it was her boyfriend's voice because he was the only one who ever called her these names and the voice sounded just like him. Following from cognitive accounts of the content of voices (Beck & Rector, 2003), it was hypothesized that the voice content reflected an externalization of her self-oriented recrimination and shame for her past promiscuous behavior and her deceit around it.

The approach taken was to focus on finding an alternative perspective on the voice content itself: when Elizabeth heard the voice state, "You're a slut," she felt guilt and shame because, in essence, she believed that what the voice said was true. The goal was to provide an alternative perspective on Elizabeth's belief about her sexual promiscuity. A potential problem was that efforts to normalize her sexual behavior would still be unacceptable to her given her religious beliefs. Again, the homework task focused on establishing questions for the priest in the form of an experiment. The results reiterated that she had been "forgiven for these sins" and to focus on positive use of her time. Moreover, the therapist was able to help Elizabeth see that having a period of promiscuity did not mean that she should be ridiculed and insulted. As homework, she was given another copy of the cognitive distortions list to review and use in conjunction with a modified DTR. Given that some of Elizabeth's previous thought records had included reported thoughts of being a "slut," part of helping her reattribute the voice to her own internal thoughts was to show the correspondence between what she thought of herself and what the voices said by comparing the two thought record forms and then, through monitoring, help her recognize that the antecedent to the voice was her own negative automatic thoughts.

Targeting Nondelusional Core Beliefs

To consolidate progress and reduce risk of relapse, it is important to address the underlying beliefs and assumptions that are conceptualized as conferring vulnerability to symptom development. One critical aspect required attention: Why did Elizabeth intentionally pray for people to be harmed or to die in the first place? Despite considerable reduction in her delusional beliefs about

being a fallen angel and being controlled by the devil, it was a challenge to find an alternative perspective on the acceptability of intentionally praying for and wishing for people to die. This was as puzzling to Elizabeth as it was to the clinician. However, it was decided that homework should focus on self-monitoring thoughts, moods, and behaviors around prayer time to learn more about the triggers for negative prayers. Very importantly, the results from this homework assignment demonstrated that Elizabeth only prayed for people to be harmed when she felt *powerless*. For instance, with exploration, Elizabeth was able to see that in the past when she was pulled over and harassed by a police officer, she prayed that harm would come to him for making her feel worthless. Or in another example, she prayed for a man at her church to become ill, because she really wanted to have his position in the church given the respect he seemed to receive from others. In an example from the prior week, she wished for something bad to happen to her nephew, because she felt that her sister had achieved everything that she never could. This formulation was shared with Elizabeth—that praying for others to be harmed was not a sign of evil but rather a sign of feeling vulnerable and powerless. This formulation was also shared to account for the times when she prayed to the devil as a child. Elizabeth was profoundly affected with this alternative and normalizing account of her negative prayers, which she fully accepted.

Functional Goal Development

Homework assignments continued with problem solving, activity scheduling, and graded task assignments with attendant thought records for the following goals: volunteering at a food bank; becoming involved in church-related activities, including a leadership role for a seniors group; and, perhaps most importantly, beginning to date a man from her church.

Relapse Prevention

The final stage of therapy included commonly used strategies and homework assignments to prepare for relapse prevention. Homework assignments included making a list of stressors, a list of warning signs, a list of coping strategies, using a DTR to "decatastrophize" early symptoms as a sign of "going crazy," and making a list of contacts for support. Finally, a plan for homework continuation was established.

Outcomes

At outcome, Elizabeth continued to experience reductions in her delusional *conviction, significance, intensity, and associated distress* around being a fallen angel and having caused harm to others. There was variability in functioning across these dimensions, depending on contextual features, such as level of stress, intensity of the trigger, and fatigue level. However, delusional beliefs were not interfering in her day-to-day life. She continued to use thought records as part of her self-developed homework plan to deal with triggers. She also carried coping cards with a review of pertinent alternative evidence communicated by the priest and developed in session. She increasingly recognized the voice of her boyfriend as reflecting her own personal concerns, although this continued to vary depending on her level of stress and fatigue. She was less distressed by the voices in her day-to-day life. She had considerably improved functional outcomes and, importantly, achieved one of her fundamental goals of finding peace within her religion again. She continued to grapple with despair around "lost opportunities" in terms of her career ambitions but was planning on returning to school.

Summary

This paper has focused on detailing the use of homework in the treatment of medication-refractory psychosis. Despite significant barriers and, at times, significantly reduced quality of homework completion, Elizabeth's treatment demonstrates how common homework strategies can be integrated into treatment to enhance skill development, reduce cognitive and behavioral features constituting vulnerability for symptom persistence, and enhance clinical and functional outcomes. Greater attention to the formal empirical investigation of homework use in CBT for psychosis is required.

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Address correspondence to Neil A. Rector, Centre for Addiction and Mental Health, 250 College Street, Toronto, Ontario, Canada M5T 1R8; e-mail: neil_rector@camh.net.

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