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# CHANGING CORE BELIEFS WITH THE CONTINUUM TECHNIQUE

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**Abstract.** Eliciting, evaluating and changing core beliefs are established features of cognitive behaviour therapy (CBT). However, care must be taken when working at this level of cognition. This is because therapists are dealing with core constructs that, whether dysfunctional or otherwise, influence the patient's self-concept, her world and future. This paper examines when it is appropriate to work at this level and some of the specific problems regarding assessment and the consequences of belief change. It is evident that achieving lasting cognitive change is a difficult task, and this may be in part due to the poor quality of the literature and training in the area. In an attempt to address this, the final section of the paper offers a set of practical guidelines concerning the continuum technique, a well-known CBT method for targeting, evaluating and changing core beliefs. It highlights process features (e.g. planning, management, and interpersonal skills) as being crucial in creating contexts in which change can take place. The work has been written for trainee cognitive therapists and those with a working knowledge of CBT who are seeking to improve their abilities in the use of change methodologies.

*Keywords:* Core beliefs, schema, change methodologies, continuum.

## Introduction

> The power of the cognitive behavioural therapies in these six disorders (depression, panic, agoraphobia, OCD, GAD, schizophrenia) is considerable, certainly equal to the power of the standard drug treatments for depression, anxiety and schizophrenia. If these psychological treatments had been drug treatments, they would have been certified as effective and safe remedies and be an essential part of the pharmacopoeia of every doctor. (Andrews, 1996, p. 1501)

This quote seems to suggest that therapy is both powerful and yet a benign form of treatment. This is rather contradictory, especially as it has been shown empirically that psychotherapy can have a profound effect on how people see themselves, their world and their future possibilities. Indeed, it can be argued that incompetently conducted therapy can result in patients leaving a course of treatment more symptomatic than when they first arrived. It is important to acknowledge that poorly conducted therapy can have side-effects that are equally as problematic as some medical treatments.

This paper focuses on some of the change mechanisms associated with core belief therapy. It is hypothesized that the greatest likelihood of therapy-induced problems occur when working

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at this level, because the long-term core constructs of an individual are being explored and challenged, that is, their unconditional self-beliefs (e.g. "I am incompetent/bad/worthless"). Despite these risks, and the sensitivity of the clinical material that is accessed, there are times when this form of therapy is desirable and even necessary, not least because stable and pervasive beliefs of this type can be the source of recurrent emotional problems, such as mood and anxiety disorders. Table 1 outlines some of the factors that help indicate the appropriateness of – or necessity for – cognitive change at this core level. These factors are listed in terms of patient characteristics, therapist and therapy factors, and in relation to the expected effects of standard cognitive behavioural therapy.

None of the factors in Table 1 are definitive for decisions about core belief work. For example, even when a patient has a personality disorder, therapist and patient may choose to work only on the Axis I problem, assuming clinical benefit can be obtained. However, the overall pattern of factors provides some indication of when patients may need to work on their core self-representation, and what therapists need to have in place to embark on this type of work. In general, before embarking on therapeutic work, it is helpful to take account of the "stepped care" approach.

> The link to stepped care is that the most intrusive/intensive/expensive interventions should be implemented only when less intrusive ones have failed, or in light of the evidence, they are likely to serve the patient's best interests. (Davidson, 2000, p. 583).

Such issues clearly help to inform the assessment procedures and the subsequent formulations developed by the therapists. For example, the degree of patient information needed to construct Laidlaw et al.'s comprehensive framework (this issue) contrasts markedly with those required for Charlesworth and Reichelt's mini-formulations (this issue). Thus it is assumed that one would not generally obtain all the information necessary to construct Laidlaw's model unless one had the plan to engage the patient in core belief work. Indeed, such in-depth assessment without then addressing such fundamental issues in therapy could be seen as unethical.

The present paper cannot examine all the factors outlined in Table 1 in detail, but will focus on a number of specific issues concerning the competence of the therapist and the strategies employed to create change. Three main aspects will be outlined, concentrating on the therapist's role: (i) the manner in which core beliefs are elicited; (ii) dealing with core beliefs when they have been identified; (iii) using the continuum technique to promote cognitive change.

## Eliciting self-referent core beliefs

Self-referent beliefs should generally be elicited via a sensitive stepped-care approach (Davidson, 2000; James, 2001), one that is compatible with the needs of the patient, the patient's presentation, and the skills of the therapist. Hence, core belief work should generally be avoided with someone with a first-episode disorder, or with someone with only mild depression, or by an inexperienced therapist. In situations where core work is deemed necessary, it is important that the methods used are truly therapeutic, and this requires planning and preparation. There are potential dangers of inappropriately applying methods such as downward arrow. For example, if the therapist is oblivious to the emotional consequences of accessing negative core beliefs.

The simple, yet powerful, technique of downward arrow takes patients from a specific situation – usually one where they have low mood – and explores the implications for them as an individual. For example, the implication of "not being selected for the team" might

**Table 1.** Factors indicating when to focus on core beliefs

| Patient factors | Therapist and therapy factors | Effects of Standard CBT |
|---|---|---|
| • DSM-IV diagnosis of personality disorder<br>• Chronic or recurrent axis I problems<br>• Chronic or recurrent interpersonal problems across a range of settings (family, work, etc)<br>• Alliance difficulties in therapy, owing to core beliefs being activated<br>• Excessive use of schema processes (avoidance, compensation and maintenance: Young, 1994)<br>• Persistent unconditional negative self-beliefs | • Sufficient therapist experience and skill to engage in core belief work competently<br>• Adequate therapy time and resources<br>• Availability of good regular supervision<br>• A sufficiently good match of therapist and patient goals (allowing for possible problems in the alliance)<br>• Therapist and patient agreement about the need for "deep" cognitive change<br>• Some indicators that change is possible (i.e. likely benefits out-weigh likely costs) | • Minimal symptom improvement (indicated by validated measures), despite use of competent therapy<br>• Minimal cognitive change (indicated by validated measures)<br>• A lack of coherence/validity of the conceptualization when formulated with only surface features (i.e. can only understand problems when utilizing core beliefs) |

be "proves I'm a rubbish player". Notice the generalization from a specific event to a social role. If downward arrow is applied to "being a rubbish player", the inference may be "shows I'm a useless person". Notice another layer of generalization. On the one hand, very useful information is being elicited about this person's perspective, but accessing beliefs about being a useless person often can serve to deepen depressed mood, at least in the short term. If they have always seen themselves as a useless person – suggesting a core belief, rather than a transient one – this could be an emotionally charged realization, making it difficult for both patient and therapist to regulate affect.

The downward arrow strategy, in the hands of experienced therapists, can be very effective. However, owing to its simplicity, it tends to be one of the first techniques CBT therapist are taught – and therein lies a potential problem. For example, a patient may arrive at the therapy session feeling depressed, and following downward arrow, one hour later she may be leaving seeing her life in terms of a few absolutist statements (e.g. "I am worthless", "I am inadequate"). As we shall discuss below, this can have huge ramifications for the person over the next few days and weeks. She may start to globally re-evaluate her whole life in terms of those beliefs (I've always been worthless; I did not have enough friends; I didn't pass sufficient exams; I only married my husband because he asked me to – in truth I never really loved him). Thus, in unskilled hands, the methodology may allow assess to core material (or activate processing biases) without adequate attention being given to the development of coping strategies for dealing with exposure of such details. In more competent hands, preparation would usually have taken place, and the patient would have been taught how to "de-centre" from such material.

The authors wish to emphasize the need for therapists to think through the possible emotional reactions and consequences of accessing core beliefs, and suggest that hypotheses about core beliefs are brought gradually and sensitively into a course of therapy, not suddenly or in confrontation. Often, automatic thoughts evaluated in standard CBT have recurrent themes that might generate hypotheses about core beliefs from quite early on in a course of therapy.[1] Standardized measures, such as the Young Schema Questionnaire (YSQ, Young & Brown, 1994), can also be used to generate and test these hypotheses, and the patient can be an active collaborator in exploring this territory and making joint discoveries about long-held beliefs. This is important partly to ensure patient consent and collaboration, and also to differentiate between transiently held beliefs that may be present during periods of depression, and genuinely "core" beliefs that have been pervasive across an individual's history and social roles. The authors urge caution about the over-liberal use of the term "core" to describe beliefs that are non-pervasive or held transiently (James, Southam, & Blackburn, 2004). Indeed, it is encouraging that new methods are being developed to assess core beliefs in terms of their emotional intensity, self-worth contingency, temporal stability and cross-situational consistency (Louisy, 1998).

To illustrate the problematic nature of poorly planned "core belief work", take the case of Miss C. Following a schema-focused therapy session, the downward arrow strategy elicited that her self-belief (being useless) had influenced her choice of job and boyfriend, and her decision to take on the responsibilities of carer for her elderly parents. The following day she

[1] It is acknowledged that sometimes NATs and core beliefs may take similar forms with respect to content, e.g. "I am useless" can be experienced as both a NAT and a unconditional core belief.

impulsively decided to resign from her job, end her relationship, and move out of the parental home, thus leaving herself in a difficult situation (financially, socially, and emotionally). While it was possible that her choice of job, partner and family situation had been influenced by schema maintenance strategies around the issues of "uselessness" (Young, 1994), her sudden reactions propelled her into a state of heightened crisis. Indeed, in her haste to reject her past, she had failed to appreciate that her job, boyfriend and home situation, although not ideal, provided her with a great deal of support and stability.

As therapists, aware of the potential impact that new insights can have on patients, it is important that a number of steps are taken. For example, if a therapist proposes core belief work, it is better to do this early on within a therapy session so as to leave sufficient time to work at this level of cognition appropriately (i.e. thorough evaluation of the beliefs, facilitation of de-centering skills and re-evaluation work). The therapist should also be mindful of the patient's thinking style and biases. If the patient is prone to black and white thinking, one might well expect to see dramatic shifts in perspective. Further, aware of the potential impact of overgeneralized negative memories in depression, therapists should ideally help the patient to retrieve the past in a more balanced way. Thus in the case of Miss C, her memory biases, (i.e. over generalizing) led her to exclusively recall negative events when she thought about her job and boyfriend (explaining why she ditched both!). In this case, it would have been helpful to make her aware of the impact of the biases, and spend time "re-contextualizing" her memories. Firstly, re-contextualizing reverses the overgeneral effect by getting the patient to think in *detail* about rewarding times – with Miss C, one could examine fulfilling experiences at work, or good times spent with her boyfriend (e.g. when they first met, or their last foreign holiday). As many depressed patients have difficulties with this exercise, and may find it hard to hold such events in memory, it is worth investing time to make sure the memories are recorded in detail and recalled as vividly as possible. Secondly, negative memories should be put in their context. By examining the contextual backdrop to negative experiences, a patient may be helped to reassess the situation or develop more flexible thinking processes. In the case of Miss C, one of her grievances about her boyfriend was her claim that he had never asked her to live with him. However, it was only when she elaborated the issue in detail that she recognized she had told him repeatedly how important it was, at present, to be "there" for her parents. The current discussion highlights the importance of the preparatory work required prior to embarking on core belief work. It suggests that competent therapists can create the conditions where change seems both highly desirable and possible for their patients. This situation often requires the development of a shared conceptual model of the patient's difficulties. Such a framework helps to guide the process features of therapy, the interventions and their timings, and helps to identify obstacles to change. Thus, it would seem that competent therapists tend to have a good understanding of the process features of change in addition to the content features. These issues are highlighted further in the following section.

## Difficulties in dealing with self-referent beliefs

Evidence gained from supervising cognitive therapy trainees, which has involved watching many hours of video-taped CBT sessions, has informed the authors that many of the trainees simply do not employ effective change techniques that are available to them. That is, therapists do not use change techniques frequently enough, and tend to perform them poorly as assessed on the CTS-R (Blackburn, James, Milne & Associates, 2001a, b). One of the reasons for the

low level of competence is that while negative beliefs can be elicited with relative ease, clinical change, particularly at the level of core belief, is difficult to achieve. When training therapists, the authors find a simple fishing analogy helpful to illustrate the difference between elicitation and change.

Imagine a depressed person's thinking can be represented by a river full of negative thinking. The stream of thinking is endless and constantly flowing in a negative direction. Hence, during the assessment phase, eliciting negative cognitions is akin to throwing a fishing net over the side of a rowing boat which is gently floating on the stream of negativity. In truth, all one needs to do is open the mouth of the net (e.g. by asking some relevant questions) and then watch all the negative cognitions flow into it. However, at some point when the net is sufficiently full, one must attempt to deal with the material that has been caught. In therapeutic terms, this point would occur when one considers sufficient details have been captured in order to (i) develop a working conceptualization, and (ii) attempt to employ change strategies. Within the analogy, the latter step is equivalent to trying to row against the current of negativity. This is clearly a difficult thing to do, but to make matters much worse one is also struggling with a large dysfunctional catch and a lot of patient expectation attached to it.

At times, because of the level of difficulty of rowing against the stream, the temptation is to keep filling one's net with more examples of negative thoughts and beliefs. Such a situation can lead therapists to become stuck in an assessment and re-conceptualization loop. This feature is most commonly seen with trainee therapists who may be observed eliciting more and more material, either hoping that insight alone will be sufficient to produce major changes with respect to their patient or for want of knowing what else to do. It is the authors' belief that, because many therapists are neither confident nor highly skilled in using change methodologies, this results in patients spending too much time in the assessment and conceptualization phases. This may be another reason for the propensity of therapists to over-examine the early years of their patients' lives, thus losing the CBT focus on the "here and now". The frequent occurrence of such practices may be related to the limited amount of literature on change strategies. To this end, the next section attempts to provide a detailed framework for conducting a technique frequently used to change beliefs – "the continuum".

### *Cognitive change with the continuum technique*

The following guidelines outline the main steps involved in setting up and using a continuum. As the name suggests, the technique involves applying *continuous properties* to beliefs that tend to be held in a *discontinuous fashion*. This reflects the presence of thinking biases such as absolutism, global inference, and black-and-white thinking; dysfunctional core beliefs are typically held in this way. In practice, a continuum is set up diagrammatically by labeling one end of a 10 cm line with the core belief (e.g. "totally useless"), then eliciting the opposite of the belief, and using it to label the other end (e.g. "very useful"). When eliciting the core belief it is important to ask the patient to label the poles herself because the statements are representations of her cognitions. One can often be surprised by the idiosyncratic nature of the statements at the extremes (e.g. "totally worthless" to "appropriately angry"). Because patients' construal of the opposites can be highly individual (e.g. "attractive" as an opposite to "useless"), a variant of this is to have two different 10 cm lines, one for the core belief (e.g. useless: "not at all" to "very much") and one for the opposite (e.g. attractive: "not at all" to "very much"). These continua can then be used by the patient to make a number of self-ratings

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or judgments, often involving contrasts with other people. Creating a continuous space for these judgments opens the possibility of less extreme or dichotomous thinking and, in relation to core beliefs, can begin to sow the seeds of doubt about pervasively held views. There are a number of variants on this, which are illustrated below in the context of a set of guidelines for using this method effectively (see also Padesky, 1994; Wells, 1997).

*Assess suitability during the session using probe questions*

It is recommended that the therapist check that the patient is able to engage in the method appropriately. Any doubts about the patient's focus, ability to move between concrete and abstract thinking, can be assessed at this stage. It is essential to review whether the patient has been able to work appropriately at the negative automatic thought (NAT) level. If she is unable to reflect and generate alternatives to her NATs, then there is a good chance she will struggle with continua. Indeed, it usually only makes sense to use continua with patients who have been able to engage in NAT re-valuation, but have had difficulties believing the outcomes generated. At this stage, prior to discussing the method with the patient, the therapist should attempt to develop a conceptualization. This conceptual overview helps to identify the potential benefits that would accrue from employing this methodology at this time. It also helps to identify potential obstacles to change. Many therapists fail to engage in this level of preparation. However, it must be remembered that one is proposing to engage with the person's dysfunctional core belief system – with all its biases, filters and interpersonal and emotional interactions. In addition, it is important to determine the patient's own conceptualization with respect to her problem, and the nature of the evidence she is using to maintain her belief.

*Explain the rationale to the patient*

It is beneficial to explain the procedure prior to engaging the patient in the methodology. Not only is this good teamwork, but the structure provided reinforces effective learning. The continuum process needs to be explained clearly and in an appropriately paced manner to meet the needs of the patient. Table 2 includes a short extract written to help provide an overview of the strategy for the patient. This description is most suitable for people who are capable of using abstract reasoning and who have already been socialized to the CBT model. After asking the person to read the material, which also contains example diagrams, the patient is encouraged to ask questions. During this socialization phase, the patient can be informed that the methodology is likely to be used routinely through out her period of treatment. Once the rationale has been explained, the future goals can be set in a truly collaborative manner.

*Discuss the potential benefits and forewarn the patient about the potential reactions and hindrances she might experience or engage in (e.g. emotional avoidance)*

In order to increase motivation, it is helpful if the therapist and patient jointly explore the potential benefits and drawbacks that are expected to occur through the successful implementation of the continuum technique. Such benefits need to be made concrete and measurable. It is also important to make explicit the sort of dysfunctional processes that are likely to produce problems for the patient. Young (1994) and McGinn and Young (1996) have described three of these: schema maintenance, avoidance, and compensation strategies.

**Table 2.** Information for patients

*The continuum technique*

The aim of this exercise is to get you to think about your negative self-belief in a way that helps you to re-evaluate it. This means trying to "get around" the biases and filtering techniques that you are currently using. As we have discussed in earlier sessions, these biases and filters prevent your negative belief from being falsified. Indeed, in all likelihood, these processes are continually twisting information to strengthen your negative self-perceptions.

To help you to re-examine your views in a more balanced way, your therapist will use a methodology known as the continuum. This strategy involves making your beliefs more open to the best available *facts* and *evidence* The therapist will attempt to achieve this by getting you to first define your view of yourself, and then asking you to compare this against various factual judgements. It is predicted that together you will find discrepancies between your perceptions and the facts, and these differences will help you to begin to re-evaluate your current view of yourself.

The continuum method will involve the therapist using a series of simple straight lines drawn on a piece of paper; these will be used to help illustrate the points he/she is trying to make. It is important to recognize that this is *not* a test of any kind, and there are no right or wrong answers. The method is designed to help the therapist and you to understand your situation better.

Indeed, by describing and explicitly acknowledging the experiences commonly reported by people when working on core issues, the patient can feel more contained. Discussions relating to these issues can also help to normalize the experiences (i.e. the cognitive and physiological, and emotional reactions) that patients often need to work through.

### *Collaboratively agree on a core-belief to target*

The next step is to agree on the content or material to be used with respect to the continuum. An unconditional statement would normally be selected. However, as Padesky (1994) has demonstrated, conditional statements may also be targeted. In determining the most appropriate belief to change, one must try to work as collaboratively with the patient as possible. Obviously the beliefs held in absolute terms are the easier to produce discrepancies with, but they are also the more difficult to change. Material from questionnaires (Dysfunctional Attitude Scale, Weissman & Beck, 1978; YSQ, Young & Brown, 1994) and from assessment techniques (downward arrow) are often helpful with respect to the selection process.

### *Set a goal relating to the change processes being employed*

It is important for the therapist to determine the process of change that he is endeavouring to use to achieve the agreed goal. This decision will have an impact on the style of continua employed and the labels ascribed to the end points (Padesky, 1994). It will also determine whether adaptive or maladaptive descriptors are used at the poles (see below). For example, if the therapist believes that the continuum method can result in core belief change, then he needs to socialize the patient to this expectation. The aim of treatment should be to get the patient to re-examine the evidence relating to her beliefs, and in so doing reduce the credibility of the dysfunctional cognitions. Simultaneously, the therapist should be working to develop and support a more adaptive perspective. In contrast, if the therapist thinks that the core belief

can not be eradicated completely and will frequently be triggered in a given situation, he can socialize the patient to a different and less ambitious expectation. In this case, the goal of the continuum may be to refine the belief so that it is less global and more flexible (e.g. becoming a conditional form of the belief rather than an unconditional form). In both of the above change scenarios, the therapist is also likely to help the patient to develop better coping strategies to assist her to deal with the dysfunctional core belief when active.

### *Select the most appropriate form of continuum*

The therapist needs to think through the theory of change underpinning the methodology. This will help to construct the most appropriate form of the continuum to meet the patient's needs. The present authors hypothesize that effective re-evaluation is achieved by presenting comparative factual information in a "novel" way, that is, in a concrete, multi-modal manner that may temporarily suspend the action of the (normally) ubiquitous negative information processing biases. For example, a grandmother suffering from obsessive compulsive disorder, with a fear that she will harm her new grandson: Therapist says: "If you were truly 100% evil as you've indicated on your continuum, would you be experiencing such high levels of anxiety when you get this image of hurting the baby? So the fact that you experience such high levels of anxiety, tell us what about your degree of evilness?"

The actual construction of the continuum will clearly always depend on a number of interacting features, for example: content of the core belief; therapist's model of change; goal of therapy; goal of session. Notwithstanding these issues, Table 3 helps to clarify a number of features regarding selection of the continuum.

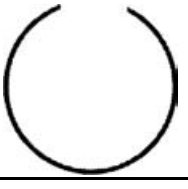
### *Engage the patient in an integrated CBT change process*

Despite the continua process being viewed as a cognitive change strategy, it is essential that the other elements of the CBT cycle are maintained. Questions should be asked about the links between belief and emotions, physiology and behaviours. Any changes with respect to the strength of the belief should be linked to changes of the other elements of the CBT cycle. For example: "Right Ann, you've rated yourself as 5% 'good' on this line, and this is consistent with your very negative feelings. OK, now if we were able to move you along this line, say to 10% 'good', would you notice a change in the way you feel. Might that improvement also, although it's ever so slight, make you a little more likely to start doing things with your friends."

### *Employ CBT processes competently*

In order for the strategy to work well, the therapist must employ all the conventional skills required of good CBT: the therapist should elicit and provide feedback; use good interpersonal skills; pace the work effectively; work collaboratively; use an effective questioning style, and a guided discovery approach. It is important that the continuum method is not dominated by the structural aspects of the technique; rather it should be directed through the use of competent therapeutic skills.

**Table 3.** The different forms and functions of continua

| Nature of continua | Example | Function |
|---|---|---|
| Use of positive poles (e.g. case example of a man who views himself as being worthless) (see Padesky, 1994) | Instead of:<br>0% worthless 100% worthless<br>Use:<br>0% OK 100% OK | Use of positive poles ensures that (i) the person can identify a positive or preferred belief that he wants to move towards (e.g. being OK); (ii) any successful re-evaluations are directly related to his goals; (iii) any positive movements can also be reinforced, and the means of achieving them operationalized in concrete terms. For example, one can ask the patient what he has actually done to move 5% further along the positive scale (i.e. seeing himself as being more OK). |
| Use of multiple lines (e.g. case example of a woman who describes herself as 95% evil based on having recurrent images of god sexually abusing children. She engaged in compulsive praying to help neutralize the images) | The notion of evil can be broken down in a number of ways. One could ask the patient to describe five features that make an evil person 'evil' (eg. they'd enjoy having horrible images, etc). She could then be asked to rate herself on each of these five lines.<br>Alternatively, one could ask the patient to score her degree of evilness with respect to five domains of her life (as a mother, carer for her sick sister, her work for the church, when playing the piano). | By breaking down the perspectives, the absolutist nature of the perceptions begin to be challenged. The patient is guided to see that she may be overgeneralizing with respect to her self-view. This format assists in redefining beliefs by increasing differentiation within its cognitive structure. In the present case, the woman moved from a view of being totally evil, to the current perspective: "*The fact that I get distressed by the thoughts shows I'm not evil, but I do still have evil thoughts*." In this case, the woman still wanted to use the term evil in her reconceptualization, but the refinement in the belief led to a more functional perspective; it also led to a reduction in her compulsions. |
| Use of non-linear representations (e.g. case example of a man who perceives himself to be inadequate. He would continually compare himself to highly successful people as reported in the media) | The horseshoe presentation (Elliot & Kirby Lassen, 1998):<br>0% adequate totally adequate<br>  | By getting the patient to rate himself on this form of scale, he appreciates that the most functional area to be is in the mid-section. This area represents flexibility and movement (e.g. sometimes, and with some things, one can feel highly adequate, but in different situations one can start to see oneself as less adequate – things will naturally tend to oscillate between the extremes). With this form of representation, patients often see that the most dysfunctional positions are at either extreme. |

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*Ask the patient to summarize the learning achieved, and whether goals were met*

After completing the continuum, it is helpful to ask the patient to summarize what she thinks has been achieved. For maximum effect, the summary is best done in written form on the page on which the continuum was drawn. The patient can also be asked to given a written statement concerning the degree of progress made towards the overall treatment goal. As in all change methodologies, after completing the strategy the patient should provide specific feedback concerning her experience of undertaking the task. This feedback can help with the debriefing process, and also assists in future adaptations should another continua be employed in subsequent sessions.

*If any change occurs, assess how it will impact on subsequent functioning*

In order to reinforce the impact of in-session change, and to help it generalize to outside the session, time should be spent discussing the implications of the change. It is advisable to get the patient to reflect on how her changes in thinking could be operationalized outside of the therapeutic arena (i.e. at work, in their interactions with others). Such reflections could be elaborated and developed through the use of experiential exercises and further consolidated via the setting of a relevant homework assignment. A different, yet associated, feature relating to subsequent functioning, concerns patient containment. Working at the level of core beliefs can sometimes produce great emotional and cognitive shifts for the patient. The therapist may not always be able to ground such a shift appropriately prior to the end of the session. In such circumstances, the patient's destabilized state may lead him/her to make dramatic life-changing decisions (i.e. to separate from partner, to leave a job, to confront an abuser) and some of these decisions may be made prematurely. In order to prevent this from happening, the therapist should carefully assess the impact the continuum work has had on the patient prior to the end of the session.

The above list has highlighted that under the appropriate circumstances there is clearly a need to work at the level of patients' core beliefs. It also acknowledged that the continuum methodology can be an effective technique when operating with such cognitions. However, it is evident that a great deal of preparatory work and therapeutic skill are required to employ this methodology, and many of the other change techniques, competently. Table 3 has outlined some of the types of continua that can be used. However, this list is not exhaustive. For example, Padesky (1994) provides a review of different forms of this methodology, including 2-axes models for examining two inter-related concepts.

## Conclusion

This paper has sounded a note of caution to those therapists working with patients' core beliefs. While it is accepted that such work is necessary with some patients, it is important that when working at this level, clinicians should be truly empathic with respect to the experiences of their patients. Indeed, it is proposed that therapists should be operating via a Theory of Mind perspective (seeing the impact of interventions through the eyes' of their patients). In doing this, they are more likely to be careful, responsive and realistic during both the assessment and treatment phases of therapy. Finally, when working with core beliefs, owing to the high levels

of emotional content of the material, evolutionary change is preferred to revolutionary change. The slower more graduated approaches can be underpinned with better support mechanisms, and they generally achieve more stable states for both the patients and therapist.

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