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Psychotherapists' Implicit Theories of Therapy

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The concept of an "implicit theory" is raised to describe the private beliefs that a therapist holds about therapy, aside from those provided by an explicit theoretical orientation (e.g., behavioral, psychodynamic). It is suggested that the combination of an explicit theory and an implicit theory will account for more variance than an explicit theory alone when studying psychotherapy process and outcome. Examples of implicit theories include "principles of practice," "role definition," "professional dilemmas," and "images." The assessment of implicit theories is described, and the application of implicit theories to psychotherapy research is illustrated in relation to three topics: the identification of expert therapists, improving training in manualized treatments, and understanding negative patient outcomes.

KEY WORDS: psychotherapist; psychotherapy; cognition; theory; schema.

INTRODUCTION

In psychotherapy research, the single most predominant way to define therapists is by their theoretical orientation (Lambert, 1989). Yet theoretical orientation has been found remarkably limited in its capacity to predict outcomes of treatment (Beutler, Machado, & Allstetter-Neufeldt, 1994). Moreover, therapists of the same orientation have been found to differ widely in their processes and impact on patients (Luborsky *et al.*, 1986; Najavits & Strupp, 1994), while, conversely, therapists of different orientations have been found highly similar in their therapeutic style (e.g., Fiedler, 1951) and outcomes (Smith, Glass, & Miller, 1980). That most psychothera-

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pists define themselves as "eclectic" and the proliferation of over 400 separate schools of therapy (Garfield & Bergin, 1994) further erode the orientation monolith.

In the past decade, two major trends in psychotherapy research have arisen in response to this dilemma. One is a rigorous focus on theoretical orientation by way of treatment manuals and adherence scales to more thoroughly inculcate allegiance to orientation and to reduce variability among therapists (Crits-Christoph *et al.*, 1991). Another is the search for alternate ways to characterize therapists, in addition to orientation (e.g., by ratings of competence or skillfulness; Beutler *et al.*, 1994). The current paper seeks to elaborate a concept that may help link these two approaches: the notion of therapists' "implicit theories of psychotherapy." "Implicit theory" is an established construct in several areas of psychology, including cognitive psychology (Schon, 1983; Sternberg, 1985), personality psychology (Schneider, 1973), social psychology (Bruner & Tagiuri, 1964), and educational psychology (Clark & Peterson, 1986). An implicit theory of therapy might be defined as therapists' private assumptions or "working model" about how to conduct psychotherapy that is distinct from, but coexists with, normal theoretical orientations.

In this paper, the construct of implicit theories of psychotherapy will be described, followed by methods of assessment, and applications to psychotherapy research.

WHAT IS AN IMPLICIT THEORY?

In the clinical literature, it has been repeatedly observed that therapists develop implicit theories of therapy in addition to the explicit theories to which they subscribe (Burrell, 1987; Kottler, 1986; Sandler, 1983; Shoben, 1962). Kottler states,

> All therapists are theoreticians. We harbor our own unique ideas about how the world works and how therapy ought to be conducted. No matter what school of thought we align ourselves with, we have our own individual notions about how . . .to work. (1986, p. 137)

An implicit theory might include personal strategies of what to do during sessions, such as Reik's (1956) emphasis on looking for elements of surprise in the patient's report, or Kottler's (1986) statement on the importance of taking risks in therapy. It could include views about what processes are actually occurring during therapy (such as the idea that the patient changes the therapist as much as the therapist changes the patient; Kottler, 1986), and views about what not to do in therapy (the discovery, after years of being a therapist, that one should not try to mold a patient into an

image of one's own life; Burton, 1972). It may also include assumptions that hinder treatment: "I must not push my clients too hard or else they'll dislike me"; "I must mainly use techniques which I enjoy or which are easy whether or not helpful to patients" (Ellis, 1983). Implicit theories might also be reflected in metaphors for the therapy process (e.g., therapy as a technical procedure, a philosophical quest, or a war; Najavits, 1993). Other topics might include personal axioms therapists tell themselves during sessions, views on what to do what particular problem situations arise, ideas of what makes therapy difficult to do well, and subjective criteria by which they measure their success.

Shoben (1962), one of the first to write on the topic, has called the therapist's theory a "personal trait" comprised of both explicit theoretical positions (e.g., Gestalt, behavioral) and implicit assumptions about the work. Implicit theories arise, he says, because explicit theories are phrased as abstractions that do not specify how to act in particular cases, or that may contradict one's experience. He suggests that therapists differ in the extent to which they rely on their explicit vs. implicit theories, and that they choose an explicit theory based in part on how well it matches their implicit theories about human personality and development (see also Vasco, Garcia-Marques, & Dryden, 1993). This may be unique to the social sciences because, unlike the hard sciences, there are fewer objective standards by which to judge explicit theories. He believes it is important for therapists to become aware of their implicit theories:

> Since theories are inescapable in the ordering of the data with which we work as counselors, it would seem important to hold them as explicitly as possible and to examine their influence on our judgment and on our professional conduct with . . .unsparing honesty . . . . The counselor who achieves this kind of honesty in dealing with his cognitive self is likely to enjoy a sense of personal growth in his professional life that is denied to others. (Shoben, 1993, pp. 620–621)

Dolliver (1991), for example, in an article titled "The Eighteen Ideas Which Most Influence My Therapy," describes his selection of parts of formal theories plus his own unique views.

Sandler (1983) states that explicit theories are often not concerned with the practical problems that a therapist faces. Also, explicit theories are not comprehensive, and contain constructs with multiple meanings that may depend highly on therapists' interpretations. He views this flexibility as a very positive phenomenon that allows the theory to change over time. However, many therapists attempt to hide their implicit theories.

> The conscious or unconscious conclusion of many analysts [is] that they do not do "proper" analysis . . .[a] conviction that what is actually done in the consulting room is not "kosher," that colleagues would criticize it if they knew about it . . . . At times he may have to depart quite far form the "standard" technique. He may be

very comfortable with this as long as it is private rather than public. (Sandler, 1983, pp. 36–37)

Sandler believes the therapist's implicit theories may at times be superior to explicit theories for a particular case, and that the development of explicit theories can be accelerated by studying implicit theories. Past development of explicit theories arose, he states, because of weaknesses in available theories and the gradual elucidation of the "partial theories" to complement them. This has also been remarked by Sternberg (1985), who states that implicit theories are the beginning point for the development of explicit theories; and by Burrell (1987), who uses the analogy of Darwinian evolution to describe the continuing adaptation of theory to the environment. Burrell makes the point that tacit theories are as fallible as explicit theories: "The tacit dimension of therapist and client is . . .neither black (i.e., the source of only 'destructive' and 'undesirable' impulses) nor white (e.g., a wellspring of creativity). Instead, it is numerous shades of gray, the hue of which will depend on the relation between the context and the rules in question" (p. 231).

DEFINITIONS

In personality psychology, which originated the concept of implicit theory, it is defined as "naïve observers' assumptions about the cooccurrence of personality traits" (Harre & Lamb, 1983, p. 296). An implicit theory of therapy might thus be defined as "the assumptions a therapist holds about psychotherapy distinct from any formal theoretical orientation, and the relationship of these assumptions to each other." Many terms from cognitive, personality, social, and educational psychology overlap with implicit theory (belief system, construct system, practical knowledge, subjective theory, private theory, tacit theory, folk theory, and meaning system). The term "implicit theory" is selected because in psychotherapy research it seems especially helpful to differentiate it from "explicit theory" (theoretical orientation). It can also be noted that implicit theories may be conscious, preconscious, or unconscious to the therapist; "implicit" simply refers to ad hoc, tacit assumptions of therapists, as distinct from the formal propositions of orientations. Finally, implicit theories refer to assumptions about psychotherapy, not to therapist's extratherapy (political, religious, or lifestyle) attitudes.

The main focus of this paper will be the important component of implicit theories known as implicit beliefs. Implicit beliefs represent the specific propositions that make up an implicit theory (Bromme, 1984). While a future goal may be to describe the implicit theories of therapists, the

lack of work in this area requires a focus on the beliefs of which therapists' theories are comprised. Also, "implicit theory" should be reserved for use when some comprehensive relationship between the propositions is being discussed (Bromme, 1984).

The term "belief" can be formally defined as a judgment of relationship between an object and some characteristic of the object (Ajzen & Fishbein, 1980; Hollon & Bemis, 1981). For example: "Therapy [an object] requires a huge amount of energy by the therapist [an attribute]." Beliefs (a cognitive construct) can also be distinguished from attitudes (a positive or negative feeling toward an object) and behavior (action toward an object; Ajzen & Fishbein, 1980). Beliefs can be distinguished from values, which are propositions about what *should* be; beliefs merely present a picture of how the world *is* to the perceiver. Values are thus a subset of the larger category of beliefs (Hollon & Bemis, 1981). While numerous terms overlap with "belief" (schema, proposition, attitude, underlying assumption, perspective, principle, opinion, model, hypothesis, theme, meaning), belief is selected because it has a long-standing usage in psychology (Ajzen & Fishbein, 1980) as well as a strongly cognitive focus that readily allows its connection to implicit theories (which are also cognitive in nature).

RESEARCH ON IMPLICIT BELIEFS

The topic of implicit therapeutic theories and beliefs is not yet an entity in itself in the psychotherapy literature, although some empirical studies exist. Examples of such studies will be described since they point to some atheoretical notions to which therapists adhere and that appear to influence their practice. However, most are limited to cross-sectional self-report surveys, average results across different types of therapists, and do not relate their results to therapists' theoretical orientations.

One of the earliest studies in this area is by Fiedler (1950). Using a Q-sort method, he asked 15 therapists of different orientations (psychoanalytic, nondirective, eclectic) and different levels of training (experienced, inexperienced) to sort qualitative statements about the therapeutic relationship into categories of most to least desirable. The statements had been derived from books, case records, and conferences and included, for example, "The patient feels free to say what he likes" and "The therapist tries to impress the patient with his knowledge." Results showed that more experienced therapists of different orientations agreed more highly with each other than with less experienced therapists of their own orientation in their concept of the "Ideal Therapeutic Relationship." In a later study (1951), he extended these results to show that the actual therapy relation-

ship created by expert and inexpert therapists again differed more due to level of expertise than to orientation.

Deutsch (1984) surveyed 264 therapists on a questionnaire of "irrational beliefs" about conducting therapy (e.g., "I should be able to help every client"; "I should always work at my peak level of enthusiasm and competence"). Her goal was to relate these to stresses therapists face in their practice, with the hypothesis that one's irrational beliefs would contribute to reported stress. She found that 40% of the sample rated three particular beliefs (all on perfectionism as a therapist) moderately stressful or higher. She also found significant differences between degree of endorsement of beliefs, and noticed that a number of subjects spontaneously added their own beliefs to her questionnaire.

McLennan (1985), developed a brief "Helping Beliefs Inventory" from discussions with experienced clinicians about helpful vs. nonhelpful responses to clients by the therapist (e.g., "Try to get the patient's mind off the problem"; "Tell the patient not to worry"). Therapists were then asked to rate their degree of belief about the helpfulness of these strategies for patients. The inventory was able to significantly discriminate novice vs. experienced counselors ($N = 270$), and counselor trainees rated high, moderate, or low in clinical skill by their supervisors ($N = 45$). However, McLennan does not report the counselors' theoretical orientation.

Davis, Elliott, Davis, Francis, Kelman, and Schroder (1987) developed a taxonomy of difficulties therapists experience during therapy, commenting that this topic "has been curiously neglected by researchers" (p. 104). Examples include "The therapist feels inadequate about his or her performance as a therapist." The therapist's private concerns are felt to be intruding into the therapy," and "The therapist feels a need to protect self against the patient." They found good reliability for their taxonomy, and found that therapists were discriminable from one another on it.

Pope, Keith-Spiegel, and Tabachnick (1988) surveyed members of APA's Division of Psychotherapy by questionnaire regarding their beliefs about what constitutes unethical practice and their associated in-session behaviors. Beliefs and behaviors were found to be correlated across the sample of 456 subjects (although the validity of therapist's self-reported behaviors is unclear).

Najavits (1993) studied therapists' metaphors for the process of psychotherapy. In a sample of 30 therapists, it was found that the most popular metaphors were art, teaching, healing and science; that the highest endorsement accrued to idiosyncratic metaphors added in by therapists; and that endorsement of metaphors was independent of professional background characteristics.

Research by Orlinsky *et al.* (1993) on the development of therapists over the career span can also be conceptualized within the implicit theories framework. For example, they have found that the greater the discrepancy between therapists' actual vs. ideal views of themselves as therapists, the greater therapists' subjective experience of difficulties in therapy and the lower their subjective rating of their own skillfulness.

Overall, the existing psychotherapy literature would suggest some initial evidence for the presence of therapists' atheoretical beliefs about therapy and a relationship between these beliefs and therapists' expertise level (Fiedler; McLennan; Orlinsky *et al.*), self-reported stress from conducting psychotherapy (Deutsch; Orlinsky *et al.*), and self-reported ethical behavior in therapy (Pope *et al.*).

ASSESSMENT OF IMPLICIT THEORIES

Clark and Peterson (1986) have called the measurement of implicit beliefs a task of "serious technical, methodological, and epistemological challenges" (p. 259). As Sternberg (1985) states, "Implicit theories are constructions by people . . .that reside in the minds of these individuals. Such theories need to be discovered rather than invented because they already exist, in some form, in people's heads" (p. 448).

Methods for assessing beliefs can be classified as researcher-assisted methods and self-report. Researcher-assisted methods are of three main types. In *sorting tasks*, subjects take a set of statements, typically printed on index cards, and sort them into categories either of their own making (*repertory grid* method) or into a range from "not at all like me" to "very much like me" (*Q-sort* method). In *think-aloud tasks* subjects' verbalizations are obtained in relation to specific professional tasks, either while performing the task (*process tracing* method) or retrospectively (*stimulated recall* method). In *free response tasks,* the subject is asked to spontaneously provide material either verbally (*interview* method) or behaviorally (*observation* method). Self-report methods include *questionnaires* and *journals.* For all of the methods, variations include development of a coding scheme by which to analyze the data, rating scales to quantify degree of endorsement of beliefs, flow charts that describe developmental models of subjects' thought processes, degree of structure provided to the subject, identification of salient beliefs, calculation of positive to negative beliefs, convergent–divergent validity analyses of beliefs; subjects' identification of "critical incidents" (salient situations that evoked particular beliefs), and posing hypothetical vignettes (Clark & Peterson, 1986; Mueller, 1986; Munby, 1982; Shavelson & Stern, 1981; Sternberg, 1985).

It has been found that repeated multiple measurement from different points of view improves the quality of results. Simple questionnaire methods are likely *not* sufficient to capture professionals' thinking (Calderhead, 1987). Questionnaires suffer from a variety of problems including response sets (acquiescence, avoiding extremes of the scale, social desirability), the difficulty of summarizing diverse beliefs about complex topics (Mueller, 1986), the lack of understanding how questions are interpreted (Munby, 1983), and an overreliance on quantification that may mask important differences (e.g., people may obtain the same score for very different reasons). The move toward complex measurement is also marked by attempts to measure beliefs in the language of professionals (e.g., Clandinin, 1986). Better studies attempt some balance between quantified and qualitative approaches: they develop coding schemes by which to organize data, use multiple raters to code results, and determine raters' reliability (e.g., Brophy & Evertson, 1976). Similarly, a balance between analysis of individual results and comparison across subjects is helpful, and specific rather than overly general questions is preferred (Brophy & Evertson, 1976).

Reliability and validity studies of beliefs assessment are also necessary. It is important, as in all assessments within psychotherapy research, to ascertain that researchers do not influence or create beliefs by their methodologies (Hollon & Kendall, 1981), to determine the honesty of responses (Mueller, 1986), to assess the stability of beliefs over time and changing contexts (Hollon & Kendall, 1981), and to link beliefs to external criteria such as behavior (Ajzen & Fishbein, 1980).

The use of existing frameworks for studying professionals' beliefs may provide a heuristic for research on therapists. For example, Elbaz (1983) conducted interview and observation research to explore teachers' implicit theories of teaching. She found that a teacher's practical knowledge is structured in three forms. These are "rules of practice" (brief statements of how to behave in particular teaching situations), "principles of practice" (abstractions that are more deliberately considered during teaching), and "images" (metaphors and analogies of what good teaching looks like). Bipolar constructs were examined by Tabachnick and Zeichner (1984) as "professional dilemmas," such as distant vs. personal teacher–student relationships, and children as unique vs. children as members of a category. Brophy and Evertson (1976) found that "basic role definition" differentiated teachers rated high or low in effectiveness. Role definition derived from questions such as "How does the teacher define the teaching task?" "What is seen as possible vs. impossible?" "What is seen as part of her responsibility vs. not her responsibility?" Successful teachers viewed teaching as an interesting

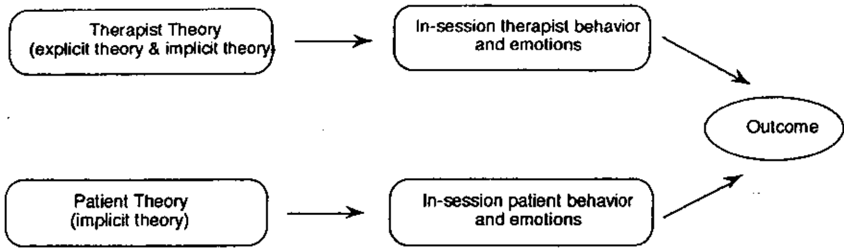

Fig. 1. Framework for implicit theories within psychotherapy research.

challenge requiring hard work while unsuccessful teachers viewed it as "just a job."

APPLICATIONS TO PSYCHOTHERAPY RESEARCH

The usefulness of the implicit theory concept will depend on its ability to address current issues in psychotherapy research. A general framework for the place of implicit theories in relation to process and outcome is presented in Fig. 1. This formulation resembles the cognitive model of treatment (Beck, Rush, Shaw, & Emery, 1979) in that cognitions are posited as the main causal influence on behavior and outcome. It is novel, however, in its equal weight to therapist cognitions as to patient cognitions. The model also implies that implicit theories will be useful to the extent that they can predict in-session behavior (process) and outcome; to this extent, implicit theories are "testable" to the same extent that explicit psychotherapy theories are. Finally, it asserts the importance of identifying the full field of therapist cognitions *vis-à-vis* treatment. That is, understanding the therapist will require empirical attention both to explicit and to implicit theories; neither alone is sufficient to explain outcome. Thus, what was previously considered "noise" in the attempt to relate therapists' theory to outcome might now be seen as informative.

The potential application of the implicit theories concept to psychotherapy research can be illustrated in the following examples.

Identification of Expert vs. Nonexpert Therapists

Implicit theories research could help refine our understanding of therapeutic expertise. After categorizing therapists by their performance

(such as average outcomes within caseloads or ratings on therapeutic alliance), the study of implicit theories may help explain such variability, particularly as such variability is known to exist independent of theoretical orientation (Luborsky *et al.,* 1986; Najavits & Strupp, 1994). For example, with regard to the alliance, therapists might be assessed for their views on what is required to build an alliance with patients, how easy or difficult they believe such a task to be, and what benchmarks they use to monitor level of alliance. It has also been hypothesized that experts could be identified by a high concordance between their stated beliefs and behavior, by the possession of more highly developed belief systems, or by characteristics of beliefs such as concreteness versus abstractness, number, extremity, internal consistency, and awareness of possessing beliefs (Brophy & Evertson, 1976; Munby, 1982; Tabachnick & Zeichner, 1984).

In one study of expertise (Bloom, 1985), for example, structured interviews with 120 top experts from five different fields lead to the delineation of two levels of expertise. The middle levels of expertise were found to be characterized by imitation of others, conformity, and adherence to rules ("technical proficiency"). The highest stages, however, were marked by development of one's own rules, and the generation of personal meanings and self-expression in one's work. In psychotherapy research, adherence to an explicit orientation may come to be viewed as a necessary but only midlevel skill, with idiosyncratic meaning systems a potentially higher level. Indeed, if expert clinicians are characterized by such essential characteristics as the desire to help (Eber & Kunz, 1984), compassion and a reverence for life (Strupp, 1978), mental health (Beutler *et al.,* 1994), and enjoyment of their work (Najavits *et al.,* 1995), such qualities may be identifiable, at least in part, by belief systems. The work of Chi, Glaser, and Farr (1988) identifying cognitive differences between experts and novices could also serve as a guide. They have found that experts show higher degrees of automaticity, abstract thinking, chunking, transfer of skills, and speed of processing than novices. It might be productive to relate such cognitive *processes* to the cognitive *content* that implicit theories represent; that is, to identify what specific therapist beliefs are associated with such higher order cognitive processes.

Training Therapists in Manualized Treatments

The popularity of treatment manuals is perhaps exceeded only by concerns about its mixed relationship to psychotherapy outcome (e.g., Beutler *et al,* 1994). In attempting to improve the use of manuals to achieve positive outcomes, it may be helpful to explore therapists' implicit theories about ther-

apy as an intermediary variable. What gets in the way of therapists' conducting treatment as specified? Even with state-of-the-art training, some therapists are unable to attain competence using a manual (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985). According to the concept of "bounded rationality" (Shavelson & Stern, 1981), professionals think and behave rationally in relation to their particular belief systems. It is possible that the theory proposed in a manual may be competing against alternative, contradictory beliefs the therapist already possesses. For example, therapists are reported to have strong negative attitudes toward "difficult" patients with disorders such as substance abuse or borderline personality disorder (Najavits *et al.*, 1995). A manual that specifies a positive, warm, optimistic view of such patients may remain just words on a page unless there is some attention to the internal conflicts the therapist may experience between the "correct" view and their own (often more negative) internal belief system. This is a function that strong supervision provides, but manuals are often used with inadequate or uncontrolled supervision, and even in high-quality controlled studies, the impact of supervision has been found to vary considerably (Henry, Schacht, Strupp, Butler, & Binder, 1991). Developing more formal models of therapists' implicit beliefs and assessing them systematically may allow greater understanding of the barriers to skill acquisition that prevent treatments from being delivered as envisioned by their originators. As Ausubel has stated, "If I had to reduce all of educational psychology to just one principle, I would say this: The most important single factor influencing learning is what the learner already knows. Ascertain this and teach him accordingly" (1968, p. 294). The study of implicit theories may be particularly relevant for training "nonspecific" relationship skills that are found to be more difficult to achieve than technical, therapy-specific skills (Binder & Strupp, 1993). Moreover, the entire definition of what constitutes "adherence" might eventually be refined to include not just observable behaviors, but also the acquisition of a particular set of beliefs that are identified as central to a particular treatment. One could imagine an adherence scale of the future that would require an interview with the therapist, or a self-report scale, in which therapists' would be evaluated for their degree of endorsement of particular beliefs that are consistent with (and also inconsistent with) that particular model. Whether certain psychotherapies (e.g., cognitive-behavioral vs. psychodynamic) are more successful at inculcating a new belief system in therapists could also be evaluated.

Negative Outcomes in Psychotherapy

It is well established that some patients become worse rather than better after exposure to psychotherapy (Lambert & Bergin, 1994). Therapist

factors related to such deterioration have been identified both in clinical reports and research. For example, a study by Lafferty, Beutler, and Crago (1991) found that negative outcome cases were more associated with therapists who valued social and economic success rather than hard work and intellectual values. Mohr's review (1995) describes negative outcome cases as related to therapist's lack of empathy, underestimation of severity of patient's pathology, negative countertransference, poor technique, high concentration of transference interpretations, and disagreement with the patient about the therapy process. According to Hollon (1995), when therapy fails, the therapist questions both the theoretical orientation and its implementation.

A research program on therapists' implicit theories could provide more explicit attention to therapists' role in negative outcomes. It could be hypothesized that any of a number of relationships are possible between the therapist's implicit and explicit theories when treatment goes awry: e.g., the therapist is operating more from an implicit theory rather than an explicit theory that has been demonstrated to work; the therapist may be distorting the explicit theory in ways that subvert the intent of the explicit theoretical orientation; or the therapist's implicit theory may be less mature than that of other therapists', all of whom are nonetheless conducting the same explicit theoretical orientation. An interesting recent study by Levenson, Speed, and Budman (1995) found that while 80% of therapists currently report conducting brief psychotherapy, only one quarter report a strongly positive attitude toward it. Such discrepancies between what therapists is required to do and what they in fact value may help shed light on negative outcomes from treatment. Discrepancy may also occur when the implicit beliefs of a therapist and a patient conflict. For example, if one views change as the result of a lengthy process of introspection, and the other sees it as something to be taught and learned, it is likely that negative outcome may result. In short, the study of implicit theories is particularly relevant to negative outcome cases, where presumably the explicit theoretical orientation has been misused or may be insufficient to override preexisting therapist or patient characteristics.

CONCLUSIONS AND FUTURE RESEARCH

It is widely agreed that the therapist is known to account for substantial outcome variance, but that, as yet, the set of key therapist variables to account for such impact has not yet been identified (Beutler *et al.,* 1994). Simple variables of therapist sociodemographic and professional background characteristics (e.g., age, gender, theoretical orientation, experience,

training) are, however, insufficient (Beutler *et al.,* 1994; Mohr, 1995). More complex variables such as therapists' extratherapy belief systems, or personality variables, also appear to have a mixed impact on outcome (Beutler *et al.,* 1994). The concept of therapist' *implicit theories of psychotherapy* offers a relatively new avenue of work. While an established area of several other areas of psychology, its application in psychotherapy research has been sparse. The combination of therapists' explicit theories (i.e., orientations) and implicit theories (i.e., orientations) could potentially offer a more sophisticated, richer understanding of how therapists work than attention solely to the explicit, prescribed theoretical orientations that they are taught. The advent of managed care has increased the importance of identifying qualifications of those who provide mental health services (Beutler & Kendall, 1995), further energizing the search for therapist variables that might explain their impact on outcome.

However, several steps are needed for implicit theories of therapy to become a productive area of work. First (and perhaps ironically), a theory is necessary to help organize the infinite realm of possible beliefs that therapists might hold. Identifying the most important dimensions and constructs of their belief systems could help move beyond existing piecemeal studies. An observation stage, in which a wide variety of therapists are interviewed, might provide the groundwork for such a theory. Second, there is a need to develop adequate assessment tools. Some of the strategies described above may prove fruitful, although it remains to be seen to what extent therapists can accurately report their implicit theories. That some initial studies have already successfully related therapists' beliefs about therapy to outcomes (e.g., Fiedler, 1951; McLennan, 1985) would suggest a case for some optimism on this point. Indeed, one of the main hindrances to research on therapists has been a relative lack of standardized measures to assess them (Beutler *et al.,* 1994). Third, relating therapists' implicit theories of therapy to outcome will be the most important test of their relevance. While apparently a large task, research on implicit theories might help bridge the often-lamented gap between clinical research and practice by delving into the inner experience of the psychotherapist. To paraphrase Clandinin (1986), research is of two types: research on what we know about therapists, and research on what therapists know.

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