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INTRODUCTION

The role that theory plays in the process and outcome of counseling has been a subject

of discussion, and sometimes heated debate, for almost as long as counseling has been a profession. While schools of therapy have argued that different theories produce differing and nonequivalent outcomes, this position has been challenged on numerous occasions. Fiedler (1951) first observed that therapists of differing orientations were very similar in their views of the "ideal therapy." Then Sundland and Barker (1962) reported that more experienced therapists tended to be more similar, regardless of their theoretical orientation. In their extensive review of the subject, Gelso and Carter (1985) stated that "most clients will profit about equally (but in different ways) from the different therapies" (p. 234). They go on to suggest that the effect of process and relationship do differ among therapies and that some clients may do better with one approach than with another, based upon these two factors. Finally, Stiles, Shapiro and Elliott (1986) concluded that "(a) common features shared by all psychotherapies underlie or override differences in therapists' verbal techniques and (b) these common features are responsible for the general equivalence in effectiveness (of therapies)" (p. 171). Process and relationship, then, may be as relevant as theoretical conceptualization of the problem. This notion has led a number of researchers (Goldfried, 1982; Highlen & Hill, 1984) to an integrationist position which emphasizes process and action in the counseling relationship over theoretical imperatives.

THE APPLICATION OF THEORY IN COUNSELING

How do counselors choose a particular counseling theory? Among the alternatives are (1) the orientation of one's initial training program; (2) one's own philosophy or life view; and/or (3) one's therapeutic experience and evolving therapeutic patterns. Given the more than 130 extant theories of counseling, do counselors tend to be purist in their theoretical orientation? Rarely. Where counselors are purist, it tends to be a function of exclusivity of training (receiving training in a single theoretical orientation) and/or recency of training (the more recent the training, the more consistent the counselor's conformity to a particular theory). How do counselors use their theory? Certainly, counselors use theory to explain or conceptualize client problems. In addition, they may use theory to dictate what they do in the counseling process. Finally, Strohmer, Shivy, & Chiodo (1990) suggest that they may also use theoretical orientation to selectively confirm their hypothesis.

SEPARATING COUNSELING INTERVENTIONS FROM THEORY

Theory, whether in pure form or adapted by the individual counselor, can be used to define the nature of the relationship between the counselor and client, to conceptualize the nature of the presenting problem(s), and to define the resulting counseling goals or desired outcomes. While some counselors would also say that theory dictates the types of interventions used in counseling, increasingly the argument is being made that

interventions are related more to goals and outcomes than to theoretical conceptualization. If one examines theoretical integrity today, based upon what counselors faithful to that theory do with clients, a convergence of theories appears to be occurring. Humanistic theories have been infiltrated by some classical behavioral interventions. Behavioral approaches acknowledge the legitimacy of feelings and the appropriateness of affect change. Cognitive approaches are frequently referred to as "cognitive-behavioral." Systemic approaches utilize many interventions that one can only describe as cognitive in nature. Thus, distinctions between theories are not as clearly defined as one might think, and intervention selection may be only indirectly related, and certainly not dictated by theoretical orientation.

MATCHING INTERVENTIONS TO CLIENT PROBLEMS

How does the counselor who is working within a consistent theory, be it a textbook theory or a personal theory, choose the interventions to use with a particular client? Logic would hold that the counselor's choice of therapeutic interventions would derive from the conceptualization of the problem(s), thus from the counselor's theory. But the theoretical world of counseling and change isn't quite that neat. From an integrative perspective, that choice is made by relating the intervention directly to the nature or character of the problem being addressed.

On the other hand, most client problems are typically multi-dimensional. A problem with negative self-talk ("I'm constantly telling myself I'm no good") is not only cognitive, but would also reflect an affective dimension ("I feel lousy about myself"), a behavioral dimension ("I choose to stay home and watch a lot of TV"), and a systemic dimension ("When I do go out, I avoid contact with others because they find me strange, or I behave strangely and others react to me accordingly"). Even though most problems are multi-dimensional, intervention at any of those dimensions affects the other dimensions, i.e., systemic change may influence affective and/or behavioral dimensions. How, then, does one plan a strategy for counseling interventions if multiple choices exist and "all roads lead to Rome?" A general guideline is that clients are most receptive when the choice of strategy matches their experiencing of the problem (Cormier & Hackney, 1993).

A THEORETICAL CLASSIFICATION OF INTERVENTIONS

If one examines the variety of counseling interventions that have been described in the professional literature, they tend to fall into four broad categories: interventions that produce affective change; interventions that produce cognitive change; interventions that produce behavioral change; and interventions that produce social system change (Cormier & Hackney, 1993). In addition, within each of these four categories, one can further differentiate among theories in terms of the counselor skill required to implement

the intervention and the level of change produced by the intervention.
AFFECTIVE INTERVENTIONS. The primary goals of affective interventions are (a) to help clients express feelings or feeling states; (b) to identify or discriminate between feelings or feeling states; or (c) to alter or accept feelings or feeling states (Cormier & Hackney, 1993). Some clients have never learned to identify and/or express their feelings. At a somewhat more complicated level, some clients come to counseling flooded with emotional reactions, overloaded by their awareness of and sensitivity to feelings. Their protective response may be to tune out the emotions, to be confused or disoriented. Interventions that may be used to unblock, bridge resistance, or develop expressive skills include teaching the client what a feeling is, affect focusing techniques, role reversal, the alter ego exercise, the empty chair, and so forth.

COGNITIVE INTERVENTIONS. The primary goal of cognitive interventions is to "reduce emotional distress and corresponding maladaptive behavior patterns by altering or correcting errors in thoughts, perceptions and beliefs (Beck, 1976). Cognitive interventions stress the importance of self-control. Clients are viewed as the direct agents of their own changes, rather than as helpless victims of external events and forces (Cormier & Hackney, 1993). Illustrations of cognitive interventions include Ellis's (1989) A-B-C-D-E analysis, thought suppression, thought postponement, therapeutic paradox, and cognitive restructuring (including reframing).

BEHAVIORAL INTERVENTIONS. The overall goal of behavioral interventions is to help clients develop adaptive and supportive behaviors to multifaceted situations. Developing adaptive behavior often means helping the client weaken or eliminate behaviors that work against the desired outcome, e.g. eating snacks when you wish to lose weight. A significant part of this process involves teaching the client. Illustrative interventions include live modeling, symbolic modeling, covert modeling, role play and rehearsal, relaxation training, systematic desensitization, self-contracting and self-monitoring.

SYSTEMIC INTERVENTIONS. Systemic interventions are premised upon the assumption that one's environment elicits and supports the individual's dysfunctional cognitive, behavioral and affective responses. The go goal of systemic interventions is to change the individual's social environment or system, thus changing the patterns of interrelationship that elicited or supported these responses. Examples of systemic interventions (in addition to those in the preceding categories that also produce system change) include: altering communication patterns through role play and renegotiation, altering family (or system) structure by reconstructing boundaries, the family genogram, family sculpture, and providing directives for change. Children pose special issues in the selection of counseling interventions for several reasons. They have little power or control over their environment, or may lack the cognitive or affective development to respond to some interventions. For this reason, a systemic view which involves significant adults in their world often is the most effective approach to intervention selection.

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