Teaching Students How to Avoid Errors in Theory Application

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This article identifies six major misperceptions and errors in the application of theory in direct practice to establish the need for a conceptual tool capable of teaching direct practice and managing the practice environment. Such a tool is introduced as part of the previous article: “Decision Tree: A Conceptual Tool for Best Practices” (p. 37). The six errors and misperceptions are as follows: (1) one theory is as good as another theory, (2) nomothetic theory is interchangeable with practice theory, (3) a single theory can accommodate complex case data, (4) any theory can explain everything and anything, (5) eclecticism does no harm, (6) theory does not matter anyway. Case examples illustrating these errors are provided. [Brief Treatment and Crisis Intervention 4:49–56 (2004)]

KEY WORDS: errors of theory application, critical thinking, human behavior theory, nomothetic theory, practice theory, case theory, model building, teaching, class and field instruction.

This article identifies the occurrence of six major misperceptions in the application of theory in direct practice to establish the need for a conceptual tool capable of teaching direct practice and managing the practice environment. Rigor in the teaching of assessment of client needs and in the application of theory-based solutions to meet those needs is required to promote best practices across diverse disciplines, fields, settings, problems, populations, theories, methods, and practitioner skill levels.

“Generalist Practice” Defined

As a profession, social work is particularly committed to the application of theory from multiple theoretical frameworks, given its commitment to the generalist mandate to be multitheoretical and open in assessment. For the purposes of this paper, generalist practice is defined according to five dimensions: a generic core; an open assessment; a choice of theory; a set of knowledge, values, and skills transferable across diverse
settings, problems, and populations; and a use of multiple methods appropriate to the size of the system targeted for intervention (Plionis, Bailey-Etta, and Manning, 2002).

As part of the mandate for open assessment, generalist practice requires that the practitioner be familiar with a range of theories that span the micro- through macro levels of practice. Therefore, in the profession of social work, one needs to know, manage, and apply multiple theories in practice. Despite texts that survey clinical theories appropriate for direct practice (Lehmann and Coady, 2001; Turner, 1996), there is no tool available for the differential selection and application of theory in a case-specific situation (Bisman, 1994; Dorfman, 1988, 1998), nor can one assess the evidence to support one theoretical choice over another when such options are available without a tool that prioritizes practice decision points.

Education for Direct Practice

Social work education for direct practice commonly includes a generic, or generalist, first year followed by a clinical specialization, or concentration, in the second year. This dichotomy in the education for direct practice has often led to confusing, misleading, and inappropriate theory application, especially in the foundation year. That such a generalist–specialist dichotomy exists in the education of students for direct practice is associated with the job-related needs of employing social work agencies.

Differential Outcomes in the Method of Direct Practice

According to Austin (1997), the job-related needs of employing social work agencies have led to expectations of two educational outcomes for social workers engaged in direct practice. One outcome is represented by the social worker who has been trained to respond to the basic survival needs of vulnerable populations, poverty-stricken children and families, and those in need of protective services. Such a practitioner, says Austin, functions as a semi-autonomous public employee within the constraints of a legislatively mandated bureaucracy marked by welfare reform, managed care, and conflicting ideologically based public policies related to children and families. (i.e., family preservation and permanency planning). This direct practice educational outcome is consistent with the educational curriculum designed for undergraduate seniors or first-year graduate students, who are often placed with highly vulnerable clients in public agencies, community-based collaboratives, or nonprofit settings.

The other educational outcome is represented by the autonomous, theory-based practitioner, who practices in a voluntary, nonprofit, privately funded social service program or in a specialized social service setting in a host organization. Included here is the clinician in private practice. This direct practice outcome is designed for those who choose an advanced, second-year specialization or a concentration in clinical practice, with the expectation that upon graduation they will become primary providers and referral sources for outsourced counseling and therapy. Instruction for direct practice is therefore made more complex, given that it is considered one method with two educational outcomes.

Teaching Theory Application in Direct Practice

Given the expectation of two educational outcomes, teaching students how to differentially select and apply theory to specific case situations is difficult. First, students must acquire knowledge of different theories, with
each theory having its own set of concepts and dynamic principles (Lehmann & Coady, 2001; Turner, 1996). Second, in each specific client case, students must be able to differentiate applicable theory from nonapplicable theory (Bisman, 1994; Dorfman, 1998). Third, during the assessment phase, the student must ascertain which theory best corresponds to the facts of the case—the client’s presenting problem, the client’s relevant past and current situation, and the individual risks and strengths the client brings to the situation. Once an inference has been made regarding “what is the matter,” the student must not only select a treatment option that reflects theoretical choice but must also make an appraisal of the empirical evidence supporting that choice. Theoretical choice reflects critical-thinking skills in the deductive application of theory to the specific case. The application must be salient with the assessment, the mission of the agency, and the client’s motivation and capacity for treatment. This choice is further refined by an appraisal of the empirical evidence that supports it. Once identified, subsequent interactive dialogue between the worker and the client is guided by that theory.

Having taught theory and practice to undergraduate seniors as well as to graduate students in both the foundation and advanced curriculum, I have observed six major misperceptions and errors in the application of theory in direct practice:

1. One theory is as good as another theory.
2. Nomothetic theory is interchangeable with practice theory.
3. A single theory can accommodate complex case data.
4. Any theory can explain everything and anything.
5. Eclecticism does no harm.
6. Theory does not matter anyway.

Misperceptions and Errors in the Application of Theory in Direct Practice

One Theory Is as Good as Another Theory

The first and most difficult misperception to counter is that provided by research. According to Lehmann and Coady (2001, p. 10), “Decades of psychotherapy research have failed to demonstrate the superiority of one type of psychotherapy over another.” According to these authors, summary reviews of this body of vast research have resulted in the “equal outcomes” conclusion. It is plausible that the application of different theories can result in equally successful outcomes, each one being applied to a specific case within an appropriate context of practice by a competent practitioner; however, it is not plausible that the misapplication of theory to a specific case will lead to an equally successful outcome, even in the presence of a positive worker–client relationship.

Nomothetic Theory Is Interchangeable With Practice Theory

A second factor driving the misapplication of theory is the misperception that nomothetic theory is interchangeable with practice theory. Bisman (1994), in her discussion of the deductive–inductive process, distinguishes nomothetic theory from ideographic case theory. Nomothetic theories tend to be taught in the human behavior and social environment (HBSE) sequence and, when applied to a specific case, take the form of “possibly this, possibly that.”

This is consistent with the generalist mandate for open assessment. Such theories are considered a part of a holistic and comprehensive psychosocial assessment. Having used nomothetic theories to consider what is possibly the matter in a specific case, the practitioner must then arrive at, or infer, a theory-based
hypothesis that defines what is actually the matter. Bisman refers to this process as moving from the specific to the general to the individual. Ideographic theory (the theory used to work the case) is true and unique only to the case at hand. At the point that the clinician arrives at a theory-based hypothesis of what is actually the matter in a specific case, the psychosocial assessment becomes one factor among many others in selecting the intervention theory that is most salient to the case at hand. Theories taught in the theory-and-practice sequence differ from the nomothetic theories taught in the HBSE sequence in that practice theories are predictive (“if this”) and prescriptive (“then that”; Polansky, 1986).

The following example illustrates these points as well as the fact that theoretical choice is complex, even when the presenting problem is a single issue, such as “failure to thrive.” For instance, possible hypotheses linked to nomothetic theories would suggest that the failure to thrive may be due to

1. a lack of maternal nurturing (attachment theory);
2. a digestive failure (biological theory);
3. an infant’s immature sucking response (maturational theory);
4. a maternal lack of knowledge or skill in feeding the infant (learning theory); or
5. a nursing mother’s poor nutrition caused by her poverty (socioeconomic theories).

Any of these hypotheses are possible when assessing failure to thrive as a generally recognizable phenomenon; however, in a case-specific situation, only one hypothesis is true.

Only when the clinician determines which theory-based hypothesis constitutes the reality of what is the matter can the clinician look for the appropriate prescriptive change theory (“if this, then that”). If the cause of the failure to thrive is biological, then the remedy lies in appropriate medical treatment. If the cause is the poor nutrition due to poverty, then the remedy is the provision of concrete services that provide the mother with financial support (Temporary Assistance for Needy Families; TANF) or nutritional support (Women, Infants, and Children; WIC). If the problem is one of attachment, then some model of counseling is appropriate—for instance, talk therapy (i.e., cognitive–behavioral theory) or attachment theory—when chosen on the basis of critical thinking and best evidence. Inherent in the “if this, then that” formula of prescriptive theory is a presumption of consistency between assessment and intervention. It is an error in theory application to regard nomothetic theory as practice theory. Consider the following chart, which illustrates the example in this discussion (Table 1).

A Single Theory Can Accommodate Complex Client Data

A third factor that contributes to the misapplication of theory in case-specific situations occurs when the student attempts to apply a single theory to complex client data. Unlike the failure-to-thrive situation described earlier, where a single presenting problem requires the selection of the “best” theory-based solution, complex data requires the selection of more than one “best” solution. In other words, it requires building a model of practice unique to the complex data presented by a single client. The following case example illustrates this point.

Latitia is a young, single, African American woman with three children, ages 5 and under. Latitia is seeking help because she is faced with eviction due to rent increases (gentrification), which is coupled with a recent job loss (layoffs, economic downturn). During the course of the intake interview, Latitia reports having insomnia, weight loss, and a feeling of impending doom. She states that the stress caused by her
job loss and the pending eviction is affecting her ability to care for her children, who are becoming more and more unruly every day.

Complex Data and Model Building. Model building is a conceptual tool useful to practitioners. A model is defined as an artificial construct, a conceptual framework based either on a single theory (as in the failure-to-thrive scenario) or on multiple theories (as in the scenario with Latitia), and its purpose is to guide the practitioner through an orderly process of change. The idea of a case-specific model of practice is consistent with Bisman’s concept of ideographic case theory in that such a model is uniquely applicable to the case for which it was developed and no other. Where the data is complex, model building is necessary to take into account more than one theory.

Faced with complex data, students new to the assessment process tend to look for and select a single theory that focuses on one aspect of the case, such as gender or mood, at the expense of excluding other pertinent case data. Whether a descriptive theory with limited applicability (such as gender role theory) or a prescriptive theory applied to one aspect of the case (such as pharmacological intervention for a mood disorder), this type of error results in an error of practice assessment and intervention.

Though the student may reflect a substantive grasp of the theory chosen, the theory itself is limited in its applicability to the case. Complex case data requires case-specific model building. Table 2 reflects this point. As shown, a focus on gender role theory in a patriarchal society fails to take into account the client’s imminent eviction, her lack of income, indicators of a possible mood disorder, and her children’s behavior. Similarly, a focus on the biology and psychology of mood disorders fails to take into account the client’s imminent eviction, her job loss, her lack of income, her children’s behavior, and her gender role status. As shown, choosing one aspect of complex data to theoretically explicate a case results in an error of practice assessment and intervention. Such errors are precluded under model building.

Any Theory Can Explain Anything and Therefore Everything

The misperception that a single theory can explain anything and therefore everything

TABLE 1. Client Presentation of a Single Problem: “Failure to Thrive”

<table>
<thead>
<tr>
<th>Single Problem: Many Plausible Causes</th>
<th>Best Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of maternal nurturing</td>
<td>Counseling options: choice based on best evidence; attachment theory, cognitive—behavioral theory</td>
</tr>
<tr>
<td>Inadequacy of infant’s digestive system</td>
<td>Biological—medical intervention: choice based on best evidence</td>
</tr>
<tr>
<td>Immature sucking response</td>
<td>Physical maturation modification to accommodate feeding and time for growth</td>
</tr>
<tr>
<td>Maternal lack of knowledge—feeding, nursing</td>
<td>Learning theory: teaching skill in feeding or nursing</td>
</tr>
<tr>
<td>Mother’s poor nutrition due to poverty</td>
<td>Socioeconomic theories: provide WIC or TANF program support</td>
</tr>
</tbody>
</table>
does contain a grain of truth. While it is true
that diverse problems (truancy, job loss, de-
pression, marital difficulties) may be assessed
and treated using a single prescriptive theory, it
is equally true that no single theory can capture
all of reality (Turner, 1996).

By definition, any prescriptive theory re-
casts the nominal categorization of problems
(truancy, depression, job loss, etc.) into its own
concepts of assessment and intervention. For
instance, when truancy, depression, job loss, or
marital difficulties are referred to cognitive–
behavioral theory, causality is hypothesized to
lie in faulty learning. Faulty learning, in turn,
results in negative cognitions that maintain the
problematic behavior or feeling state. This
constitutes the “if this” side of the prescriptive
theory equation. If truancy, job loss, depres-
sion, marital difficulties are independently
explainable by negative cognitions, then the
action side of the prescriptive theory equation
(“then that”) lies in challenging such negative
cognitions (technique: the downward spiral)
and in establishing new cognitions, thereby
bringing about a change in truancy, job loss,
depression, and marital difficulties. There is
consistency within prescriptive theory be-
tween the theoretical assumption of causality
(negative cognitions) and the theory-based
therapy chosen to remedy it (challenging nega-
tive cognitions and instilling new cognitions).

What is not true, however, is that cognitive–
behavioral learning theory is the only pre-
scriptive theory capable of intervening with
truancy, job loss, depression, or marital diffi-
culties. Similar to the number of possible and
plausible practice theory alternatives shown
in the chart on failure to thrive, many possible
and plausible practice theory alternatives can
be used to intervene with truancy, job loss,
depression, or marital difficulties. Given plau-
sible alternatives, theoretical choice can be
bolstered by examining the evidence that
supports the effectiveness of one action over
another in achieving the desired outcome.

For instance, if a person suffers from clinical
depression, is it better to offer cognitive–
behavioral therapy, ego-supportive therapy,
pharmacological intervention, hospitalization,
or some combination of all of the above?

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**TABLE 2. Latitia: An Either–Or Orientation to Complex Data**

<table>
<thead>
<tr>
<th>Intake Information</th>
<th>Theoretical Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sociodemographic</td>
<td>Gender role theory. The following role statuses attach to Latitia based on her</td>
</tr>
<tr>
<td>information</td>
<td>gender: female in a minority group, single parent, member of a lower socioeconomic</td>
</tr>
<tr>
<td></td>
<td>class.</td>
</tr>
<tr>
<td>Eviction, housing</td>
<td>Conflict theory, case advocacy. Overturn eviction or secure alternative housing.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of income</td>
<td>Structure–functional theory, case management. Match financial need with financial</td>
</tr>
<tr>
<td></td>
<td>resource.</td>
</tr>
<tr>
<td>Job loss, employment</td>
<td>Socioeconomic theory: supply and demand equals job loss. Structure–functional role</td>
</tr>
<tr>
<td></td>
<td>theory: job expectations, employee skills.</td>
</tr>
<tr>
<td>Symptoms of mood disorder</td>
<td>Chemical imbalance: pharmacological intervention.</td>
</tr>
<tr>
<td></td>
<td>Talk therapy: choice of counseling model for depression.</td>
</tr>
<tr>
<td>Parenting difficulties</td>
<td>Talk therapy: Choice of model on teaching parenting behaviors. Psychoeducational</td>
</tr>
<tr>
<td></td>
<td>therapy (PET) on parenting; behavioral management training.</td>
</tr>
</tbody>
</table>
According to Roberts and Yeager (2004), evidence-based practice (EBP) is defined as “the conscientious, explicit and judicious use of the best available scientific evidence in deciding which treatment to use in order to attain the most desired outcome.”

The requirement to evaluate practice corrects for errors of incorrect assessment or incorrect selection of an intervention theory. The idea behind practice evaluation, after all, is the recognition that a clinician may make a mistake in assessment or intervention or that the clinician may render ineffective treatment due to the lack of efficacy of the theory or the practitioner’s lack of skill in employing the techniques of the theory.

Eclecticism Does No Real Harm

The misperception that eclecticism does no real harm belies the importance of scholarship and practice accountability. Inherent in the “if this, then that” formula of prescriptive theory is a presumption of theoretical consistency between assessment and intervention. While some view eclecticism as making a best-evidence choice after considering plausible alternatives, others view eclecticism as a way to avoid taking responsibility for one’s practice. It is within the latter context that the term is understood in the discussion that follows. In this paper, eclecticism is used to convey the practice of taking selective aspects of a variety of theories while ignoring the integrity and premises of the theory from which the aspects were borrowed. In the latter instance, eclecticism interferes with the unitary nature of practice theory (i.e., consistency between assessment and intervention) by introducing confounding (eclectic) variables.

Consequently, outcome evaluations of eclectic practice are opaque. What specifically worked or did not work remains unknown. Serious compromises in scholarship and accountability occur under this form of eclecticism. For a more elaborate discussion of eclecticism and a different view, see Lehmann and Coady’s book *Theoretical Perspectives for Direct Social Work Practice: A Generalist-Eclectic Approach* (2001).

Theory Doesn’t Matter Anyway

The misperception that theory doesn’t matter anyway is sustained in part by the “equal outcomes” research discussed in an earlier section (One Theory Is as Good as Another). Of greater concern is the postmodern challenge to modernism. Within the scientific way of knowing, theory is a structural component of the conduct of inquiry (Kaplan, 1998). Postmodernism is a philosophical stance against the scientific way of knowing and therefore a stance against theory and its deductive application or its inductive inference. Is not then the idea of postmodern theory an oxymoron? Postmodern knowing is always temporary, local, subjective, and uniquely cocreated in the moment of dialog. Logically it follows that postmodern therapies are, by definition, atheoretical. I suspect that narrative therapy, social construction, and deconstruction therapies are more likely derivatives of symbolic interaction theory and structural–functional theories (which focus on the meaning of things, including language) than they are representative of postmodernism per se. However, this is subject matter for another paper.

Summary

Misperceptions and errors in theory application require remedy. Combining model building with the properties of the decision hierarchy presented in the preceding article helps students and practitioners to prioritize interven-
tions and avoid errors in the application of theory to practice.

References


