Strengthening the Efficacy of Adlerian Play Therapy Through the Measurement Model

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To promote the credibility of play therapy and encourage the trend of practitioners utilizing evidence-based practices (EBPs), researchers are called to continue providing evidence and establishing fidelity within the leading approaches in the field. Past studies have identified Adlerian Play Therapy (AdPT) as one of the most widely used approaches (Lambert et al., 2007) as well as an EBP (Substance Abuse and Mental Health Services Administration [SAMSHA], 2016). Through the use of qualitative video content analysis of 27 individual play therapy sessions, researchers created the instrument, the Adlerian Play Therapy Measurement Model (AdPTMM), to establish and evaluate fidelity of treatment.

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Recent trends in the field of therapy tend to guide research and implementation of counseling theories and practices. Due to agency cuts and/or university incentives, therapists and mental health professional educators have been encouraged to apply for grants to fund projects or provide services at low cost to individuals who would otherwise not receive mental health support (Burrow-Sánchez et al., 2016; Vernon & Rainey, 2009). In addition, there is an uptick toward evidence-based practices (EBPs) to establish credibility in the mental health profession (Generali et al., 2013; Kline, 2003; Wester et al., 2013). This process appears cyclical in nature: the researcher needs substantial funding to develop and execute a study that is likely to demonstrate evidentiary support for a counseling modality; and researchers have a greater likelihood to receive funding if the model is an EBP (Daniel et al., 2006).

Both researchers and professional organizations encourage counselors to advance the field through the use of EBPs. Van Herck et al. (2013) identified several intentions for clinicians to adhere to EBPs: (a) policy reimbursement; (b) experience, expertise, and judgment of decision-makers; (c) financial impact—including cost-effectiveness—and resources; (d) values, ideology, and political beliefs; (e) habit and tradition; (f) lobbyists and pressure groups, pragmatics and contingencies; (g) media attention; and (h) adoption of innovation by other payers or countries to this framework. Expanding the list, insurance policy companies recommend mental health professionals to engage in EBPs to protect against litigation (Healthcare Providers Service Organization [HPSO], 2014); and mental health professionals are ethically required to use therapeutic models that are based on rigorous research or have a strong empirical foundation.
AdPT

Terry Kottman developed AdPT in the 1980s as a theoretically grounded approach to play therapy based on Adler’s assertion that play can be an education aid, a stimulus for the child’s imagination and development of life skills (Adler, 1927, 1998). Children’s involvement in play and games help prepare them for the future, develop necessary social skills that frame their view towards life and relationships; therefore, play is considered critical to the growth and development of every child.

Kottman combined the concepts and strategies outlined in Individual Psychology (Adler, 1927, 1998, 1956) with the process of play therapy. In AdPT, the therapist uses toys, play material, art, metaphor and storytelling, sand tray experiences, and movement to learn about, communicate with, and educate the child client (Kottman & Meany-Walen, 2016).

AdPT is comprised of four phases in which the therapist and child move through: (a) building a collaborative and egalitarian relationship, (b) investigating the child’s lifestyle, (c) helping the child gain insight into their lifestyle, and (d) reorienting/reeducating the child. Due to the premise that Adlerians view people as socially embedded and must be understood within their social environments (i.e., nuclear family, early school experiences), therapists ensure that caregivers or other important adults, such as teachers, are a part of the therapeutic process by participation in caregiver/teacher consultations. Therapists work with significant adults to gather information about their relationship with the child, the child’s history, current functioning, and any significant changes. Over the duration of the play therapy process, the play therapist establishes and maintains a positive relationship with these important adults in order to encourage new strategies to use with their child that likely will promote positive change for the child. For more information about the theoretical foundation and process of AdPT, see Kottman and Meany-Walen (2016).

Adlerian Play Therapy Research

Chambless and Ollendick (2001) indicated that rigorous research requires that an intervention follow a treatment protocol. Therefore in 2009, Kottman developed the Treatment Manual for Adlerian Play Therapy (AdPT), and Kottman and colleagues revised the manual in 2020. Kottman et al. (2020) included the following information in the manual: (a) the theoretical rationale for AdPT; (b) the role of the therapist; (c) the goals of treatment; (d) the therapeutic skills used across the four phases; and (e) the structure of play therapy sessions, including the setting, appropriate play materials, and logistics of sessions. The Treatment Manual also contains the Adlerian Play Therapy Skills Checklist (AdPTSC) for each of the four phases and conceptualization and treatment plan forms to be completed for each client when using this model. We summarized pertinent information from the Treatment Manual such as the therapist skills, time spent in session, and therapeutic targets in the Adlerian Play Therapy Measurement Model (AdPTMM) — Addendum (See Supplemental Material).

In 2016, the Substance Abuse and Mental Health Services Administration (SAMSHA) labeled AdPT as one of the first applications of play therapy to be “evidence-based.” In large part to Meany-Walen’s dissertation research, AdPT was deemed effective with children who have externalizing behavior problems and “promising” for working with children on self-esteem issues (Meany-Walen et al., 2014). Meany-Walen et al. (2014) implemented a randomized control trial to investigate the effectiveness of AdPT. Fifty-eight children (K—3rd grade) who scored in the borderline or clinical range on at least one of the following assessments: the Direct Observation Form (DOF) Total Behaviors scale, the TRF Externalizing Problems scale, or on one of the Teacher Report Forms (TRF) subscales: Attention Problems, Rule Breaking, Aggressive Behavior, ADHD, Oppositional Defiant Problems, or Conduct Problems qualified for the study. Students were randomly assigned to participate into the treatment group (AdPT) or an active control (reading mentoring program). Meany-Walen et al. (2014) used the active control group to account for the effects of receiving attention. Children in both groups received 30-min sessions, twice weekly for a total of 16 sessions.

Per teacher and independent observer reports, children who received AdPT showed statistically
significant differences across time for TRF Externalizing Problems, DOF Total Behaviors, DOF On-Task Behaviors, and Index of Teacher Stress (ITS) Total Stress (Meany-Walen et al., 2014). The researchers also found statistically significant differences in group membership (AdPT and reading mentoring). For children who received AdPT, results revealed a moderate treatment effect for decreasing TRF Externalizing Behaviors and ITS Total Stress and revealed a large treatment effect for increasing DOF Total Behaviors and On-Task Behaviors.

Other researchers have implemented single-case design studies to investigate the effectiveness of AdPT for children struggling with behaviors such as perfectionism and anxiety (Akay, 2013), disruptive classroom behaviors for individual (Dillman Taylor & Meany-Walen, 2015; Meany-Walen, Kottman, et al., 2015) and group (Dillman Taylor et al., 2015, 2019; Meany-Walen, Bullis, et al., 2015), and social skills (Meany-Walen & Teeling, 2016). Each of these studies showed promising results, and future researchers are highly encouraged to produce large, randomized control trials for replication. However, a model with target mechanisms to access progress in conjunction with the AdPT manual is needed to ensure the fidelity of Adlerian play therapists conducting play sessions using this model of treatment.

**Purpose of the Study**

The purpose of this study is for the researchers to establish procedures for measuring treatment fidelity of AdPT and inter-rater reliability of the Treatment Manual using the AdPTMM (Dillman Taylor & Kottman, 2016). To accomplish this purpose, we worked toward establishing inter-rater reliability on the AdPTMM through examining the child’s progress across the phases of AdPT. We sought to answer the following research question: (a) What is the utility of the model to assess the progress of clients who participate in AdPT?

**Research Context**

The researchers include (a) a Counselor Education faculty member in a large Southeastern, CACREP accredited university, (b) a doctoral student, and (c) an expert Adlerian play therapist. The first author is a Registered Play Therapist-Supervisor (RPT-S), Licensed Professional Counselor (LPC), Licensed Mental Health Counselor (LMHC), and a certified Adlerian play therapist supervisor and trainer. The second author is a counseling doctoral student, Registered Mental Health Counseling Intern, and a National Certified Counselor (NCC). The third author is a RPT-S, a NCC, a LMHC, and a certified Adlerian play therapist supervisor and trainer. Two of the researchers have extensive experience in AdPT and served as the coders for this study.

**Method**

We conducted a qualitative video content analysis to examine the research question. We developed a coding frame to test the utility and fidelity of the AdPTMM when evaluating the progress of the child client across the four phases of AdPT. Within this model, we chose three distinct counselors-in-training and at least one of their series of play therapy sessions. Counselors-in-training received a 3-day intensive AdPT play therapy in addition to the play therapy certificate coursework and completion of two practicums. All counselors-in-training were enrolled in internship. We opted to use counselors-in-training to assess the feasibility of this model at an earlier stage of counselor development given it is one of the top theoretical approaches across APT members. We selected the counselors-in-training for review if (a) their sessions were recorded and (b) the counseling intern identified using AdPT as the primary intervention. We collected multiple sources of evidence to support the research questions (Schreier, 2012), including (a) pre- and post-intervention TRF (Achenbach & Rescorla, 2001) to acknowledge the clinical significance of AdPT for each child, (b) direct observations (video-recorded) of the AdPT sessions, and (c) observers’ notes. As part of a larger research study investigating the effectiveness of AdPT for children with disruptive behaviors, the sessions were recorded and collected over the course of 3 years.

The expert reviewers watched the recorded play therapy sessions using the AdPTMM (Dillman Taylor & Kottman, 2016). The AdPTMM will be described in the instrumentation section below. In utilization of a content analysis approach, we contemplated several rivals that may be threats to validity, such as maturation and instrumentation. Given that the sessions occurred over time and
across multiple children, we could logically conclude that changes in a child’s behaviors were not gained naturally due to the development. Further, we used inter-rater agreement (raters had to reach at least 80% agreement) in order to reduce instrumentation biases. For the purposes of this study, the coders’ inter-rater agreement was .95 on the AdPTMM (see Instrumentation for more details). Additionally, we created the option to select a “no phase” code when the counselor did not hit the necessary targets, as well as the option to select codes for multiple phases within one session if criteria was met for each phase.

**Participant Recruitment**

We recruited participants as part of a larger study investigating the effectiveness of AdPT on children’s disruptive behaviors. Participants qualified for this project if (a) they participated in the intervention (AdPT) and (b) at least 80% of their 16 sessions were recorded. Three participants met these criteria and were included in the analysis: AS, FS, and IP. The participants include an 8-year-old, Hispanic boy, a 7-year-old, Caucasian boy, and a 5-year-old girl whose caregivers did not disclose her ethnicity.

**Procedures**

We acquired Institutional Review Board (IRB) permission for the larger study prior to the children participating. Prior to the main coding of data, we developed a coding frame for the qualitative video content analysis and conducted a pilot phase.

**Coding Frame**

We selected a qualitative video content analysis, specifically using a coding frame to formalize the AdPTMM. We followed the recommendations of Schreier (2012) for building a coding frame. We used the child clients’ series of play therapy videos and the Adlerian Play Therapy Treatment Manual (Kottman et al., 2020) to develop a coding frame. Next, we established the structure of our coding frame with subcategories for each dimension. To help capture the data in a meaningful manner, we developed two documents in a concept-driven way (Schreier, 2012): (a) AdPTMM and (b) the corresponding Addendum (see Instrumentation for detailed descriptions for each of these documents). Further, we defined the categories and subcategories based on previous knowledge, expertise, and research on AdPT (e.g., Kottman & Meaney-Walen, 2016; Kottman et al., 2020). Each category has four parts: name (i.e., Phase I), description (i.e., directions), examples (i.e., skills listed with definitions found in the AdPT Treatment Manual), and decision rules (i.e., targets to be met by therapist and/or child prior to moving into the next phase). Similar to Dillman Taylor and Kottman (2019), we divided the video sessions into units of coding (e.g., each videoed session is considered a unit of analysis). To test the coding frame, we conducted a pilot phase; and through this process, we revised and expanded the coding frame (Schreier, 2012) to include additional information not originally captured by the preliminary coding frame (i.e., nontherapeutic responses). The AdPTMM can be found in the Supplemental Material. Due to the length of the final coding frame, readers interested in the AdPTMM Addendum can contact the authors for copies.

**Pilot Phase**

“A pilot phase is essential for discovering short-comings at an early stage” (Schreier, 2012, p. 147). We decided to watch a full series of play therapy sessions (n = 16) of one child to confirm that all four phases of AdPT were covered in the selection. This decision ensured that we met the criteria for the pilot phase: used the entire coding frame for this selection and the material varied (Schreier, 2012). Prior to coding, we met to discuss the coding frame and the process of coding (e.g., coding simultaneously, keeping a record of codes). After watching the selection in its entirety, we discussed the units of coding, disagreements of codes, and our interpretations of the findings (i.e., codes that needed to be expanded, added, or modified; if the information enabled us to make decisions about progress of AdPT with that child and therapist). When disagreements surfaced, we modified the coding frame to be inclusive of content (i.e., skills) not originally captured by expanding, adding, or deleting items. In the pilot phase, we agreed to two primary changes to the AdPTMM. The therapist we reviewed in the sample frequently used nontherapeutic skills—skills not captured by the checklist in the AdPT Treatment Manual.
We modified the list to include “nontherapeutic skills” to be inclusive of all statements made by the therapist (see Addendum). This addition will allow future supervisors to note the frequency of these statements compared to appropriate therapeutic responses and provide feedback accordingly. We also decided to emphasize that the skill of metacommunication is a required skill in AdPT. Collectively, we determined that if the therapist did not use this skill within a session, that therapist was not using AdPT; thus, we adjusted our decision to allow for the indication of no phase for that session. Given that metacommunication is the foundation of working with clients to gain understanding of their lifestyle, the therapist is required to use this skill throughout every session to reflect insight and understanding.

Instrument

Adlerian Play Therapy Measurement Model and Addendum

The first author developed this model in response to a federal grant reviewer requesting a process for determining the targets (i.e., how an observer knows when the child is ready for the next phase of therapy or termination) for AdPT. This model is based on the extensive writing of Kottman (1997, 2011). The model is comprised of a flow chart from the moment a child enters therapy to termination (See Supplemental Material). The addendum to this model assesses the therapeutic change targets/mechanisms (e.g., the change processes that are hypothesized to account for downstream clinical benefit) in the play therapy process. The Addendum outlines each phase to include the following instructions/information: therapist skills checklist for that phase, directions for the therapist specific to that phase, time typically spent in the phase, and targets to be met by child and/or therapist before progressing to next phase.

In Phase I, the therapist checklist includes all skills outlined on the AdPT skills checklist (see AdPT Treatment Manual; Kottman et al., 2020) for Phase I and directions for the therapist: therapist engages in (a) metacommunication, (b) responds responsively to the child (i.e., matches the child’s progress), and (c) engages in at least 6 of the 13 identified skills from the AdPTSC for this phase. Typical time spent in this phase is one to four sessions. To progress to Phase II, the therapist will notice the child beginning to engage in the following targets: (a) engaging the counselor verbally and/or nonverbally, (b) initiating collaborative interactions with the counselor, and (c) spending less than half of session involved in periods/blocks of restricted play. Restricted play can be defined as “too tight,” in which a child may focus on one item/toy without the freedom to explore.

In Phase II, the therapist checklist includes all skills outlined on the AdPTSC for Phase II and directions for the therapist: Therapist engages in (a) reflective skills from Phase I, (b) responds responsively to the child (i.e., matches the child’s progress), and (c) conducts at least one of the nine skills from the AdPTSC for this phase; and the therapist uses solicited information gathered in Phase II to complete the conceptualization form and treatment plan, located in Kottman et al. (2020). Time typically spent in this phase ranges from four to six sessions. To progress to Phase III, the following targets must be met: (a) the therapist will notice the child beginning to respond appropriately to play techniques, questioning strategies, art techniques, metaphoric and storytelling techniques, body-centered techniques (i.e., movement and dance), and/or sand tray techniques designed to gather information about the child’s lifestyle and (b) the therapist will have developed a conceptualization of the child and the child’s issues, the caregiver and the caregiver’s issues, [and the teacher and the teacher’s issues] and completed a treatment plan based on the conceptualization of the child and/or caregivers, and/or teacher(s).

In Phase III, the therapist checklist includes all skills outlined on the AdPTSC for Phase III and directions for the therapist: Therapist engages in (a) reflective skills from Phase I, (b) responds responsively to the child (i.e., matches the child’s progress), and (c) conducts at least one of the skills from the AdPTSC for this phase. Time typically spent in this phase averages four to six sessions; however, this phase can be longer dependent on the child’s readiness to modify their private logic. To progress to Phase IV, the following targets must be met: child exhibits change that would reflect insight into their lifestyle (i.e., recognition reflex, play themes).

In Phase IV, the therapist checklist includes all skills outlined on the AdPTSC for Phase IV and directions for the therapist: therapist engages in (a) reflective skills from Phase I, (b) responds
responsively to the child (i.e., matches the child’s progress), (c) uses at least one of the other skills from Phase III, and (d) uses at least one of the skills from the AdPTSC for this phase. Time typically spent in this phase ranges from four to six sessions. To assess readiness for termination from AdPT, the following targets must be met: child begins to generalize new ideas and skills for positive behaviors, thoughts, and feelings (a) inside the playroom as evidenced by observation of the therapist (i.e., play themes, verbal patterns) and (b) outside the playroom as evidenced by caregiver, teacher, and/or child report of improvement. Improvement is noted in at least half of the following areas: capitalization of assets, improvement of Crucial C’s, healthier functioning in personality priorities, identification of more positive goals for behavior, identification of positive convictions and common sense, reduction of self-defeating behaviors, increased positive behaviors, and increased skills such as social skills, negotiation skills, communication skills, assertiveness, taking responsibility for behavior, etc. We utilized this instrument to answer the research question: What is the utility of the model to assess the progress of clients who participate in AdPT?

Data Analysis

We selected a qualitative video content analysis to assess the utility of AdPTMM. To code this procedure, we adhered to the steps outlined by Schreier (2012): preparing for the main coding, conducting the main coding, processing the codes found, and preparing results for presentation and further analysis.

In preparing for the main coding process, we selected to code the video sessions using the AdPTMM and Addendum and to keep a thorough record of our coding. To follow step one, we coded by (a) viewing the session in its entirety (b) adding notions to the AdPTMM and Addendum to determine the current phase of therapy, and (c) deciding if the therapist was utilizing AdPT (based on directions listed on the Addendum) and if the child was ready for the next phase. The coders conducted these steps for all material (n = 27 AdPT sessions). After coding each therapist’s sessions, the coders met to discuss codes prior to the next round of coding, for a total of four discussions before preparing the results. In the discussions, the coders compared notated phases and decided on the final meaning of the units (i.e., phases) of coding (Schreier, 2012). The coders used a matrix as a visual to integrate data, providing an overview of the results.

Results

To examine the research question (i.e., what is the utility of the model to assess the progress of clients who participate in AdPT?), we viewed 27 AdPT counseling sessions to evaluate the key targets as outlined by the AdPTMM. Utilizing our coding frame, we reached an acceptable inter-rater agreement (r = .95) for determining the phase each therapist and child appeared to be in using the AdPTMM. After the initial development of the coding frame, we decided to allow for the potential to identify multiple phases per session if necessary. The framework of AdPT supports this decision, which acknowledges that the phases are fluid; and at any time, the therapist can resort to an early phase to gain further information (Dillman Taylor & Bratton, 2014; Kottman et al., 2020; Meany-Walen et al., 2014). In addition, based on the AdPTSC (see AdPT Treatment Manual; Kottman et al., 2020), we acknowledged that the therapist may lack the skills necessary for AdPT (i.e., metacommunication); therefore, we opted to allow the option of “no phase” for these instances. We reached 80% agreement (r = .80) for the sessions identified as “no phase,” which still falls within the acceptable guidelines for inter-rater agreement.

Further, we examined inter-rater agreement across phases. For Phase I of AdPT, we reached a perfect agreement (r = 1.0) identifying 6 of the 27 sessions in this phase. Therefore, it appears as if based on the defined targets (e.g., child engages the counselor verbally and/or nonverbally, initiates collaborative interactions with the counselor, and spends more than half of session involved in periods/blocks of nonrestricted play) that this phase is easiest to observe and identify. We found similar results for Phase II. Of the 27 sessions, we identified that 11 sessions met the targets (i.e., the therapist will notice the child beginning to respond appropriately to play techniques, questioning strategies, art techniques, metaphoric and storytelling techniques, body-centered techniques, and/or sand tray techniques designed to gather information about the child’s lifestyle)
for this phase, reaching an inter-rater agreement of 100% ($r = 1.0$).

For Phase III, we reached an inter-rater agreement of 75% ($r = .75$), in which we agreed on six of the eight sessions identified in this phase based on the AdPTMM targets (i.e., child exhibits change(s) that would reflect insight into their lifestyle). In one of the sessions, we both identified Phase II and IV, with one coder also identifying the session as Phase III. After meeting, we reached verbal agreement that Phase III was also possible due to the use of skills (i.e., metacommunication about child’s lifestyle). In the second session in which we disagreed, one coder identified the session as in Phases III and IV due to skills used; however, the other coder determined this session as “no phase” due to the lack of metacommunication used. Based on modifications to the AdPTSC, we determined that “no phase” was the correct identification.

We also reached an acceptable inter-rater agreement for Phase IV ($r = .83$). We agreed that five of the six sessions could be identified in this phase based on the targets outlined on the AdPTMM (i.e., child begins to generalize new ideas and skills for positive behaviors, thoughts, and feelings). For the sixth session identified by at least one coder as Phase IV, the other coder noted no phase. Similar to Phase III findings, we reached agreement that this session would be correctly identified as “no phase” due to the lack of metacommunication used.

**Discussion**

The purpose of this study established preliminary support for the AdPTMM plus Addendum to aid in the utility of training for current and future therapists. Through the inclusion of these documents, the counselor educator, supervisor, or research assistant can more easily identify the phase of the AdPT session to assess progress across the four phases of therapy. In the process of using the qualitative video content analysis, we found the ease of fidelity checks increased when the two documents were used alongside of each other. Additionally, changes were made based on continuous discussion between the coders throughout the review process in order to reach verbal agreement. These updates included (a) mandating the use of metacommunication as a skill in each of the phases, (b) incorporating a “no phase” option when the necessary skills were not exhibited, and (c) having the ability to be in multiple AdPT phases synchronously.

**Implications**

It is important for the observer to receive training on the AdPT Treatment Manual (Kottman et al., 2020) as well as the AdPTMM plus Addendum prior to observing any sessions. Training specifically on these documents’ use will enhance the fidelity of their implementation. The coder will observe a live session behind a two-way mirror or a recorded session using the AdPTMM plus Addendum in order to take notes regarding the progress of the session. Based on the therapist’s responses and child’s interactions/ reactions to the therapist and materials in the room, the observer could then identify the phase of the session using the AdPTMM plus Addendum. Therefore, if the observer/supervisor/trainer chooses to only use one of the documents, critical information may be lost to inform them of the progress within AdPT—is the therapist accurately matching the child’s progress? Does the child appear to be ready for an advanced phase and the therapist is missing these clues?

To date, AdPT is one of the most widely used play therapy approaches (Lambert et al., 2007) and one of the few EBP play therapy modalities (SAMSHA, 2016); therefore, a clear, step-by-step guide to assess progress within AdPT is needed. Due to current trends in the counseling field toward grant funding, brief therapy, EBPs, and quality, informed research, the utility of the AdPTMM is considerable. Therapists can implement this assessment tool to evaluate the fidelity of a child’s progress in therapy within the areas of research, education/training, and supervision. For example, a well-trained research assistant can observe multiple sessions and assess for the accuracy of the phase in which the therapist and child are in for research fidelity in large, randomized control trials investigating the impact of AdPT across presenting issues and populations. Further, and we highly encourage this process, therapists might implement check-ins through monthly assessments using these tools to evaluate their own practice. We hypothesize that the self-assessment will likely increase quality and progress, thus eliminating unnecessary or extended therapy when it is not justified. Supervisors, counselor educators, and trained AdPT consultants can also evaluate the fidelity of the
implementation of AdPT by supervisee/consultee and provide feedback and education to use this model more accurately.

Limitations

AdPT is a complex, theoretical approach to counseling children. Seasoned counselors trained in AdPT may have a greater ease of evaluating progress within therapy; however, the implementation of this modality is not as easily conducted with newer trainees or counselors. Therefore, it is critical that the individual (e.g., counselor as self-assessor, supervisor, consultant) using these tools must be trained in AdPT, Adlerian theory and terminology, and the phases of AdPT prior to its use. An additional limitation is the skill level of the counselors observed. Although the recorded sessions provided valuable dialogue regarding inappropriate therapist responses and techniques, bringing AdPT to a basic level for evaluation, we believe future research should include expert therapists to assess the utility of this tool across experience.

Conclusion

Mental health professionals across major disciplines are encouraged to utilize EBPs, interventions, and treatment (ACA, 2014; APA, 2006; NASW, 2021) to ensure the effectiveness of therapeutic services. In order to meet this ethical standard, further research is needed to support currently established EBPs (e.g., AdPT for children with externalized behaviors; SAMHSA, 2016) and continue expanding the field with quality assessment tools to utilize in future studies. The AdPTMM and Addendum can be used to increase the effectiveness of AdPT in clinical practice, education/training, and research, and we recommend its use alongside the AdPTSC to maximize treatment fidelity, counselor development, and client progress.

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