COMPETENCE AND ADHERENCE SCALE FOR TRANSDIAGNOSTIC MODULAR COGNITIVE BEHAVIOURAL THERAPY

psykiatri fonden
SAMMEN BEKÆMPER VI PSYKISK SYGDOM

TrygFonden

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Scale for Transdiagnostic Modular
Cognitive Behavioural Therapy

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The Adherence and Competence Scale for Transdiagnostic Modular Cognitive Behavioural Therapy is available for free by download for research and non-commercial use to assess therapist's adherence and competence in supplying psychotherapy. In the event of researchers wishing to use the instrument for specific research projects, please contact Pia Jeppsen by mail: **pia.jeppesen@regionh.dk**.

A printed copy of the instrument can be bought through the webshop of the Psykiatrifonden **https://www.psykiatrifonden.dk/**

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1. INTRODUCTION

The Competence and Adherence Scale for Transdiagnostic Modular Cognitive Behavioural Therapy (CAS-TM-CBT) is an observation-based instrument measuring the therapist's adherence and competence in transdiagnostic modular cognitive behavioural therapy for children.

The instrument is a modified version of the "Competence and Adherence Scale for Cognitive Behavioural Therapy (CAS-CBT)" (Bjåstad, Haugland and Fjermestad, 2014, 2015; Bjaastad et al., 2016). The CAS-CBT includes 12 items measuring the therapist's adherence and competence in carrying out cognitive behavioural therapy for children with anxiety. (http://katsiden.no/cas-cbt.html)

The CAS-TM-CBT has been developed in connection with the testing of the Mind My Mind (MMM) treatment program (Clinical Trial Identifier: NCT03535805) which is a CBT program for school children with anxiety, depressive symptoms and/or behavioural problems. MMM consists of therapy directly with the child as well as parental behaviour training, where the parents are the agents of change for the child. All in all, the MMM treatment program (Kjerholt, Arendt, Jørgensen and Jepsen, 2016) consists of 35 problem specific and generic modules, which each consist of a number of interventions. The MMM manual can be used flexibly so it is adapted to the individual child. MMM therefore differs from other CBT manuals where CAS-CBT has been used.

The CAS-TM-CBT includes the operationalization of all items and scoring instructions, which have been adjusted for transdiagnostic and modular CBT manuals. The CAS-TM-CBT includes a new item *Flexibility in treatment plan* (item 13) which measures the therapist's measuring out and sequencing of modules adapted to the individual child compared to a prototypical treatment. The CAS-TM-CBT does not in advance state fixed goals for the session, but for the individual interventions that are performed.

The CAS-TM-CBT can be used to measure adherence and competence in other flexible transdiagnostic and modular CBT manuals by replacing the catalogue of MMM interventions in appendix C with a corresponding catalogue of interventions in the treatment program in which measuring of fidelity is wanted. Likewise, the specific scoring instructions can be adjusted under Notes for the individual items.

Assessing adherence and competence requires thorough training using the CAS-TM-CBT instrument and training in MMM or other corresponding CBT manuals as well as profound knowledge of the principles of CBT methods and of psychopathology in children.

CLARIFICATION OF TERMINOLOGY

The term *adherence* refers to the degree to which the therapist performs the tasks/interventions that are described in the treatment manual. Adherence may be seen as the quantity of tasks/interventions performed by the therapist.

Competence refers to the quality of the therapist's interventions.

The term *child* refers to both children and adolescents.

The term *parents* refers to the adults participating in the treatment program regardless of their relation to the child.

The term *intervention* refers to CBT methods and techniques. The interventions must be defined and delimited in advance.

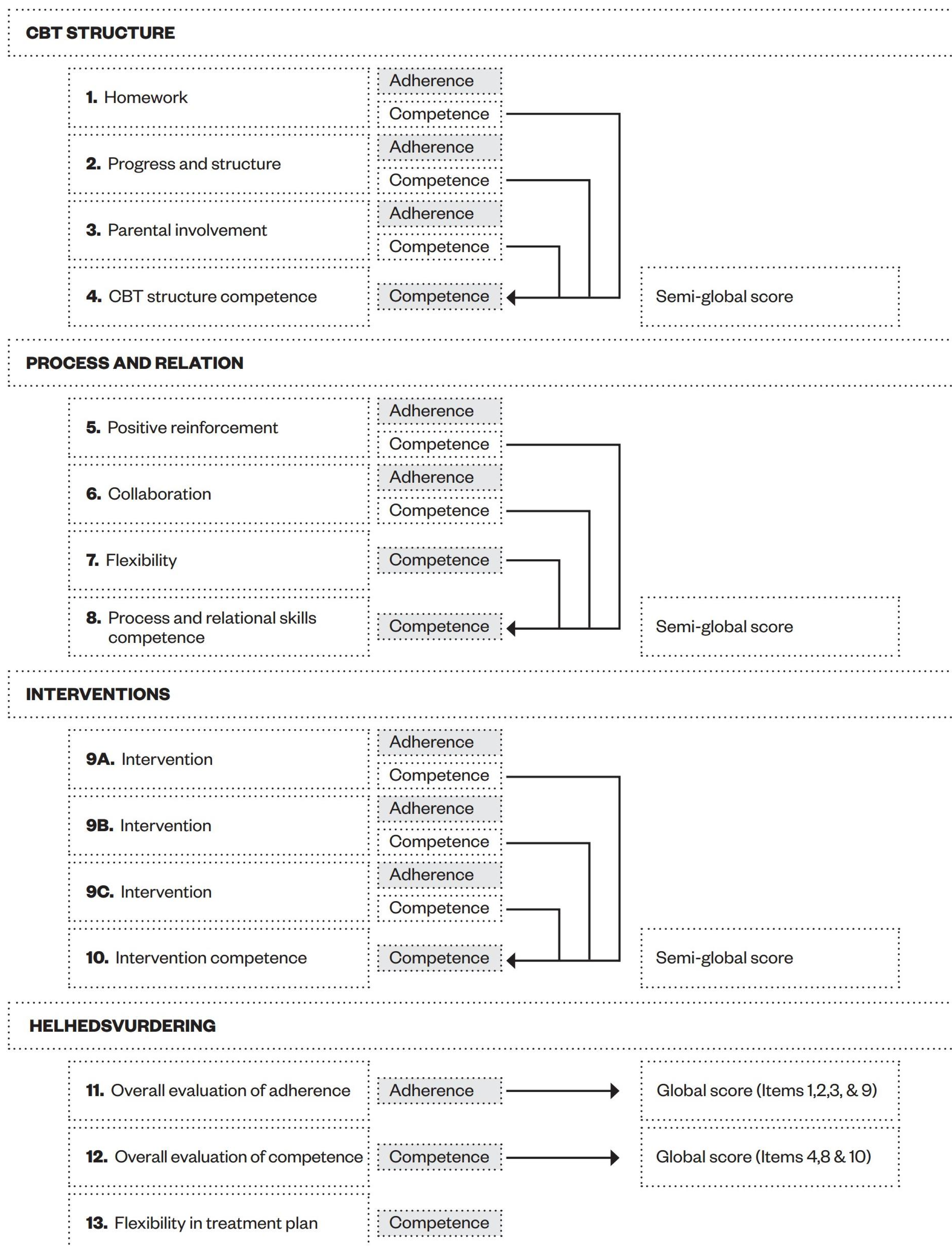
General *cognitive behavioural* therapy tasks refer to the activities apart from the actual interventions in the session (items 1-8).

The main treatment refers to the treatment to which the child has been referred, e.g. treatment for anxiety, depressive symptoms, and behavioural problems respectively, as is the case in MMM.

OVERVIEW OF THE SCORING INSTRUMENT

The rater must score the behaviour of the therapist on the basis of the video showing the treatment sessions. A score on eight items (items 1-8) is given regarding general cognitive behavioural therapy tasks *(Homework, Progress and structure, Parental involvement, Positive reinforcement, Collaboration and Flexibility),* four items regarding interventions (items 9A, B and C and 10), two items measuring overall evaluation of the session (items 11 and 12) and one item (item 13) measuring flexibility in the treatment plan (see Figure 1).

FIGURE 1: COMPETENCE AND ADHERENCE SCALE FOR TRANSDIAGNOSTIC MODULAR COGNITIVE BEHAVIOURAL THERAPY



NOTE. The final scores of the CAS-TM-CBT are marked with grey (9 adherence and 6 competence scores)

2. PROCESS OF SCORING

BEFORE THE RATER WATCHES THE SESSION

The rater must obtain information about the child and the session, which will help the rater prepare and make the evaluations of adherence and competence. In the MMM study the raters had the following information at their disposal: (1) The child's main treatment (anxiety, depression or behavioural problems), (2) The child's main problem described in the child's own words (3) Who was the main client (child/parents), (4) The child's age, (5) The number of the session (Video-ID-number), (6) The chapters from the MMM treatment manual used in the session (up to four) and (7) Worksheets used. The information is noted down on the Note sheet (Appendix A).

WHILE THE RATER IS WATCHING THE SESSION

The rater must watch the whole session from the beginning to the end.

The rater must strive to identify the therapist's verbal and non-verbal behaviour in relation to the individual items. In order to score the therapist's behavioural reactions to the behaviour and reactions of the parents and child the rater's assessments should also include observations of the parents and child. The rater must score the session on the basis of observation of behaviour and not on the basis of guessing the motives, thoughts and feelings of the therapist.

While the rater is watching the video, the rater should write down relevant observations on a separate note sheet (Appendix A). The video can be paused if the rater needs to make longer notes. Individual sequences can be watched again as needed. The rater must perform the scoring only when the entire session has been reviewed.

AFTER THE RATER HAS WATCHED THE SESSION

The rater must write down the final scores on the score sheet (Appendix B) by circling the scores.

The rater must use the middle score of the scale (3) as a vantage point representing acceptable adherence and competence and give a higher score (4-6) if the rater evaluates that the therapist displays more adherence/compentence than the middle score, and a lower score (0-2) if the rater evaluates that the therapist displays less adherence/competence than the middle score. The rater must use this scoring manual as the reference for scoring.

3. GENERAL SCORING INSTRUCTIONS

The instrument measures the therapist's adherence and competence in delivering the treatment as it is described in the treatment manual. Adherence as well as competence is scored on a 7-step Likert-scale from 0-6.

SCORING INSTRUCTIONS FOR ADHERENCE ITEMS
(ITEMS 1, 2, 3, 5, 6, 9A, B AND C AND 11)

The therapist's adherence to the general cognitive behavioural therapy tasks and interventions is scored on a 7-step Likert-scale from 0 (No/insignificant degree) to 6 (Very high degree)

0	1	2	3	4	5	6
No/ insignificant		Some		Considerable		Very high

GENERAL COGNTIVE BEHAVIOURAL THERAPY TASKS (ITEMS 1, 2, 3, 5 AND 6)
Adherence must be scored for all items regarding the general cognitive behavioural tasks apart from *Flexibility* (item 7) where only competence is scored. *Homework* (item 1), however, can be scored Not Applicable (N/A) if evaluating a session where, according to the manual, no prior homework is reviewed, and no new homework task is set. The same applies to *Parental involvement* (item 3) if no adult is participating in the session.

When scoring general cognitive behavour therapy tasks (items 1-3 and 5-6) the score 0 is used when the therapist does no or an insignificant number of tasks. The score 6 is used when the therapist performs the general cognitive behavioural therapy tasks optimally or with few insignificant mistakes.

INTERVENTIONS (ITEMS 9A, B AND C)
Up to three interventions per session can be scored. In scoring *Interventions* (items 9A, B and C) an intervention is only scored if it has been started. It must be defined in advance when the individual intervention is started. If the therapist does not perform any of the interventions in Appendix C *Interventions* is scored Not Applicable (N/A).

The score 0 is used if the therapist starts an intervention, which is interrupted shortly afterwards and not resumed later in the session. The score 6 is used when the therapist performs the whole intervention as described in the treatment manual with few insignifi-

cant mistakes. The therapist can obtain a relatively high score in spite of major mistakes if the therapist discovers and corrects the mistakes.

OVERALL EVALUATION OF ADHERENCE (ITEM 11)
Overall evaluation of adherence (item 11) is a total overall score for *Cognitive behavioural therapy structure* (items 1, 2 and 3) and *Interventions* (items 9A, B and C)(see Figure 1). The score does not include the adherence scores from *Process and relational skills* (items 5 and 6).

The overall evaluation is not an average, but a total global evaluation of the therapist's adherence in the session.

The score 0 is used if the therapist performs no or an insignificant degree of the cognitive behavioural therapy tasks (items 1, 2, 3, 5 and 6) and of *Interventions* (items 9A, B and C). The score 6 is used when the therapist overall performs the cognitive behavioural therapy tasks and interventions with few insignificant omissions.

SCORING INSTRUCTIONS FOR COMPETENCE ITEMS (ITEMS 1, 2, 3, 5, 6, 7 AND 10)

The therapist's competence in performing the general cognitive behavioural therapy tasks and interventions is scored on a 7-step Likert-scale from 0 (Poor/No) to 6 (Excellent)

0	1	2	3	4	5	6
Poor/no		Limited		Good		Excellent

GENERAL COGNITIVE BEHAVIOURAL THERAPY TASKS (ITEMS 1, 2, 3, 5, 6 AND 7)
Competence in general cognitive behavioural therapy tasks regards a number of ways in which the therapist performs the tasks. See scoring examples under each item.

The competence evaluations from items 1-3 are part of a semi-global score for *cognitive behavioural therapy structure* (item 4). The competence evaluations from items 5-7 are part of a semi-global score for *Process and relational skills* (item 8), (See Figure 1 and Appendix B). The semi-global scores are not an average, but a total evaluation of the therapist's competence in performing the tasks.

The score 0 is used when the therapist performs the cognitive behavioural therapy tasks in a poor or an actually non-therapeutic way. The score 0 is also used if an adherence score of 0 is given on the corresponding item. The score 6 is used when the therapist performs the tasks optimally or with few insignificant mistakes.

INTERVENTION COMPETENCE (ITEM 10)
A competence score is only given if at least one intervention (items 9A, B and C) is scored, otherwise item 10 is scored Not Applicable (N/A). If there are several interventions in a session, the competence scores for *Intervention competence* make part of a total semi-global

score (see Figure 1 and Appendix B). The semi-global score is not an average but a total evaluation of the therapist's competence in performing the interventions.

The score 0 is used when the therapist performs the interventions of the session in a poor or actually non-therapeutical way. The score 0 is also used if an adherence score of 0 is given on the corresponding item. The score 6 is used when the therapist performs interventions optimally or with few insignificant mistakes.

OVERALL EVALUATION OF COMPETENCE (ITEM 12)
Overall evaluation of competence (item 12) in the session is a global score of the competence scores for *Cognitive behavioural therapy structure, Process and relational skills* and *interventions* (items 4, 8 and 10). The overall evaluation is not an average, but a total global evaluation of the therapist's competence in the session.

The score 0 is used when the therapist overall performs the tasks of the session in a poor or actually non-therapeutical way. The score for *Overall evaluation of competence* (item 12) may be more than 0 even if the *Overall evaluation of adherence* (item 11) is 0. This is because the competence score for Process and relational skills (item 8) is part of the *Overall evaluation of competence as opposed to Overall evaluation of adherence,* which does not include *Process and relational skills* (items 5 and 6).

The score 6 is used when the therapist overall performs the tasks and interventions of the session optimally and competently with few insignificant mistakes.

FLEXIBILITY IN TREATMENT PLAN (ITEM 13)
In *Flexibility in treatment plan* the rater must evaluate the therapist's competence in adjusting the therapy session to the individual child/parents through the measuring out and sequencing of complete modules or specific interventions. *Flexibility in treatment plan* (item 13) is scored on a 7-step Likert-scale from 0 (Poor) to 6 (Excellent). If the therapist does not make adjustments in the carrying out of the treatment manual compared to the prototypical treatment, item 13 is scored Not Applicable (N/A). The score 0 is used for poor flexibility in the treatment plan, and the score 6 is for excellent flexibility with few insignificant mistakes.

0	1	2	3	4	5	6
Poor/no		Limited		Good		Excellent

OTHER SCORING INSTRUCTIONS

SCORING INSTRUCTIONS FOR HOW CHALLENGING WAS THE SESSION?
The rater must evaluate how challenging the session was on a 7-step Likert-scale from 0-6, where 0= no challenges and 6= maximum challenge. The evaluation of how challenging the session was may be based on the following:

- Factors regarding the child's/parents': mood, problem, level of energy, engagement, motivation, level of cognitive, emotional and social development and also degree of psychopathology
- External factors such as disturbance
- Difficult situations, events or crises since the last session, which the therapist has to handle
- The child/parents expressing mistrust of the treatment
- The child/parents not having done homework or forgetting worksheets

SESSIONS TO BE SCORED

A session is scored in full, i.e. from beginning to end. A video can be included if it is possible to score 50 % of it.

A session lasts approx. 60 minutes, and videos of at least 30 minutes minimum can be scored.

Sessions where the angle of the camera is unfortunate (e.g. if the therapist goes outside the picture writing on a whiteboard or only the participants' bodies are visible in a standing position during role play) are scored as well as possible. Sessions with distorted picture or sound are also scored, unless 50 % of the session is too indistinct to be scored.

THE PRIMARY CLIENT

In MMM the child is the primary client in the treatment of anxiety and depression apart from the parent sessions where the parents receive treatment without the child being present. In these sessions the parents are the primary clients (here parental involvement is not scored).

In the treatment of behavioural problems, the primary clients are the parents unless the child is present in the session. In this case both are primary clients and Parental involvement (item 3) is not scored and *Positive reinforcement* (item 5), *Collaboration* (item 6) and *Flexibility* (item 7) is scored with regards to the child as well as the parents. In the children's treatment of behavioural problems, the child is the primary client even if the parents are present.

In the Trauma modules the child is the primary client. In the Motivation module the primary client is the person to whom the interventions are directed.

4. COGNITIVE BEHAVIOURAL THERAPY STRUCTURE

ITEM 1. REVIEWING HOMEWORK AND PRESENTING NEW HOMEWORK TASKS

The score for *Reviewing homework and presenting new homework* tasks is based on whether and how the therapist reviews the homework set for the child/parents in the previous session and presents/explains the homework tasks for the child/parents to do before the next session.

In the adherence score reviewing homework that has been done should be given 50 % weight and presentation of new homework tasks also 50 % weight. In the first session presentation of new homework tasks is given 100 % weight. Likewise, the revision of homework done is usually given 100 % in the last session unless a new homework task is given for the Booster session. If the therapist has chosen to give homework tasks for the Booster session, this is scored, while homework is scored Not Applicable (N/A) if it is not part of the Booster session. If the homework is relevant for a session, but the therapist neither reviews the homework that has been carried out nor presents new homework tasks, this is scored 0.

ADHERENCE SCORES

- The degree to which the therapist reviewed previous homework
- The degree to which the therapist handled homework tasks that had been missed or misunderstood
- The degree to which the therapist presented (and maybe demonstrated) new homework tasks
- The degree to which the therapist set relevant homework tasks
- The degree to which the therapist used relevant worksheets

0	1	2	3	4	5	6
No/ insignificant		Some		Considerable		Very high

COMPETENCE SCORE

0 - POOR COMPETENCE
- The therapist seemed unclear, uninterested in the reviewing of the child's/parent's new and previous homework

1

2 - LIMITED COMPETENCE
- The therapist briefly mentioned the homework, gave unclear information and paid only superficial attention to the child's/parent's new and previous homework

3

4 - GOOD COMPETENCE
- The therapist reviewed (and if relevant demonstrated) new and previous homework tasks clearly and distinctly with positive attention and interest

5

6 - EXCELLENT COMPETENCE
- The therapist reviewed (and if relevant demonstrated) new and previous homework tasks very thoroughly and clearly with positive attention

NOTES ON REVIEWING HOMEWORK AND PRESENTATION OF NEW HOMEWORK TASKS

Presenting new homework tasks requires a verbal instruction from the therapist so that it is clear that the task is to be done at home between sessions. The score is lowered, if the therapist does not use the sheets required for homework tasks.

If the child/parents has/have not carried out or misunderstood the homework task, the ideal is that the therapist addresses this, which is scored under adherence. How this is done specifically, is scored under competence.

Ideally, the therapist handles missing homework by for example:
- Giving psychoeducation about why homework is important
- Uncovering other problems
- Having a dialogue about how the child/parent can do the homework task
- Working with the child's/parent's motivation to do the homework task

Ideally, the therapist handles misunderstood homework tasks by for example:
- Going through and demonstrating the method again
- Checking whether the child/parents has/have understood the homework
- Doing the homework task in the session

If a therapist tries to handle misunderstood homework tasks, which are also misunderstood by the therapist him/herself, the actual attempt to handle the misunderstanding should count positively in the adherence scoring. The terapist's misunderstanding of the principles for and purpose of homework tasks in cognitive behavioural therapy will on the other hand be included in the competence score, as the therapist handles the homework task in a poor way.

Homework is NOT
- If the therapist just asks how things have been since the last session
- If the therapist starts a new intervention reaching beyond the homework task that the child/parents has/have done at home, the new homework task is scored under *interventions* (items 9A, B and C)

ITEM 2 PROGRESS AND STRUCTURE

The score for *Progress and structure* is based on whether and how the therapist sets a written agenda, reviews and follows the agenda and uses time efficiently to cover the content of the whole session.

ADHERENCE SCORE
- The degree to which the therapist presented a written agenda and reviewed it orally
- The degree to which the therapist followed the agenda or adjusted it and followed the adjusted agenda
- The degree to which the therapist used the specific structure for the build-up of the session
- The degree to which the therapist prioritized using time on the most important content of the session
- The degree to which the therapist used time relevantly to perform the session in 60 minutes

0	**1**	**2**	**3**	**4**	**5**	**6**
Non/ insignificant		Some		Considerable		Very high

COMPETENCE SCORES

0 - POOR COMPETENCE
- The therapist facilitated the agenda in an unclear and unstructured way
- The session did not seem goal-directed
- The therapist did not use time efficiently in relation to tasks and interventions in the session

1

2 - LIMITED COMPETENCE
- The therapist presented and followed the agenda, but could have been more structured and clear
- The therapist carried out the session with some direction
- To a minor degree, the therapist used time efficiently in relation to tasks and interventions in the session

3

4 - GOOD COMPETENCE
- The therapist presented and followed the agenda in a good way

- The therapist maintained focus and structure in the session in a good way
- The therapist used time efficiently in relation to tasks and interventions in the session

5

6 - EXCELLENT COMPETENCE
- The therapist presented and followed the agenda in an excellent way
- The therapist maintained focus and structure in the session in a very clear manner by steering the session forward with good transitions between the different activities, creating coherence for the child/parents
- The therapist used time very efficiently in relation to tasks and interventions in the session

NOTES ON PROGRESSION AND STRUCTURE

The score is lowered if, for example, the therapist puts up a written agenda in the room without reviewing it with the child/parents.

Ideally, the therapist follows the agenda in a structured way; however, as flexibility is emphasized in the MMM treatment manual, it may be necessary for the therapist to adjust the content in the session. The score is lowered if the therapist is not very clear about adjusting the agenda. In session 1 the item Introductory Update on the agenda is omitted.

When the therapist has reviewed the agenda or the adjustments of the agenda, it should ideally be clear to the rater. If the content of the session is unclear, the score is lowered.

The score is lowered if the therapist digresses or includes irrelevant activities, which are not a part of an intervention, an assessment or building up the alliance.

Whether the therapist uses time relevantly in the session, depends on contextual factors. Usually the score is lowered if the therapist uses considerably more or less than an hour, but it will not affect the score if the session is terminated before time, if e.g. the child is very depressed and cannot complete 60 minutes of therapy.

The evaluation of the therapist using time efficiently is based on an overall evaluation of the session related to the individual child/parents. Ideally, the therapist uses time efficiently on what makes sense in the session with a focus on interventions and the general cognitive behavioural therapy tasks. Prioritizing time depends on for example how many times interventions have to be repeated/practised, how much focus is needed on the homework tasks in the individual session, scoring of SMART goals, how much the child/parents recounts/recount from the previous session, the need for games/playing and for parental involvement.

In the Booster session a considerable amount of time is used talking about what has been like to continue work on your own. If this item is extensive, the adherence score for *Progress and structure* is not lowered.

ITEM 3 PARENTAL INVOLVEMENT

The score for *Parental involvement* is based on whether and how the therapist involves the parents in the session. *Parental involvement* is only scored in sessions where parents participate, and the child is the primary client. Parental involvement is scored Not Applicable (N/A) in parents' sessions or if the parents are not participating in the children's session.

ADHERENCE SCORE

- The degree to which the therapist presented the content of the session to the parents
- The degree to which the therapist defined the role of the parents in the session
- The degree to which the therapist actively involved the parents in dialogue and interventions when relevant
- The degree to which the therapist intervened against inappropriate involvement initiated by the parents themselves and/or included parents' contributions when relevant

0	1	2	3	4	5	6
No/ insignificant		Some		Considerable		Very high

COMPETENCE SCORE

0 - POOR COMPETENCE

- The therapist presented the content of the session, e.g. the agenda, the interventions and homework, to the parents in a poor way
- The therapist defined the role of the parents in a poor way
- The therapist intervened against inappropriate parental behaviour in an unsuitable or non-therapeutic way
- The therapist did not include the parents' contributions, was critical or over-involved in the parents

1

2 - LIMITED COMPETENCE

- The therapist presented the content of the session, e.g. the agenda, the interventions and homework, to the parents in an unclear way
- The therapist defined the role of the parents in an unclear way
- The therapist did not intervene against inappropriate parental behaviour
- The therapist did not include the parents' contributions or did it in a poor way.

3

4 - GOOD COMPETENCE

- The therapist presented the content of the session, e.g. the agenda, the interventions and homework, to the parents in a good way
- The therapist defined the role of the parents in a good way
- The therapist intervened against inappropriate parental behaviour in a good way
- The therapist included the parents' contributions in a good way

5

6 - EXCELLENT COMPETENCE

- The therapist presented the content of the session, e.g. the agenda, the interventions and homework, to the parents in an excellent way

- The therapist defined the role of the parents in an excellent way
- The therapist intervened against inappropriate parental behaviour in an excellent way
- The therapist included the parents' contributions in an excellent way

NOTES ON PARENTAL INVOLVEMENT

Parental involvement is important in terms of the parents supporting the child in the therapy until the child is able to participate independently. The manner and extent of parental involvement varies according to the child's cognitive, social and emotional level of development, the degree of psychopathology, the specific treatment module and the parents' comprehension of the methods.

Examples of parental involvement:

- Involving the parents actively in interventions, e.g. exposure, relaxation exercises and other activities which support the parents' comprehension of the methods and thereby improving their possibility of supporting the child's practice at home
- Involving the parents actively in the dialogue; if, for example the child has difficulty remembe-ring or talking about a situation, the parents can be invited to help
- Involving the parents more passively by letting them listen to and watch the therapist model behaviour or pass on knowledge
- Involving the parents by actively working with their presence in the room; e.g. having the parents leave the room when working wih separation anxiety

Inappropriate parental behaviour is any kind of behaviour initiated by the parents, which distracts the child and removes focus from the most important content for the child. Examples of this might be if parents are critical towards the child or behave as co-therapists.

Compentence score 0 = The therapist is actively harmful (e.g. asking the child to be quiet if he/she tries to interrupt a monologue initiated by the parents)
Compentence score 1 = The therapist is passively harmful (e.g. letting parents speak negatively of the child in his/her presence)
Compentence score 2 = The therapist is passive (does not intervene)
Compentence score 3 = The therapist intervenes in a sufficient way

The therapist should intervene against inappropriate behaviour by for example:

- Ignoring or deliberate use of attention
- Using the physical surroundings and the dialogue with the child to stucture the role of the parents
- Commenting on the behaviour
- Setting limits

In the Booster sessions treating anxiety and depression, parents are invited to be involved and have more opportunity to tell the therapist what it has been like to work on their own, but the main focus should still be on the child.

Parental involvement is NOT

- How and to which extent the therapist collaborates with the parents. This is scored under *Collaboration* (item 6) and only when the parents or the child and the parents together are the primary clients

5. PROCESS AND RELATIONAL SKILLS

POSITIVE REINFORCEMENT

The score for *Positive reinforcement* is based on whether and how the therapist reacts to the child's/parents' verbal and non-verbal behaviour with positive reinforcement and rewards.

ADHERENCE SCORE
- The degree to which the therapist used verbal encouragement and praise
- The degree to which the therapist used non-verbal encouragement and praise
- The degree to which the therapist gave rewards, e.g. stickers or time for games

0	**1**	**2**	**3**	**4**	**5**	**6**
No/ insignificant		Some		Considerable		Very high

COMPETENCE SCORE

0 - POOR COMPETENCE
- The therapist gave rewards, encouragement and praise in a poor and actually non-therapeutic way by giving to unwanted behaviour (e.g. praising avoidant behaviour in an anxious child)
- The therapist was critical, disrespectful or judgmental

1

2 - LIMITED COMPETENCE
- The therapist gave rewards, encouragement and praise in a general and superficial way, verbally as well as non-verbally, in relation to desired behaviour
- The therapist gave limited specific response in relation to desired behaviour
- The therapist used stickers in an unclear way

3

4 - GOOD COMPETENCE
- The therapist gave rewards, encouragement and praise in a good way, verbally as well as non-verbally, in relation to desired behaviour
- The therapist gave response in relation to desired behaviour, but the response could have been more specific
- The therapist used stickers in a good way

5

6 - EXCELLENT COMPETENCE

- The therapist gave rewards, encouragement and praise in an excellent way, verbally as well as non-verbally, in relation to desired behaviour
- The therapist gave excellent specific response in relation to desired behaviour
- The therapist used stickers in a clear and consistent way

NOTES ON POSITIVE REINFORCEMENT

Positive reinforcement:

- Verbal encouragent and praise can be for example saying ”Good, that you tried” or ”Good example!”
- Non-verbal encouragement and praise can be for example nodding or maintaining eye contact
- Rewards can be for example stickers or game time with the therapist (small games like UNO or Connect Four). It must be clear whether games and time on the iPad are rewards or break activities

The adherence score should reflect whether the therapist misses obvious opportunities for positive reinforcement.

The competence score should reflect whether the positive reinforcement is given immediately after the behaviour, which the therapist wishes to reinforce, or given all together, e.g. at the end of the session.

Parents are not given rewards. In parents' sessions and in parental behaviour training ideally the parents are given clear verbal and non-verbal acknowledgement and praise for active participation as well as respectful feedback on wanted behaviour. A lower level of verbal and non-verbal positive reinforcement towards parents than towards children is expected to be seen. Therefore, a low frequency of verbal and non-verbal positive reinforcement in the parents' session does not lower the score as much as in the children's session.

If the adolescent finds rewards childish, the therapist can omit rewards.

Positive reinforcement is NOT

- Normalising
- Validation

ITEM 6 COLLABORATION

The score for *Collaboration* is based on whether and how the therapist collaborates with the child/parents. Collaboration is scored in relation to the primary client who is either the child, the parents or both the child and the parents.

ADHERENCE SCORE

- The degree to which the therapist invited the child/parents to collaborate
- The degree to which the therapist worked with input and initiatives from the child/parents

0	1	2	3	4	5	6
No/ insignificant		Some		Considerable		Very high

COMPETENCE SCORE

0 - POOR COMPETENCE

- The therapist's way of inviting the child/parents to collaborate was negative and ambivalent which did not motivate the child/parents to engage in activities or explore their own ideas, solutions or examples. The therapist may for example have been confrontative, critical, suggestive, putting words in their mouths or rigid
- The therapist dismissed the input from the child/parents or worked with it in a negative, ambivalent way which did not welcome the child's/parents' initiatives

1

2 - LIMITED COMPETENCE

- The therapist's way of inviting the child/parents to collaborate was partly constructive, but the therapist's attempts to facilitate collaboration were too active, too passive or too clumsy
- The therapist worked with the input from the child/parents in a partly constructive way

3

4 - GOOD COMPETENCE

- The therapist's way of inviting the child/parents to collaborate was good. The child/parents were invited to engage actively in the session and explore their own ideas, solutions or examples
- The therapist worked with the input from the child/parents in a good way

5

6 - EXCELLENT COMPETENCE

- The therapist's way of inviting the child/parents to collaborate was excellent. The child/parents were invited to engage actively in the session and explore their own ideas, solutions or examples.
- The therapist worked with the input from the child/parents in an excellent way

NOTES ON COLLABORATION

Collaboration is scored for the whole session whether during smalltalk or interventions, as long as the therapist invites the child/parents to collaborate and/or makes use of child's/parents' input.

Collaboration will differ according to the child's/parents' mood, problem, level of energy, engagement and cognitive, emotional and social level of development as well as the degree of psychopatology. E.g. it may be necessary for the therapist to be more directive and pose closed-ended/concrete questions to younger children or children with depressive symptoms.

Examples of collaboration:

- The therapist facilitates active participation of the child/parents in therapy. The therapist may encourage the parents or older children themselves to write on the worksheets. If the therapist writes on the worksheets, the therapist must leave the sheets visible and readable for the child/parents
- In defining the child's problem and possible solutions, the therapist uses the child's/parents' own experience, and understanding as the starting point. The opposite being that the therapist takes over or leaves the task to the child/parents themselves
- The therapist makes room for the child/parents as opposed to monopolizing, interrupting and "taking up too much space" in the session, by for example giving too many inputs or making it difficult for the child/parent to contribute. Please note that the therapist may need to be more directive, for example working with younger children or children with severe psychopathology.
- The therapist puts in words that the child/parents are collaborating with the therapist in performing interventions, e.g. "Now *we* will try..."
- In sessions with two or more parents the therapist should facilitate collaboration with all the parents and intervene if one parent is domineering and taking up too much space in the session
- The therapist checks that the child/parents are following and understanding the session and agreeing with the therapist's presentation, e.g. the case formulation

A high adherence score may be given if the therapist makes an effort to invite the child/parents to collaborates/collaborate even if the child/parents actually collaborates/collaborate to a minor degree.

Collaboration is NOT

- How and to what extent the parents are involved in sessions where the child is the primary client. This is scored under *Parental involvement* (item 3)
- How the therapist tunes in and adjusts the interventions to the child. This is score under *Flexibility* (item 7)

ITEM 7 FLEXIBILITY

Flexibility is only a competence item based on how the therapist tunes in relationally and adjusts the tasks and interventions of the session to the child's/parents' mood, problem, level of energy, engagement and cognitive, emotional and social level of development as well as psychopatology.

COMPENTENCE SCORE

- Competence in tuning in to the child/parents
- Competence in adjusting interventions to the child/parents

0	1	2	3	4	5	6
Poor/no		Limited		Good		Excellent

NOTES ON FLEXIBILITY

Flexibility refers to minor adjustments to the individual child and parents with the aim of establishing and maintaining contact and a good treatment alliance. The score should be raised if the session is running smoothly, even if no particular actions by the therapist are observed. Here the rater must assume that several micro-adjustments are being made.

The examples in the MMM manual are formulated to fit children at the age of 10-12. The therapist may therefore need to adjust dialogue and interventions to the individual child/parents.

Examples of adjustment:

- The therapist explains difficult words or themes to the child/parents and asks whether they have understood the explanations
- The therapist uses the language of the family (e.g. using everyday terms rather than academic/psychological concepts)
- The therapist mirrors the pace, body language and intonation of the child/parents
- The therapist uses open-ended and closed-ended questions relevantly, offers a range of possible answers or makes an obvious wrong guess if the child is not able to find an answer
- When necessary, the therapist changes the wording of the examples in the manual
- When necessary, the therapist simplifies the interventions, e.g. in the relaxation exercise, a younger child may have difficulty tightening his/her muscles in his/her toes/legs/buttocks and it may be relevant to start with the hands/shoulders/face which are visible to the child
- The therapist maintains the attention of the child by activating him/her, if the child is easily distracted
- If the therapist adjusts an intervention to the child/parents, the intervention must still be performed with the same purpose of learning and in accordance with the general principles of cognitive behavioural therapy

Flexibility is NOT

- When the therapist changes the main treatment program (anxiety, depression, behaviour) . This is scored under *Flexibility in treatment plan* (item 13)
- When the therapist includes interventions or modules from other main treatment programs or generic modules, the Trauma module or the Child behaviour module as described in Appendix C. These are scored under *Flexibility in treatment plan* (item 13)
- When the therapist includes interventions from the ongoing main treatment programs as described in Appendix C. These are scored under *Progress and structure* (item 2) or *Interventions* (items 9A, B and C)

6. INTERVENTIONS

ITEMS 9A, B AND C INTERVENTIONS AND ITEM 10 INTERVENTION COMPETENCE

Interventions are scored by the rater by identifying the intervention(s) performed in the session and evaluating adherence and competence as described in the treatment manual. The rater may choose up to three interventions per session to be scored.

ADHERENCE SCORE

- The degree to which the therapist performed a suffient and relevant part of main activities related to the interventions
- The degree to which the therapist used relevant worksheets and materials

INTERVENTION A: ....

0	1	2	3	4	5	6
No/ insignificant		Some		Considerable		Very high

INTERVENTION B: ....

0	1	2	3	4	5	6
No/ insignificant		Some		Considerable		Very high

INTERVENTION C: ....

0	1	2	3	4	5	6
No/ insignificant		Some		Considerable		Very high

COMPETENCE SCORE

0 - POOR COMPETENCE
- The therapist used the general principles of cognitive behavioural therapy in the intervention(s) in a wrong way or gave misleading information
- The therapist used the methods of learning in a wrong or misleading way
- The therapist seemed unclear, uninterested or vague in the performing of the intervention(s)

1

2 - LIMITED COMPETENCE
- The therapist used the general principles of cognitive behavioural therapy in the intervention(s) to a limited extent
- The therapist used relevant methods of learning to a limited extent
- The therapist performed the intervention(s) with limited clarity and interest and without the use of relevant concrete examples

3

4 - GOOD COMPETENCE
- The therapist used the general principles of cognitive behavioural therapy in the intervention(s) in a good way
- The therapist used relevant methods of learning in a good way
- The therapist performed the intervention(s) with interest in a clear and precise way

5

6 - EXCELLENT COMPETENCE
- The therapist used the general principles of cognitive behavioural therapy in the intervention(s) in an excellent way
- The therapist used relevant methods of learning in an excellent way
- The therapist performed the intervention(s) with interest in a clear and precise way with relevant examples in terms of the problem/situation of child/parents

NOTES ON INTERVENTIONS

An intervention is defined as such if described in Appendix C. The therapist must start an intervention before it can be scored. The rules for deciding when an intervention has started, must be defined in advance.

The interventions of the session may be stated on the agenda, but since the MMM manual emphasizes a flexible planning of the session in accordance with the individual child/parents, the therapist can choose to adjust the specified agenda for the session. Please note that the rater must not score interventions, which have not been started by the therapist, although the therapist has planned to do the interventions according to the agenda.

Up to three interventions per session can be scored. It may therefore vary how many interventions the rater must score per session. In the case of more than three initiated interventions, the rater must choose the three primary interventions according to time spent on the intervention/how thoroughly the intervention is performed by the therapist.

If the intervention is performed so badly that the rater is in doubt which intervention from Appendix C is to be rated, the rater must identify the intervention judging from the apparent aim of the intervention.

If the therapist tries to perform an intervention but performs it wrong according to the principles of cognitive behavioural therapy, the therapist will not have followed the cognitive behavioural treatment manual and will therefore not obtain a high adherence score. When the therapist does not follow the principles, the compentence score is also lowered. The therapist may for example carry out a Stepladder with goals, steps and rewards for each step without following the cognitive behavioural therapy principles for gradual exposure. In this case the therapist will not obtain a high adherence score despite a completed Stepladder-worksheet.

All parts of an intervention count, regardless of when they are performed in the session, they may for example be performed little by little during the session.

If the therapist performs two interventions of the same kind, which have the same goal/ are aimed at the same problem, they are scored as one intervention. E.g. the therapist may perform Detective Thinking twice aimed at the same worry-thought, which is therefore only one intervention. If the therapist performs the intervention with a score of 4 the first time, but with a score of 2 the second time, the score is not lowered to 3. The competence score will be lowered, however, if the intervention is performed in an unclear way the first or the second time.

If the intervention is performed off camera, e.g. during exposure, only the parts of the exposure intervention performed in front of the camera can be scored. Please note that parts of preparing and reviewing of e.g. the exposure may also take place off camera and therefore cannot be scored.

The performing of an intervention includes different elements depending on whether it is introduced to the child/parent for the first time or is a repetition of an already known intervention. E.g. in the treatment of anxiety, the intervention Detective Thinking requires an introduction at first using the worksheets *14. Situations can be understood in different ways* and *15. Worrying thoughts and helpful thoughts*. Afterwards the therapist discusses three thought errors with the child upon which worksheet *19. Camilla's Detective evidence, 20. Jacob's Detective evidence* and *16. Detective evidence* is used. Later in the treatment of anxiety the child will already have practiced using Detective thinking and the introductory steps will therefore not be necessary. Using all the worksheets again will thus not be relevant. In this case the therapist will only use worksheet *16. Detective evidence.*

If the therapist starts an intervention unknown to the child/parents in the last few minutes of the session, the score is lowered if the therapist does not perform a relevant part of the main activities before the end of the session.

If it is clear that an intervention was started in a previous session and is now continued in the present session, it is scored as an intervention (items 9A, B or C), unless it is homework. Here only the new part is scored, and the score is not lowered for the missing parts, as they

have supposedly been delivered in the previous session. If the therapist reviews previous homework, it is only scored as an intervention if the therapist adds something new to the reviewed intervention.

The use of MMM materials raises the adherence score, but the lack of use of materials does not neccessarily lower the score. Materials, which are not important for the content of the session (e.g. the use of hats for role play), can be omitted without lowering the score.
If, however, the therapist omits essential materials, e.g. the audio file for attention exercises, the score is lowered.

Examples of learning methods:
- Socratic dialogue
- Guided discovery
- Problem solving
- Role play
- Modelling
- Demonstration

Interventions are NOT
- Other interventions which are not mentioned in Appendix C are not scored under *Interventions,* but under *Progress and structure* (item 2)
- If a therapist starts more than three interventions from Appendix C, and these are terminated very fast or performed very fast and superficially, these secondary interventions are scored under *Progress and structure* (item 2) where the score will be lowered for the therapist not having kept focus on the most important parts of the session and consistently spent time on these

OVERALL EVALUATION

ITEM 11 OVERALL EVALUATION OF ADHERENCE

This item is based on an overall evaluation of the session, which includes *Cognitive behavioural therapy strucure and Interventions* (Please note that *Process and relational skills* are only scored under *Overall evaluation of competence*).

ADHERENCE SCORE

- The degree to which the therapist reviewed homework and presented new homework tasks
- The degree to which the therapist maintained structure in the session
- The degree to which the therapist involved the parents when relevant
- The degree to which the therapist performed the intervention(s)

0	1	2	3	4	5	6
No/ insignificant		Some		Considerable		Very high

ITEM 12 OVERALL EVALUATION OF COMPETENCE

This item is based on an overall evaluation of the session, which includes the semi-global scores for *Cognitive behavioural therapy structure, Process and relational skills* and *Interventions respectively.*

COMPETENCE SCORE

0 - POOR COMPETENCE
- The therapist maintained structure in a poor or inappropriate way
- The therapist lacked process skills and relational skills
- The therapist performed the interventions in a poor or inappropriate way

1

2 - LIMITED COMPETENCE
- The therapist showed limited skills in maintaining structure
- The therapist showed limited process skills and relational skills
- The therapist showed limited skills in performing the interventions

3

4 - GOOD COMPETENCE

- The therapist maintained structure in a good way
- The therapist showed good process skills and relational skills
- The therapist performed the interventions in good way

5

6 - EXCELLENT COMPETENCE
- The therapist maintained structure in an excellent way
- The therapist showed excellent process skills and relational skills
- The therapist performed the interventions in an excellent way

ITEM 13 FLEXIBILITY IN TREATMENT PLAN

Flexibility in treatment plan is a competence item and is only scored when the therapist in the session makes one or more adjustments compared to the prototypical treatment described in the treatment manual. This item is scored Not Applicable (N/A) if the therapist does not make adjustments in the session.

In the competence score the relevance of the adjustments in the session is given 50 % weight and the competence with which the therapist adjusts the session to the individual child/parents is given 50 % weight.

KOMPETENCESCORECOMPETENCE SCORE
- The relevance of the adjustment in the session
- The competence with which the therapist adjusted the session to the individual child/ parents

0	1	2	3	4	5	6
Poor/no		Limited		Good		Excellent

NOTES ON FLEXIBILITY IN TREATMENT PLAN
Scoring *Flexibility in treatment* plan is based on the evaluation of whether the therapist's flexible adjustments are made competently and work well in the session as a whole.

The three types of flexibility in treatment plan which can be made in MMM are:
- When the therapist changes the main treatment program (anxiety, depression, behaviour) in the session
- When the therapist includes modules or specific interventions (Appendix C) from other main treatment program or includes optional generic modules outside the prototypical treatment
- When the therapist makes distinct adjustments of the prototypical treatment by including future modules or interventions (Appendix C) in the ongoing main treatment.

The information given to the therapist during the course of treatment and the decision-making processes prior to the session are not known to the rater. The scoring of *Flexibility in*

treatment plan is therefore based solely on what the rater can observe in the session in question and on the information about the session, which the rater can obtain in advance.

Flexibility in treatment plan within the ongoing main treatment program is only scored if the therapist includes modules/interventions, which according to the prototypical treatment should have been covered later and only if the flexibility is very distinct and not just a continuation of work from previous sessions. A distinct adjustment is when, for example, the therapist includes Exposure in session 2 in a treatment for anxiety. However, flexibility in treatment plan is not neccessarily the case if a module is presented a session too early according to the flowchart of the prototypical treatment. Here the decision regarding flexibility in treatment plan must depend on whether the rater observes a distinct indication of flexibility in the treatment plan in the session.

Examples of relevance and competence:

- If the therapist indicates that flexibility in treatment plan is relevant by for example referring to themes which the child/parents and therapist have worked with earlier in the session (e.g. homework tasks), in previous sessions, in the referral interview and the like
- If the child/parents indicates/indicate that flexibility in treatment plan is relevant, by for example expressing that flexible adjustment was necessary or by participating actively with their own examples and perspectives in relation to the new material
- If the therapist establishes coherence and a common thread between the flexible adjustment and the rest of the content/material of the session/treatment
- If the therapist is clear and transparent regarding the flexible adjustment
- If the therapist explains the rationale of the flexible adjustment

Non-relevance of flexible adjustment may be observed if, for example, the child/parents cannot identify their own examples related to the new material or if they openly express that the new material seems irrelevant for them.

Flexibility in treatment plan is NOT

- Adherence and competence in interventions are scored as *Interventions* (items 9A, B and C and 10)
- If the therapist sets homework tasks that do not fit the session but may have been included from other modules/main treatment programs. This is scored under *Reviewing homework and presenting new homework tasks* (item 1)
- If the therapist tunes in to the child/parents. This is scored under *Flexibility* (item 7)
- If the therapist adjusts the intervention according to the child/parents. This is scored under *Flexibility* (item 7)
- If the therapist uses previously presented interventions later in the treatment, for example using the Detective sheet in the 8th session of a treatment for anxiety. This is scored under *Interventions* (items 9A, B and C)
- If the therapist has changed the main treatment program, for example on the telephone and the telephone call is mentioned in the session.

APPENDIX A
NOTE SHEET FOR CAS-TM-CBT

Date:
Rater-ID:
Video-ID:
Primary client: Parents Child Both
Age of child:

Main treatment: Anxiety Depression Behaviour
Top problem:
Primary chapter:
Secondary chapter:
Worksheet:

COGNITIVE BEHAVIOURAL THERAPY STRUCTURE

ITEM 1 Reviewing homework and presenting new homework tasks (N/A)

Adherence	0 1 2 3 4 5 6
Competence	0 1 2 3 4 5 6

ITEM 2 Progress og structure

Adherence	0 1 2 3 4 5 6
Competence	0 1 2 3 4 5 6

ITEM 3 Parental involvement (N/A)

Adherence	0 1 2 3 4 5 6

Competence	0 1 2 3 4 5 6

PROCESS AND RELATIONAL SKILLS

ITEM 5 Positive reinforcement

Adherence	0 1 2 3 4 5 6

Competence	0 1 2 3 4 5 6

ITEM 6 Collaboration

Adherence	0 1 2 3 4 5 6

Competence	0 1 2 3 4 5 6

ITEM 7 Flexibility

Competence	0 1 2 3 4 5 6

INTERVENTIONS

ITEM 9A Intervention no. (N/A)

Adherence	0 1 2 3 4 5 6

Competence	0 1 2 3 4 5 6

ITEM 9B Intervention no. (N/A)

Adherence	0 1 2 3 4 5 6

Competence	0 1 2 3 4 5 6

ITEM 9C Intervention no. (N/A)

Adherence	0 1 2 3 4 5 6

Competence	0 1 2 3 4 5 6

OVERALL EVALUATION

ITEM 11 Overall evaluation of adherence

Adherence	0 1 2 3 4 5 6

ITEM 12 Overall evaluation of competence

Competence	0 1 2 3 4 5 6

ITEM 13 FLEXIBILITY IN TREATMENT PLAN (N/A)

[ ] Change of main treatment program
[ ] Inclusion of interventions/modules from other problem-specific modules or optional generic interventions/modules
[ ] Inclusion of future modules/interventions from ongoing main treatment program

Competence	**0 1 2 3 4 5 6**

How challenging was the session? (0 = no challenges, 6 = maximum challenge)	**0 1 2 3 4 5 6**

Was the video of the session complete?	**YES NO**

Were there any scoring difficulties due to the quality of the tape (picture, sound, angle of camera etc)?	**YES NO**

APPENDIX B
SCORING SHEET FOR CAS-TM-CBT

Individual Consensus
Date:
Rater-ID:
Video-ID:
Primary client: Parents Child Both
Age of the child:

Main treatment: Anxiety Depression Behaviour
Top problem:
Primary chapter:
Secondary chapter:
Worksheet:

COGNITIVE BEHAVIOURAL THERAPY STRUCTURE

ITEM 1	Adherence	Homework (N/A)	0	1	2	3	4	5	6
ITEM 2	Adherence	Progress and structure	0	1	2	3	4	5	6
ITEM 3	Adherence	Parental involvement (N/A)	0	1	2	3	4	5	6
ITEM 4	Competence	Cognitive behavioural therapy structure	0	1	2	3	4	5	6

PROCESS AND RELATIONAL SKILLS

ITEM 5	Adherence	Positive reinforcement	0	1	2	3	4	5	6
ITEM 6	Adherence	Collaboration	0	1	2	3	4	5	6
ITEM 7	Competence	Flexibility	0	1	2	3	4	5	6
ITEM 8	Competence	Process and relational skills	0	1	2	3	4	5	6

INTERVENTIONS

ITEM 9A	Adherence	Intervention no. (N/A)	0	1	2	3	4	5	6
ITEM 9B	Adherence	Intervention no. (N/A)	0	1	2	3	4	5	6
ITEM 9C	Adherence	Intervention no. (N/A)	0	1	2	3	4	5	6
ITEM 10	Competence	Intervention (N/A)	0	1	2	3	4	5	6

OVERALL EVALUATION

ITEM 11	Adherence	Overall evaluation of adherence	0	1	2	3	4	5	6
ITEM 12	Competence	Overall evaluation of competence	0	1	2	3	4	5	6

▶▶

OVERALL EVALUATION

ITEM 13	Competence	Flexibility in treatment plan (N/A) [ ] Change in main treatment program [ ] Inclusion of modules/interventions from other main treatments/optional generic modules/interventions [ ] Inclusion of future modules/interventions from ongoing main treatment program	**0**	**1**	**2**	**3**	**4**	**5**	**6**

A. How challenging was the sessionen? (0 = no challenge, 6 = maximum challenge)	**0**	**1**	**2**	**3**	**4**	**5**	**6**

B. Was the videotape of the session complete?	**YES**	**NO**

C. Were there any scoring difficulties due to the quality videotape (picture, sound, angle of camera etc.)?	**YES**	**NO**

APPENDIX C
OVERVIEW OF INTERVENTIONS IN THE MMM RCT

CHAPTER	METHODS	NO.	INTERVENTIONS (ARE SCORED)	MAY INCLUDE THE FOLLOWING TECHNIQUES/THEMES
1	The first column describes the overall methods and themes used in MMM. A method may make up a chapter in the MMM treatment manual, but a chapter may also contain several methods.	1	The second column describes the MMM interventions that can be scored in the sessions	The third column describes what the intervention may look like: the themes which should be covered in psychoeducation, and the techniques which can be part of an intervention.*

* As part of the intervention the therapist should always explain the purpose of the intervention before the intervention is started and is not described in the third column. Often the therapist will provide psychoeducation or make an introduction to the theme as part of the intervention. E.g. doing exposure for the first time the therapist should introduce the principles of gradual exposure and the development of feelings. This psychoeducation or introduction is also not described in the third column, as it will vary from session to session whether or to which extent this is relevant. Furthermore, full adherence does not need to include all elements. Using the Motivation module for example, the therapist might choose one or more techniques described to work with the client's motivation. Points may be deducted if the therapist chooses too many techniques, as the child or the parents might be overwhelmed.

FIRST SESSION

CHAPTER	METHODS	NO.	INTERVENTIONS (ARE SCORED)	MAY INCLUDE THE FOLLOWING TECHNIQUES/THEMES
2	Case formulation	1	Case formulation*	Case formulation
	SMART- goals	2	SMART- goals*	SMART- goals

* Case formulation and SMART-goals are interventions that can be scored in all main treatments and in all sessions. Apart from the first session these interventions are only scored, if major revisions of content are made, e.g. setting new SMART- goals.

MOTIVATION WORK

CHAPTER	METHODS	NO.	INTERVENTIONS (ARE SCORED)	MAY INCLUDE THE FOLLOWING TECHNIQUES/THEMES
4	Motivation work	3	Motivation	The Stages of Change Model Importance, confidence and timing Cost benefit analysis Functional analysis

ANXIETY

CHAPTER	METHODS	NO.	INTERVENTIONS (ARE SCORED)	MAY INCLUDE THE FOLLOWING TECHNIQUES/THEMES
2	Psychoeducation on anxiety	4	Psychoeducation on anxiety	Psychoeducation on anxiety Body signals Knowledge of feelings Feelings can have different sizes The link beween thoughts, feelings, body and behaviour
3	Methods of thinking	5	Different thoughts in the same situation	Different thoughts in the same situation
	Restructuring	6	Detective thinking	Detective thinking Coping cards
	Excessive worry	7	Excessive worry	Functional analysis Attention exercise The worry box
	Perfectionism	8	Perfectionism	Cost benefit analysis Detective thinking Coping cards
4	Psychoeducation for parents	9	Psychoeducation for parents	Psychoeducation on anxiety Functional analysis Non stigmatizing Excessive reassurance Over involvement Permitting avoidant behaviour Parents as role models and guided attention to regulate behaviour Rewards
5	Exposure*	10	Stepladder	Stepladder
		11	Interoceptive exposure	Interoceptive exposure (in vivo)
		12	Experiment	Experiment
		13	Gradual exposure	Gradual exposure (in vivo)
	Body exercises	14	Breathing exercise	Breathing exercise
		15	Progressiv afspænding	Progressive relaxation
6	Problem solving	16	Problem solving	Problem solving

ANXIETY

CHAPTER	METHODS	NO.	INTERVENTIONS (ARE SCORED)	MAY INCLUDE THE FOLLOWING TECHNIQUES/THEMES
7	Social skills	17	Perspective taking	Perspective taking Prior understanding affects the perspective
		18	Basic social skills	Basic social skills
	Social cognition	19	Problem solving	Problem solving
		20	Being a good friend	Being a good friend
		21	Managing group pressure	Brainstorm
8	Summing up	22	Summing up of helpful methods	Status Summing up of helpful methods
	New goals	23	New goals	Stepladder
9	Maintaining progress	24	Relapse prevention plan	Relapse prevention plan
	Ending of treatment	25	Presenting diplomas	Presenting diplomas
10	Booster	26	Focus on progress	Focus on progress Handling problems
		27	Repetition of techniques	Repetition of techniques
		28	Future goals	Stepladder

* The exposures Experiment, Interoceptive exposure and therapist-guided exposure in vivo consist of (1) preparation for exposure, (2) performing the actual exposure and (3) reviewing the exposure. Any of these parts may take place off camera in which case they cannot be scored. The rater must only score what can be observed in the session.

TRAUME

CHAPTER	METHODS	NO.	INTERVENTIONS (ARE SCORED)	MAY INCLUDE THE FOLLOWING TECHNIQUES/THEMES
1	Psychoeducation on trauma	29	Psychoeducation on trauma	Trauma Rationale for talking about trauma instead of avoiding it
	Body exercises	30	Breathing exercise	Breathing exercise
		31	Progressive relaxation	Progressive relaxation
	Creating the narrative about the experience	32	Creating the narrative about the experience	Creating the narrative about the experience
	Exposure to the retelling of the experience	33	Exposure to the retelling of the experience	Exposure to the retelling of the experience

DEPRESSION

CHAPTER	METHODS	NO.	INTERVENTIONS (ARE SCORED)	MAY INCLUDE THE FOLLOWING TECHNIQUES/THEMES
2	Psychoeducation on depression	34	Psychoeducation on depression	Psychoeducation on depression Knowledge of feelings Feelings may have different strengths Links between thoughts, feelings, body and behaviour Rewards between sessions
	Monitoring	35	Mood monitoring Positive diary	Mood monitoring Positive diary
3	Psychoeducation on depression to parents	36	Psychoeducation on depression to parents	Symptoms of depression: mood, energy and cognitive difficulties Relevant support and relieving of the child Ambivalent feelings Dependency versus detachment Recharging your own batteries
4	Problem solving	37	Problem solving	Problem solving
5	Activity monitoring	38	AktivitetsregistreringActivity moni-toring	Activity monitoring Links between mood and activities Fluctuations – lacking or more than expected Activities independent of mood
	Behavioural activation	39	Behavioural activation	List of ideas for nourishing activities Activity planning Challenges in activity planning Fixed daily structure Sabotaging mind traps Overactivity
6	Restructuring	40	Identifying negative automatic thoughts	Identifying negative automatic thoughts Different thoughts in the same situation Dark thoughts
		41	Detective thinking	Detective thinking
		42	Behaviour experiments	Behaviour experiments
	Depressive rumination (incl. perfectionism)	43	Depressive rumination Perfectionism	Functional analysis Getting the thought at a distance The stop sign The worry box Never mind Attention exercise Cost benefit analysis
7	Relaxation exercise	44	Breathing exercise	Breathing exercise Supplement

DEPRESSION

CHAPTER	METHODS	NO.	INTERVENTIONS (ARE SCORED)	MAY INCLUDE THE FOLLOWING TECHNIQUES/THEMES
7	Relaxation exercise	45	Progressive relaxation	Progressive relaxation Supplement
8	Perspective taking	46	Perspective taking	Perspective taking
	Social skills	47	Basic social skills	Basic social skills
		48	Problem solving for social problems	Problem solving for social problems
		49	Being a good friend	Being a good friend
		50	Handling group pressure	Handling group pressure Brainstorm
9	Summing up	51	Summing up	Summing up
	New goals	52	New goals	New goals
10	Maintaining progress	53	Relapse prevention plan	Relapse prevention plan
	Ending of treatment	54	Presenting diplomas	Presenting diplomas
11	Booster	55	Focus on progress	Focus on progress Handling of problems
		56	Repetition of techniques	Repetition of techniques
		57	Future goals	Future goals

PARENTAL BEHAVIOUR TRAINING

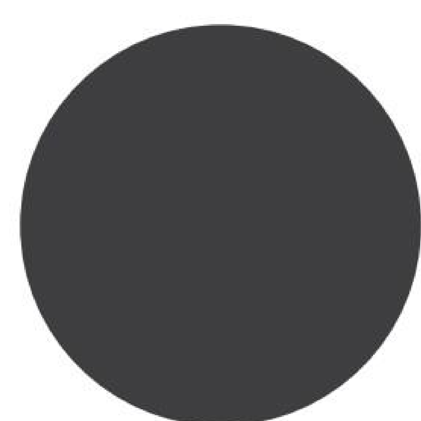
CHAPTER	METHODS	NO.	INTERVENTIONS (ARE SCORED)	MAY INCLUDE THE FOLLOWING TECHNIQUES/THEMES
2	Making clear kind demands	58	Making clear kind demands	Making clear kind demands
3	Clear household rules	59	Choosing and formulating simple rules	Formulating and setting clear household rules
4	Recognition and encouragement	60	Praise	Praise
		61	Creating reward systems	Creating reward systems
		62	Token system	Token system Involving older children/adolescents
5	Limit setting	63	Ignoring and deliberate use of attention	Ignoring and deliberate use of attention

PARENTAL BEHAVIOUR TRAINING

CHAPTER	METHODS	NO.	INTERVENTIONS (ARE SCORED)	MAY INCLUDE THE FOLLOWING TECHNIQUES/THEMES
5	Limit setting	64	Time out	Consequences of behaviour Exploring the parents' experience with limit setting Conflicts The balance between positive and negative interactions Time out procedure
		65	Exercises regarding consequence	Exercises regarding consequence
		66	Immediate loss of privileges	Immediate loss of privileges
6	Clear involvement in the child's life	67	Clear involvement in the child's life	Creating opportunities for positive time together Obtaining information about the child's movements Making new agreements
7	Problem solving	68	Problem solving	Problem solving Family meeting
8	Supportive communication	69	Supportive communication	Supportive communication
9	New energy for the parents	70	New energy for the parents	New energy for the parents
10	Maintaining progress	71	Relapse prevention plan	Relapse prevention plan
	Ending of treatment	72	Presenting diplomas	Presenting diplomas and other forms of celebrationHåndtering af problemer
11	Booster	73	Handling problems	Handling problems
		74	Repetition of techniques	Repetition of techniques
		75	Plan for maintaining development	Plan for maintaining development

CHILD BEHAVIOUR TRAINING

CHAPTER	METHODS	NO.	INTERVENTIONS (ARE SCORED)	MAY INCLUDE THE FOLLOWING TECHNIQUES/THEMES
2	The child's self-image	76	The child's self-image	Mapping out and emphasizing the child's strengths Adjusting the child's self-image to a more realistic self-image
3	Social skills and social cognition	77	Perspective taking	Perspective taking
		78	Basic social skills	Basic social skills
		79	Solving social problems in a structured way	Problem solving Cost benefit analysis
		80	Being a good friend	Being a good friend
		81	Handling group pressure	Handling group pressure
4	Recognition of feelings and regulating feelings	82	Recognition of feelings	Recognition of feelings Body signals Feelings thermometer
		83	Regulating feelings	Regulating feelings Feelings thermometer Strategies to control anger Brainstorm and cost benefit analysis
		84	Body exercises	Breathing exercise Progressive relaxation



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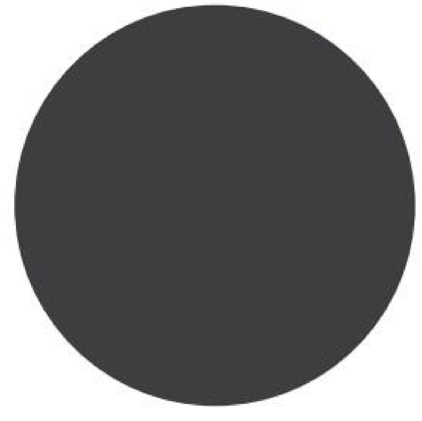

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