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CTHERAPEUTICS ADVANCES

- 1 Best practices in supervising cognitive behavioral therapy with youth
Friedberg RD

REVIEW

- 9 Behavioural and emotional disorders in childhood: A brief overview for paediatricians
Ogundele MO
- 27 Controversies in diagnosis and management of Kawasaki disease
Pilania RK, Bhattra D, Singh S

MINIREVIEWS

- 36 Review of the evidence for the management of co-morbid Tics disorders in children and adolescents with attention deficit hyperactivity disorder
Ogundele MO, Ayyash HF

ORIGINAL ARTICLE

Case Control Study

- 43 Abdominal obesity adversely affects bone mass in children
Krishnan S, Anderson MP, Fields DA, Misra M

Retrospective Cohort Study

- 49 Neither hereditary periodic fever nor periodic fever, aphthae, pharyngitis, adenitis: Undifferentiated periodic fever in a tertiary pediatric center
De Pauli S, Lega S, Pastore S, Grasso DL, Bianco AMR, Severini GM, Tommasini A, Taddio A

Retrospective Study

- 56 Pediatricians lack knowledge for the diagnosis and management of functional constipation in children over 6 mo of age
Widodo A, Hegar B, Vandenplas Y

Clinical Practice Study

- 62 Outcomes of transconjunctival sutureless 27-gauge vitrectomy for stage 4 retinopathy of prematurity
Shah PK, Prabhu V, Narendran V

ABOUT COVER

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World Journal of Clinical Pediatrics
 Baishideng Publishing Group Inc
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Best practices in supervising cognitive behavioral therapy with youth

Robert D Friedberg

Robert D Friedberg, Center for the Study and Treatment of Anxious Youth, Palo Alto University, Palo Alto, CA 94304, United States

ORCID number: Robert D Friedberg (0000-0001-8821-1723).

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Correspondence to: Robert D Friedberg, PhD, ABPP, ACT Professor, Director, Center for the Study and Treatment of Anxious Youth, Palo Alto University, 1791 Arastradero Rd, Palo Alto, CA 94304, United States. rfriedberg@paloaltou.edu
Telephone: +1-408-7754904

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Abstract

Clinical supervision of cognitive behavioral therapy (CBT) with youth ensures better patient care and fosters trainees' professional development. However,

often insufficient attention is directed toward disseminating best practices in supervision of CBT with youth. This Therapeutic Advances contribution aims to communicate the core content of supervision. Additionally, the key supervisory practices associated with CBT with youth are described. Supervisory outcomes are summarized and recommendations for supervisory practices are made.

Key words: Cognitive behavioral therapy; Pediatric populations; Supervision

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Core tip: There are several core tips in this therapeutic advances article. First, the pivotal content of supervision of cognitive behavioral therapy with youth include training in case conceptualization, ethics/laws, collaborative empiricism, guided discovery, session structure, embracing immediacy, measurement-based care, and cognitive-behavioral technique. Enactive supervision characterized by behavioral rehearsal is essential. Further, tracking trainee progress *via* objective rating scales and providing frequent, constructive feedback is indispensable.

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INTRODUCTION

Fortunately, the state of the science of cognitive behavioral therapy (CBT) with youth is strong^[1-3]. CBT shows good results with patients diagnosed with multiple disorders including depression^[4], anxiety^[5] obsessive-compulsive disorder^[6], trauma^[7], and disruptive behavior

disorders^[8,9].

Equipping supervisees with state-of-the-practice cognitive behavioral therapy skills for youth is an important yet very challenging training imperative. Didactic training acquired in classes and workshops is not a powerful way to change professional practices^[10,11]. Ongoing consultation potentiates didactic training. More specifically, "consultation likely provides therapists with a venue for clarification and practice of concepts, learning concepts over time, case consultation, and using problem solving to overcome implementation barriers"^[10].

Clinical supervision of CBT with youth is a multi-pronged professional activity that targets various foci^[12,13]. Of course, assuring the emotional and psychological well-being of young patients is the pre-eminent goal. Additionally, building trainees skills, knowledge and attitudes is a second pivotal task. Finally, assisting supervisees with difficult patients and igniting their professional development are important undertakings. Achieving these meritorious goals is both a rewarding and challenging endeavor.

This therapeutic advances article highlights several issues. The paper begins with a discussion about the importance of supervision. Second, the common content of supervision is explicated. Next, core supervisory practices are explained. A consideration of supervisory outcomes follows. The article concludes with recommendations for proper supervision of CBT with youth.

IMPORTANCE OF SUPERVISION

In the United States, there is a growing call for evidence-based approaches for treating psychiatric disorders in youth^[14]. Lack of access to good supervision is commonly seen as an obstacle to effective implementation in community contexts^[15]. Many clinicians label themselves as cognitive behavioral therapists, but this self-identification does not reflect the actual behaviors demonstrated in sessions^[14]. In particular, a recent study found that 71% of clinicians who self-labeled as CBT therapists failed to display evidence of CBT competence^[14]. Further, there were equivalent levels of non-competence between those clinicians who did and did not identify themselves as CBT clinicians. Additionally, over 50% of community clinicians trained in CBT reported departing from the approach suggesting that CBT is not being implemented with sufficient fidelity^[16]. Truth in labeling is imperative. If clinicians inaccurately claim a CBT orientation, the treatment dose is diluted and the delivery method is compromised. Competent supervision enables essential quality control. Without this quality control, clinicians are free to go rogue and suffer sizeable theoretical/technical drift.

CONTENT OF SUPERVISION

CBT clinicians are made not born. There is much to learn when becoming a cognitive behavioral therapist with youth^[17]. Good CBT with youth involves numerous

competencies^[17-21]. Appreciating the state of the science supporting CBT and the theoretical foundations which underlie the approach is imperative. Fashioning flexible and robust case formulations is also expected. Employing guided discovery and collaborative empiricism throughout the clinical work is another vital component. Adhering to the prototypical cognitive therapy session structure is *de rigueur*. Of course, mastery of the variety of CBT procedures and processes such as Socratic questioning, self-instruction, problem solving, imagery, behavioral activation, social skills training, behavioral experiments, and exposure/response prevention is fundamental.

Supervision is portrayed as the "pedagogical engine" of clinical training in CBT^[22]. Attention to core content areas and allocating sufficient time for training are vital. Research has indicated that in community based clinics, there is little discussion of evidence based procedures in supervision^[23]. Insufficient training times are associated with trainees' overestimation of their competence^[24]. Indeed, there is much heavy lifting to do in CBT training. Therefore, supervisors must promote high level didactic, procedural, and self-reflective learning experiences in an efficient manner. Fortunately, CBT supervision is described as goal-directed, structured, time limited, and personalized to the trainee^[25,26].

Supervisors and trainees are wise to remember that "cognitive therapy is work not magic"^[27]. This section details the core elements embedded in good supervision of CBT with youth including training in case conceptualization, ethical and legal alertness, multicultural responsiveness, employing collaborative empiricism and guided discovery, measurement based care, technical proficiency, as well as addressing trainees' beliefs about the clinical work.

Case conceptualization^[13,17-21,28-32] is an indispensable task. In fact, case conceptualization is seen as the nucleus of good CBT practice^[19]. Case formulation obviates an eclectic approach and bag of tricks mentality. Authors^[33] recently argued, "We have no data to suggest that an 'a la carte' approach to CBT produces positive patient outcomes". The selection, timing, and targets of various interventions are launched by case conceptualization. However, the ability to formulate cases is an acquired skill set^[20,34]. Case conceptualization involves several component bits of knowledge^[19,20]. More specifically, fluency in operant, classical, and social learning theory paradigms is essential. Additionally, full comprehension of theoretical tenets such as the hierarchical organizational model^[35,36] and the content-specificity hypothesis^[37-41] is necessary. Appreciation of socio-cultural variables and developmental vicissitudes is also pivotal. Required reading lists are encouraged to bulk up trainees' knowledge bases. Fortunately, several excellent teaching and training resources exist^[42-46]. Additionally, completing written case formulations and receiving supervisory feedback on them is also recommended^[30].

Instruction in ethics and legal regulations is also

necessary when supervising CBT with youth^[13,17,47]. Attention to issues of confidentiality are especially important when working with young patients. Clinicians need to be ever mindful regarding WHO is their patient. Additionally, alertness to child abuse and maltreatment is a priority. Training supervisees in identifying and managing common hazardous issues such as self-injurious, suicidal, homicidal, risky sexual and substance abusing behaviors is also pivotal.

Training in collaborative empiricism^[32,48] is an indispensable pedagogical task. Collaboration is especially valuable since it promotes trust and fosters experimentation with techniques^[32]. The empiricism part of the equation refers to the transparent data based nature of CBT with youth. Moreover, the reliance on data coming directly from young patients and their families is linked to CBT's phenomenological roots^[49]. In particular, collaboration is a difficult practice to develop especially for supervisees who are more comfortable with either overly prescriptive or non-directive approaches.

Teaching trainees the rudiments of guided discovery is important yet quite challenging^[48]. Many supervisees perceive guided discovery as a common pitfall in clinical practice^[33]. Simply stated, guided discovery involves helping young patients form more adaptive conclusions and flexible attitudes based on their personal data base. Similar to collaborative empiricism, guided discovery is rooted in a hypothesis testing stance^[50]. Simply stated, guided discovery facilitates the art of the possible^[45]. Empathic listening, Socratic dialogues homework assignments and behavioral experiments are components of guided discovery.

Teaching trainees' to implement the trademark session structure is another crucial task. Mood check-ins, agenda setting, processing session content, assigning homework, and eliciting feedback are the requisite components^[51]. Applying a regular format to sessions is typically foreign to most beginning trainees. It is also helpful to teach them that these elements are both procedures and processes so they are less likely to apply a mechanical, stereotyped approach to session structure.

Embracing immediacy in CBT with is another core skill^[52-54]. Immediacy involves addressing emotionally evocative moments in the here and now. A contemporary article contended immediacy occurs when "psychotherapeutic moments are charged with the urgency and genuineness of emotional experience in present tense and real time^[53]." Immediacy in session avoids an intellectualized, emotionally sterile, and mechanical approach to CBT with young people.

Measurement based care (MBC) is another vital content element. MBC ensures accountability and collaborative monitoring of treatment progress. Simply, MBC involves regular periodic examination of patients' functioning through a combination of symptom scales, indices of functional improvement, and patient satisfaction measures^[55].

Instruction in the theory, empirical support and practice of traditional cognitive behavioral techniques

is standard fare in CBT supervision with youth^[56-67]. Teaching psychoeducational, behavioral tasks, cognitive restructuring techniques, and exposure procedures typically involves reading assignments, verbal discussion, modeling, and opportunities for trainees to rehearse the intervention. Of course, practice is accompanied by supervisory feedback.

Supervisees' experience various thoughts and feelings regarding clinical work with young patients. Accordingly, processing trainees' thoughts, feelings and actions^[13,21,25-27,30,45-47,57,67-69] is an integral supervisory responsibility. Trainees hold various dysfunctional beliefs about their competence and adhere to unrelenting performance standards. Moreover, trainees may be impatient and intolerant of ambiguity. Some supervisees may be reluctant to address patients' heightened negative affectivity. Others may fear their young patients' anger. Trainees may also worry about risking their supervisees' disapproval. It is not uncommon for students' to resent getting direction from their supervisors. Regardless of the particular beliefs about their clinical work that go through supervisees' minds, supervisors apply cognitive behavioral practices and processes such as collaboration, guided discovery, and socratic dialogues to straighten out crooked thinking during training.

SUPERVISORY PROCEDURES AND PROCESSES

Supervisees' skills are sharpened *via* audio/video taped review didactic instruction, Socratic methods, modeling, behavioral rehearsal, and feedback^[12,13]. The procedures and processes utilized in supervision of CBT for youth are embedded within a productive learning environment. This section discusses the deployment of audiotaped/review, enactive supervision, and structured rating scales during training.

Trainees appear to learn best from supervisory relationships that are characterized by supportiveness, authenticity, and are clinically relevant^[70]. Moreover, supervisors who are respectful, knowledgeable, and collaborative appear most effective^[62]. Supervisees appreciate sessions that address clinical practice^[70]. In short, supervisors are well advised to cultivate a productive learning environment^[30].

Audio and/or video-taped review of trainees sessions with young patients is widely recommended^[12,13,18,22,23,59,60,62,63,70,71]. However, the actual use in community settings is disappointing^[23,71-74]. Several studies in the United Kingdom found reviews of tapes to occur in 6%^[74] and 20% of cases^[72]. Further, only 18% of supervisors studied in the United Kingdom reported reviewing tapes^[72]. These low incidences also characterize supervision in the United States. Only 12% of supervisors studied employed video-tape review and 8% used audiotape^[23].

Enactive supervision is recommended a best training strategy^[12,13,20,30,31,69]. Behavioral rehearsal is a powerful

training tool^[26,63,75-78]. In a recent study^[78], the procedure was defined as “a simulated interaction between a trainee and another individual”. Essentially, behavioral rehearsal facilitates learning through repeated practice. Authors^[63] have argued that “providing an opportunity for trainees to experiment with nascent skills promotes greater self-efficacy and better conceptual understanding”.

Supervisors are advised to keep several guidelines for role-playing in mind^[20,78]. Role-plays need to be explicitly and systematically processed. The lessons learned through the role-play need to be reviewed with the supervisee. Second, role-plays need to be emotionally similar to real life clinical scenarios in order to facilitate transfer of learning. More specifically, “if role plays are too emotionally sanitized and dissimilar to genuine therapist-patient interactions they are merely abstract intellectualized activities rather than experiential learning exercises”^[20].

There is some evidence that BR is anxiety producing for trainees^[79]. For instance, in one study, fewer trainees were willing to participate in a study involving performance evaluations based on BR and there was a high attrition rate. There appears to be a dose effect for BR with a 2:1 passive to active learning ratio suggested^[70]. Supervisors should strike a balance between exhausting trainees with too much BR and electing to do too little practice. Additionally, behavioral rehearsal is shown to be most effective with supervisees who are most engaged in the learning process^[77].

Providing positive and negative feedback to supervisees is another critical task^[12,13,29,61,80]. More specifically, trainees who engaged in behavioral rehearsal tended to overestimate their performance following the role-play^[81]. Further, supervisors tend to be overly complimentary perhaps in a desire to please their trainees^[26]. When constructive feedback is given, the criticisms are generally vague and unstructured^[26]. Feedback is important so supervisees can identify and address their smart spots, dumb spots and blind spots^[20]. In particular, smart spots are strengths, dumb spots refer to gaps in knowledge, and blind spots are errors caused by lack of awareness and/or obliviousness to the patient^[20].

Recording trainee progress on rating scales is an essential practice for providing feedback^[12,13,21,22,57,80]. Various instruments for measuring trainee progress were recently summarized^[22]. Most of the available measurement methods are based on work with trainees treating adults. The instruments emphasize application of procedural knowledge. The Cognitive Therapy Rating Scale (CTRS)^[56] is a widely used gold standard. It includes 11 items evaluated on a 6 point Likert scale. The items include understanding, interpersonal effectiveness, pacing, agenda setting, feedback, homework, focus on key cognitions, strategy for change, collaboration, guided discovery, and proficiency in cognitive behavioral procedures.

The Cognitive Behavioural Therapy Scale for Children and Young People (CBTS-CYP)^[64] assesses supervisees’

performance on across various competency areas. These domains include general skills, investigating, partnership, empathy, cognitive techniques, behavioral techniques, emotional techniques, formulation, and discovery experiments. Initial data indicates very sound psychometric properties.

The Cognitive Therapy Rating Scale for Children and Adolescents^[65,81,82] is a promising new measure that is based on the original CTRS but is modified to fit the needs of clinicians working with young patients. It retains items addressing pacing, interpersonal effectiveness/empathy, agenda setting, feedback, homework, strategy for change, focus on key cognitions, guided discovery, collaboration, and technical proficiency. However, the CTRS-CA adds extra items evaluated clinicians’ playfulness, informality, and credibility. Initial reports indicate supervisors’ high levels of satisfaction with the instrument^[83].

The Self-evaluation learning form (SELF)^[83] was originally developed for supervision with psychiatric residents, but it is also applicable to work with trainees from other disciplines. The SELF tracks patient metrics and supervisees’ progress as well as summarizing content from each supervisory session. The worksheet also serves as a reminder for any homework tasks assigned to the supervisee.

Training professionals to become supervisors is an area gaining increased attention. Most recently, meta-supervision is being employed as a training procedure. Meta-supervision is defined as the circumstance where “a highly experienced clinician serves as a consultant to a clinical supervisor^[84].” Essentially, this is supervision of supervision. Meta-supervision works to improve supervision skills, operationalize progress through performance ratings, and offers case management tips^[84].

A useful rubric and accompanying rating scale for meta-supervision is recently available^[25]. The rating scale addresses the supervisory context, aims, session structure, use of educational principles, CBT competencies, feedback, theoretical faithfulness, intervention methods, supervisory relationship issues as well as pacing and timing. The items are scored on a 1 (incompetent)-6 (expert) scale with higher scores indicating greater skillfulness. Further, the Cognitive Therapy Supervision Checklist^[85] is a checklist for supervisors to rate trainees’ competence. The scale evaluates clinical proficiency on various CBT procedures and processes. It explicitly addresses competencies set for by the American Association of Directors of Psychiatric Residency Training (AADPRT).

SUPERVISION OUTCOMES

While clinical supervision is the primary way trainees learn to do psychotherapy, there is minimal literature evaluating its effectiveness^[23]. Effectiveness may be studied in a variety of ways. Outcomes could be operationalized as positive changes in supervisory performance or young patients’ clinical presentations. For instance,

effectiveness could be measured as increases in young people's adaptive functioning or improved symptom scores. Alternatively, good supervisory outcomes could be evaluated in terms of trainees' acquisition/application of skills, fidelity to a treatment approach, and/or self-reflection.

Clinical effectiveness or improved treatment outcome is defined as the "acid test" of good supervision^[86-88]. In a recent study, supervision was found to have a significant moderate effect on clinical outcomes^[88]. More specifically, supervision accounted for 18% of the variance in patient outcomes. This effect is approximately two times the effect size owned by the common factors research^[88]. In general, there is wide agreement that good CBT training on is associated with improved supervisee performance^[74,89,90]. Effective training improves staff performance and technical proficiency^[15].

There is a growing body of research examining the effectiveness of supervision emphasizing self-practice and self-reflection^[90-94]. Self-reflection and self-practice increased trainees understanding of the cognitive model^[91-93]. Additionally, this model of supervision enhanced supervisees' technical proficiency^[90-92]. Finally, supervisees' flexibility was improved *via* this practice^[91].

LIMITATIONS

The majority of work on supervision of cognitive behavioral therapy is characterized by anecdotal reports, case studies, surveys, and quasi-experimental designs rendering the results vulnerable to various threats to internal and external validity. Factors such differential history, maturity, selection bias, and attrition compromise scientific conclusions. Finally, there is significant ambiguity regarding the selection of proper outcome variables or measures. Some investigators propose patient improvement as the gold-standard or acid-test whereas others employ indices reflecting improved skills, knowledge, and attitudes. The unclarity of outcome measures truncates generalizability of results.

RECOMMENDATIONS

Delivering and receiving good clinical supervision in CBT with youth are necessary steps toward improving the care of young patients. Achieving these lofty goals requires deliberate action. Based on the literature reviewed, several recommendations for advancing the science and practice of CBT supervision follows.

Competent supervision for CBT with youth requires that trainers are skillful in both clinical practice with young patients and training inexperienced colleagues. Consequently, supervisors need to be properly credentialed in the approach. Fortunately, credentialing bodies exist (American Board of Professional Psychology, Academy of Cognitive Therapy, British Association of Behavioral and Cognitive Psychotherapy, Oxford University, *etc.*). In short, supervisees are well-advised to seek supervision from documented experts.

Focused attention should be directed to the core content in supervision of CBT with youth. Acquiring and applying didactic and procedural knowledge is essential for trainees. Enactive supervision is highly recommended. Consequently, the opportunity to engage in behavioral rehearsal is key. In an action-oriented approach, practicing procedures is a priority. Behavioral rehearsal seems especially important when training supervisees in exposure techniques. Gaining greater self-efficacy in this crucial intervention may increase more application in clinical settings.

In order to do their job well, supervisors need first-hand knowledge of their students' work and young patients' functioning. Audiotape, videotape, or direct observation of sessions is a preferred pedagogical strategy. Reviewing tapes is commonly anxiety producing to supervisees. Additionally, tape review is time-consuming for supervisors. Finally, taping requires the proper electronic equipment which translates to increased cost to agencies. Perhaps, these are some the reasons that tape reviews are relatively rare in treatment-as-usual settings.

Hiring competent supervisors and creating a training infra-structure that supports best practices in supervision are costly endeavors. Good training efforts should be scalable and reach as many practitioners as possible. In an environment where lean budgets are pervasive, scalability of training is clearly linked with economic considerations.

Administrators, clinical supervisors, and front-line staff should be on the same page regarding the value of good supervision. However, often these multiple stakeholders are at odds with each other. Administrators worry about the loss of revenue when staff are engaged in activities that do not involve reimbursable clinical encounters. Staff then become concerned about their ability to meet productivity benchmarks if they take time away for supervision. Advocates for better supervision and training must persuade stakeholders that these educational activities are good returns on their investment of time and money. The studies listed in the supervisory outcome section offers a nice launching pad for arguments regarding returns on investment.

This therapeutic advances article made the case for providing competent supervision to clinicians conducting CBT with youth. The value of supervision was delineated. The core elements of supervision of CBT with youth were outlined and the fundamental supervisory processes were discussed. Finally, a sample of supervisory outcome studies were summarized. Ideally, this contribution in therapeutic advances spurs academicians, clinicians, and behavioral health care administrators to fully invest in competent supervision of clinicians who provide CBT to young patients.

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