A Problem in Our Field

Making Distinctions Between Evidence-Based Treatment and Evidence-Based Practice as a Decision-Making Process

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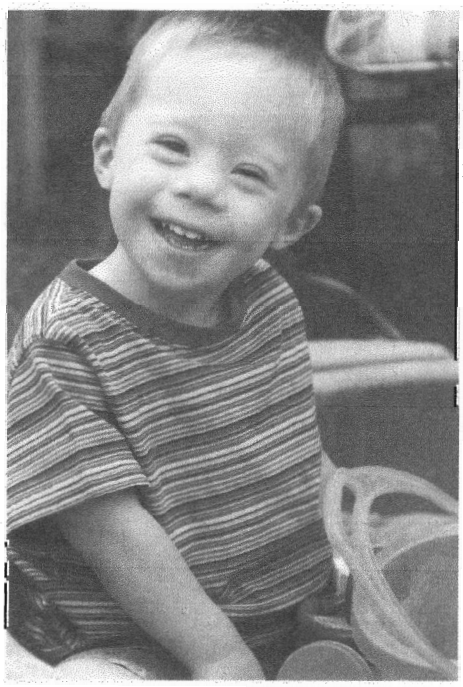
The term *evidence-based treatment* (EBT) is often used synonymously with the term *evidence-based practice* (EBP). If a practitioner is applying an EBT, it is assumed that one is "practicing" the evidence. Within the infant–family and early childhood field, this confusion threatens the quality and appropriateness of services provided for infants, young children, and their families. In this interdisciplinary field, practitioners share a desire to provide services that are developmentally appropriate, grounded in sound theory, and support children and families in achieving and maintaining lifelong optimal health and well-being. This shared desire drives practitioners to exclusively use EBTs in infant–family and early childhood work, without understanding that EBTs are only a part of the more useful concept of EBP.

What EBTs Offer...And What They Don't

PRACTITIONERS RECOGNIZE THE importance of research on treatment, where they define what they are doing, to whom, for what purpose, and how they are measuring outcomes. Thus, EBTs are typically discreet, manualized, or prescriptive approaches to care that have been researched and replicated to determine their effect in specific conditions (e.g., high risk, low socioeconomic status), with a specific diagnosis (e.g., depression), or with a specific discipline of provider (e.g., educator, psychotherapist, nurse), or a combination of these. Use of EBTs requires fidelity to the approach with limited latitude for tailoring to meet the unique needs of the child, family, and context. Still, EBTs technically require a specific presenting condition, diagnosis, or history in order to use the intervention, such as a history of trauma, low socioeconomic status, being a primipara under 28 weeks gestation, or being a child in a divorcing family. So although EBTs can be shown to be effective in these specific circumstances, they rarely address the richness and complexity of the family with multiple challenges, conditions, or risks, and are often directed at outcomes that may not be those the family is seeking or the



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clinician is hoping for. The structure of EBTs emerging from singular diagnostic criteria and narrow contexts risks mismatches with the complex families practitioners serve. Over the course of about 25 years, the recognition of this limitation in the broader fields of clinical science have led to a more functional conceptualization of how to understand and use research in a manner that can be applied to real clinical situations. This more global and functional approach is referred to as an EBP decision-making process.

The History and Definitions of EBP

THE CONCEPT OF EBP grew from the work of Bennett et al., 1987; Bennett & Bennett, 2000; Graham-Smith, 1995; Malterud, 1995, 2006, and others, and was conceptually advanced by Sackett et al. in 1996 noting the problems inherent in relying on either research alone or on subjective clinical judgment alone. Sackett's concerns are now considered prerequisite to true informed consent and were adopted in 2001 by the nonpartisan American Academy of Sciences Institute of Medicine. The Institute of Medicine's decision-making process integrates three prongs: (a) the best of what research and published findings can provide; (b) the best of professional wisdom, judgment, and experience; and (c) the desires and consent of the family (Sackett et al., 1996). While other professional organizations have adopted the Institute of Medicine's definition into their philosophical statements, Buysee and Wesley (2006) have led the way in applying this definition of EBP to the early childhood field, in the context of working with infant caregivers.

The professional culture that limits practice to static lists of EBTs serves to undermine critical thinking and integrated clinical wisdom (theory and practice), and can disenfranchise the families practitioners are trying to help. Practitioners are robbed of the right to weigh several factors at once while working within complex, contextual processes with a family and lose the scientific enterprise of a hypothesis-driven formulation that is systematically reviewed and inevitably shifts dynamically as cases unfold. EBP as a decision-making process offers the best approach to complex situations, and more so to protect families from the tyranny of static lists on the one hand and the tyranny of unfounded practices on the other.

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EBP offers the most efficient use of limited resources in difficult economic times by flexibly matching treatments to situations, avoiding inefficient mismatches that result in poor outcomes.

Mismatches Between EBTs and Clinical Practice

BELOW WE REVIEW some of the ways in which the sole use of EBTs creates clinical dilemmas to highlight the importance of understanding and using EBP.

Developmental Versus Chronological Age

EBTs may require capacities on the part of the child or parent linked to chronological age, such as the child having a coherent narrative, but may neither require nor prepare the provider of the EBT to determine the child's or parent's developmental age across domains relevant to the treatment. Often, providers of an EBT are not educated in the stress arousal continuum and the need to observe during each session for changes in functional developmental age based on activation of the arousal system.

Some models of care provide a more global EBP approach, such as Brazelton's Touchpoints Model (Brazelton,1992; Brazelton, O'Brien, & Brandt, 1997), Perry's (2006; Perry & Hambrick, 2008) Neurosequential Model of Therapeutics (NMT), and the Neurorelational Framework by Lillas and Turnbull (2009). These models support providers in understanding development and building therapeutic alliances. For example, Brazelton's Touchpoints approach offers an understanding of disorganizations and functional regressions before each step in a child's development, and helps providers discern typical developmental disorganization from worrisome deviations and consider the meaning of this to the parent. Using the model's relational components, parent and provider co-construct a therapeutic direction. While Touchpoints in general is an EBP, applications of Touchpoints in specific settings and populations, such as Touchpoints-based home visiting, can be EBTs.

The NMT (Perry, 2006) provides an integrated understanding of the sequencing of neurodevelopment embedded in the experiences of the child and supports biologically informed practices, programs, and policies. Coupled with the NMT's brain mapping matrix, this global EBP model guides providers to identify specific areas for therapeutic work, selecting appropriate therapies, including EBTs, within a comprehensive therapeutic plan. NMT-based interventions, such as NMT therapeutic child care, can also be EBTs.

Lillas and Turnbull's (2009) Neurorelational Framework also offers a functional approach to brain mapping, wherein four brain systems allow one to look at multiple dimensions at the same time. Within these brain systems, distinctions between "bottom-up" and "top-down" aspects to neurodevelopment are emphasized. Bottom-up processes

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For the sake of the children and families practitioners serve, they must safeguard and staunchly adhere to EBP as a decision-making process.

include nonverbal and automatic habits, routines, and reactions to relationships, while top-down processes include verbal and cognitive capacities with the ability to inhibit behavior. This distinction allows providers to clinically match EBTs and other salient clinical perspectives to the child and family's neurodevelopment.

Static Lists of EBTs Versus Informed Consent and Professional Wisdom

Global EBP often includes EBTs and helps families decide which EBT might be the best fit. Perhaps a family with a child that has experienced severe trauma is working to decide between Trauma-Focused Cognitive Behavioral Therapy and Child Parent Psychotherapy—both of which are EBTs. In the current fiscal climate, a therapeutic approach may be offered to a family with limited latitude on the part of the agency to take into consideration multiple diagnostic possibilities and neurodevelopemental needs of the child and family. This may happen because of reimbursement restrictions, because the agency is invested in only one therapeutic approach, because clinicians are trained in a single therapeutic modality, etc. Regardless of the cause, the role of the provider is not simply to offer what the agency can provide but to think with the family about each approach, discuss what the intervention looks like in a session, the cost and who pays, relevant issues like transportation and child care, how the family feels about the proposed type of therapy (e.g., Parent-Child Interaction Therapy, Floortime, speech and language therapy), explore issues related to stigma or concerns about therapy, and to be with the family as a decision is made. It is crucial to have an understanding of whether a more affectively driven approach (Child Parent Psychotherapy) or a cognitively driven perspective (Trauma-Focused Cognitive Behavioral Therapy) provides the best neurodevelopmental match for the client and family. This process lies at the heart of informed consent.

EBP is critical for children with autism spectrum disorders. Therapeutic options might include DIR/Floortime, Applied Behavior Analysis, Discrete Trial Training, specialized speech and language (communication) therapy, occupational therapy for sensory processing and praxis, parent training, and school placements of various kinds. All have evidence to suggest effectiveness in certain circumstances. Some are listed on national and statewide lists of EBTs. How to choose? In EBP, the provider must understand the research on these options, know who is judging the studies, and how the circumstances in the published studies resemble a specific child and family. Providers work with the family to understand how they are coping and what type of program they might want. This is the critical juncture where providers offer their clinical experience and judgment about what might be a good match.

The above are abbreviated examples of EBP as an advanced, dynamic, state-of-the-art practice, far more complex and multifaceted than providing an EBT. Consider the needs of child with intrauterine malnutrition, physical abuse after birth, multiple placements, no opportunity to attach, having experienced profound neglect, and now severe developmental delays. No single EBT can address all these challenges. The commitment of the provider to think globally and developmentally about this child, work thoughtfully and respectfully with her caregivers, to share professional wisdom, and jointly create a developmentally grounded therapeutic plan is at the heart of EBP.

EBPs in Policy and Practice

EBP offers the most efficient use of limited resources in difficult economic times by flexibly matching treatments to situations, avoiding inefficient mismatches that result in poor outcomes. Given the impact of a well-documented global economic crisis on community resources and support for very young children and their families, a widespread scarcity of services and access to treatment has increasingly been a tragic shared experience. Waiting times for psychiatric consultation can be several months, dyadic psychotherapies may be unavailable in a given region, and eligibility requirements for some treatments are becoming more stringent. These diminished resources only intensify and complicate the presenting problems. The use of EBP as

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Weighing the Evidence: Evidence-Based Practice & Evidence-Based Treatments in Infant Mental Health

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The book *Infant & Early Childhood Mental Health: Core Concepts & Clinical Applications* is scheduled to be published by American Psychiatric Publishing early in 2013. With chapters authored by specialists from a wide variety of disciplines, this book will offer cutting-edge information on neuroscience, theoretical foundations, and assessment and intervention in this vital and expanding field.

a decision-making process helps providers and policymakers engage in more completely informed determinations related to multiple complex variables such as service frequency, type, access point, location, and other relevant aspects of care for the ultimate benefit of the child and family who seek assistance. Through appreciating the dynamic tension between the three strands of EBP, practitioners can help a family select developmentally appropriate and effective treatment approaches that they can embrace. Then practitioners stand the best chance of alleviation of distress and restoration of health and well-being.

EBP can exist without use of an EBT, but EBTs are sadly often delivered without being grounded in EBP. Practitioners can no longer allow the term EPB to be co-opted and used interchangeably with EBT. While the field is rich with EBTs, practitioners must remain committed to a practice that includes the best of research, the wishes and desires of the family, and the best of professional wisdom. For the sake of the children and families practitioners serve, they must safeguard and staunchly adhere to EBP as a decision-making process. It is in weighing all three forces that a practitioner can provide an individualized decision with the clear understanding that the "evidence does not make decisions, people do" (Haynes, Deveraux, & Guyatt, 2002, p. 1350).

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