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Abstract: Professionals in the child trauma field, eager to bring best practices to children and their families who have suffered from traumatic life events, have developed a number of evidence-based treatments (EBTs) and promising practices available for adoption and implementation into community practice. Clinicians and researchers alike have raised questions about "if, when, and how" these EBTs can be applied to some of the more complex trauma presentations seen in real world practice. The authors take an evidence-based practice approach, including critical appraisal of clients' unique needs and preferences, utilizing applicable trauma treatment core components and current EBTs, and emphasizing monitoring strategies of client progress, particularly when needing to adapt EBTs for select clients. [ABSTRACT FROM AUTHOR]

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Treatment Considerations for Clinicians in Applying Evidence-Based Practice to Complex Presentations in Child Trauma

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Professionals in the child trauma field, eager to bring best practices to children and their families who have suffered from traumatic life events, have developed a number of evidence-based treatments (EBTs) and promising practices available for adoption and implementation into community practice. Clinicians and researchers alike have raised questions about "if, when, and how" these EBTs can be applied to some of the more complex trauma presentations seen in real world practice. The authors take an evidence-based practice approach, including critical appraisal of clients' unique needs and preferences, utilizing applicable trauma treatment core components and current EBTs, and emphasizing monitoring strategies of client progress, particularly when needing to adapt EBTs for select clients.

Perhaps the proper attitude toward Evidence Based Treatment (EBT) is one of respect but not reverence.

Miller, Zweben, and Johnson, 2005, p. 274

According to David Sackett (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996), pioneer of the evidence-based medicine movement, evidence-based practice is "the judicious, explicit, & conscientious use of the evidence base to guide one's clinical practice" (p. 71). In other words, clinicians are asked to integrate the best available research evidence while using their clinical expertise and taking into consideration their patient's unique values and circumstances (Sackett, 1997). This requires flexibility and the wisdom of clinical judgment to individualize one's approach. Evidence-based practice typically incorporates systematic assessment, requires clear articulation of treatment goals, and implementation of core components of the treatment in combination with ongoing monitoring and outcome assessment. This approach asks that clinicians

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articulate, define, monitor, and refine their approaches. This skill is invaluable in the face of the complex cases clinicians often encounter.

In this article, we provide a brief overview of the current evidence base for child trauma treatment and an examination of the mental health debate regarding the adoption of evidence-based trauma treatments in day-to-day practice. We will describe how a particular group of community-based clinicians have thoughtfully and purposefully tackled the challenges of adopting evidence-based treatments, and reflect on some of their thoughts on how to apply current evidence-based treatments (EBTs) to the more complex scenarios they encounter in their day-to-day practice. The authors suggest that using Sackett's evidence-based practice approach serves not only to guide clinicians treating complex trauma scenarios, but also to facilitate further development of empiric treatment approaches for child and adolescent survivors of chronic interpersonal trauma and maltreatment.

There are multiple EBP advocates who have written articulate arguments in support of a scientific approach to improve the quality of mental health care (e.g., Levant, 2005; Weisz, Jensen-Doss, & Hawley, 2006). Clinicians and clinical researchers alike have described the benefits of collaborative, comprehensive training, and consultation in community practices implementing EBT (e.g., Gotham, 2006; Katon, Zatzick, Bond, & Williams, 2006; Schmidt & Taylor, 2002). In a comprehensive review, Weisz et al. (2006) found that EBTs for youth with a variety of psychological difficulties were generally better than youth in treatment as usual. Weisz and his colleagues examined a number of moderating variables, including treatment provider (research clinic vs. community practice), ethnicity, comorbid diagnoses, and severity of symptoms, and reported that with modest effects EBT repeatedly outperformed treatment as usual.

In the trauma field, randomized controlled trials (RCTs) with chronically traumatized youth are starting to emerge that highlight the benefits of specific interventions and practices. For example, with preschool children living with domestic violence Lieberman, Van Horn, and Ippen (2005) have demonstrated that child–parent psychotherapy, compared to individual treatment in the community, significantly improved psychiatric symptoms in both mother and child. Cohen, Deblinger, Mannarino and their colleagues have several studies with sexually abused children, many of whom have other co-occurring traumas (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen, Mannarino, & Knudsen, 2005) and found that compared to supportive psychotherapy, trauma-focused CBT (TF-CBT) yielded significant improvements in trauma-related domains after 3 months, which were maintained 1 year later. Stein et al. (2003) had success with a school-based trauma-specific CBT approach (cognitive behavioral intervention for trauma in schools; CBITS) with sixth graders exposed to violence who reported significantly fewer PTSD symptoms compared to the wait-list control group. Among physically abused youth, Kolko (1996) demonstrated significant improvements with both individual CBT and family therapy compared to routine community services that were maintained at the 1 year follow-up. Also working with families, parent–child interaction therapy (PCIT) clinicians have successfully decreased future abuse reports compared to parenting groups in the community (19% vs. 49%; Chaffin et al., 2004). Treating older youth, Najavits, Gallop, and Weiss (2006) have conducted the only RCT with traumatized adolescents and found significant improvements compared to treatment as usual across a number of variables including trauma-related symptoms, substance use, problematic cognitions, somatization, and eating disorders.

A number of promising practices in child trauma are also being evaluated as part of ongoing research projects and/or pilots in the field. Some of them include similar core components, but are adapted for specific trauma populations or operationalized in different ways. Others incorporate EBTs originally designed for other populations (delinquency, borderline personality disorder, foster care) and adapt them in their work with traumatized youth. Others emphasize different components of trauma-specific treatment altogether. For example, although the traditional CBT focus may be on managing stress and fear and changing cognitive distortions, some promising practices focus more on

current functioning, social problem-solving, attachment, and problems in interpersonal relationships (Ford, Courtois, Steele, Van der Hart, & Nienhuis, 2005). A number of these promising practices are specifically delineated later in this article.

While the research literature slowly grows in the area of mental health interventions, funding agencies, foundations, and state initiatives are working to disseminate EBT. A number of health services research initiatives have begun studying this process, but much remains unanswered with significant debate over the merits and sufficiency of disseminating evidence-based treatment practices. At its worst, EBT has been described as an inflexible, cookie-cutter approach, blindly following research findings without regard for the best needs of a particular client (see Chaffin & Friedrich, 2004, for more information on the debate). Westen, Novotney, and Thompson-Brenner (2004) point out that EBT is often misused as a dichotomous variable (empirically informed or not empirically informed) with little regard for how much we do not know about what works with whom and under what circumstances. Noteworthy EBT studies raise important questions in the following areas: (a) problematic design and reporting practices of RCTs, (b) what constitutes evidence and how it may apply to a clinical case, and (c) whether the significant outcomes reported are always functionally significant or meaningful in a particular child's life (see Jensen, Weersing, Hoagwood & Goldman, 2005; Kazdin, 2006; Miller et al., 2005; Westen et al., 2004). For a noteworthy review of EBP in mental health implementation issues see Barwick, Boydell, Stasiulis, Ferguson, Blasé, & Fixen (2005).

Trauma clinicians in the community, like clinicians across the country, have debated the issues around EBT as it applies to their clients, particularly those with the more complex presentations. Fixen, Wallace, and Naoom (2005) identify field clinician's top five reasons for not using evidence-based programs as (a) the research base is not convincing, (b) they are difficult to implement, (c) they require too much change, (d) they are incomplete given the problems we face, and (e) the infrastructure for implementation does not exist or is not supported. It is important to note that the majority of the reasons, three out of five, are implementation problems. Research and training must address challenges to implementation and we reference these here; however, our primary focus in this article is to begin to address the other two reasons. Within the child trauma field, interesting questions are also being raised among those who are treating severely dysregulated traumatized youth and implementing EBT. The questions include "What about comorbidity?"; "What about translation, or applicability to populations not used in the original studies?"; "What about when components of one treatment are necessary, but insufficient to treat an individual client?"; and "What about when caregiving is compromised, leaving an inadequate holding environment to support the child?" Here we will describe the ways in which the trauma field is beginning to address these questions for child and adolescent survivors of chronic interpersonal trauma and maltreatment.

LEARNING FROM RESEARCH AND CLINICAL PRACTICE

Miscommunication and varying definitions of what constitutes EBP seem to have created frustration, disdain, and at times, have drawn arbitrary lines in the sand among researchers and clinicians alike. One thing does seem clear; to develop effective treatments that can be transported across a wide range of cultures and regions, clinicians and researchers must partner together. The National Child Traumatic Stress Network (NCTSN) funded by the Substance Abuse at Mental Health Services Administration (SAMHSA), was designed to support such collaboration to enhance the quality of care of traumatized children. The NCTSN is a diverse group of 69 sites across the United States that includes researchers and clinicians, working together to develop, disseminate, and enhance trauma-specific EBT and promising practices (PP). While this effort is still being evaluated, agencies across the Network have used state of the art adoption and implementation strategies (Agosti et al., 2007) to support trauma-specific practices. There are many lessons to be learned from their successes and failures. There were significant adjustments on the part of both the clinician and model delivery that

enabled their success. It is no small feat for agencies to take this on—the administrators and the clinicians alike must recognize that the preparation and planning to integrate and support a new practice into their programs requires much more than a training session and some consultation. And yet, despite all of the obstacles, community practice sites across this Network have begun successfully implementing and delivering services to children using evidence-based models, achieving both the clinical competence and the implementation capabilities as measured by fidelity checklists, model-specific supervision ratings, documented use of model components in charts, and consultation calls with expert trainers. By all intents and purposes, this may be child trauma's highest success level of EBT adoption and implementation efforts to date. So, for the topic at hand, what are community clinicians such as these, well educated in trauma-specific EBP, doing when they encounter the most complex clinical presentations in children?

Over the last year, the NCTSN coordinating center, the National Center for Child Traumatic Stress, has organized several focus groups with clinicians, administrators, and supervisors from several sites, who were implementing at least two or more evidence-based and/or promising practices (see www.nctsnet.org). Field clinicians participating in these focus groups, from community clinics, schools, and residential settings, readily attest that complex presentations are part of everyday clinical practice. Complex presentations refer to the multiple symptom sets and adaptations that children and adolescents of chronic multiabuse and multitrauma commonly experience to cope with ongoing chaotic environments and extreme stress. Furthermore, these field clinicians attest that, for the most part, the EST models are useful and effective.

Key features of protocols found in the latest EBTs and PPs have an important history and foundation in the child trauma literature dating back to the 1980s and 90s (see Berliner & Saunders, 1996; Cohen & Mannerino, 1996; Deblinger, Lippmann, & Steer, 1996; Friedrich, 1996; Gil, 1991; James, 1994; Kolko, 1996; Layne, Saltzman, Savjak, & Pynoos, 1999; March, Amaya-Jackson, Murray, & Schulte, 1998; Pynoos & Eth, 1986; Pynoos, Steinberg, & Wraith, 1995; Terr, 1989; Yule & Canterbury, 1994) Having learned from both research findings and clinical practice expertise, our field appears to recognize a number of core components as critical to treating child trauma and promoting children's developmental progression. Looking across the assortment of the EBTs and PPs available, one could argue that many of them have operationalized similar core components. These components include psychoeducation, management of anxiety and trauma reminders, trauma narration and organization, cognitive and affective processing, problem solving regarding safety and relationships, parenting skills, and behavioral management (imported and adapted from a strong nontrauma empirical base), addressing grief and loss, emotional regulation, and supporting youth to resume developmental competencies that may have been delayed or lost. Developers of EBTs took a hand at operationalizing these components and have moved our field forward by showing positive outcomes in the way they have packaged them that supports systematic delivery to children and their families. These core components, present in many EBTs, highlight the important skills that child trauma clinicians should consider essential best practice knowledge.

Across the Network, clinicians have utilized trauma-specific EBTs, applied with fidelity, conscientious thought, and supervision, which they report has transcended practice and outcomes. However, the thoughtful ways in which agencies, their individual clinicians, and their supervisors have applied these models to the more complex presentations is anything but plain and simple.

USING CRITICAL APPRAISAL IN EVIDENCE-BASED PRACTICE

One of the fundamental skills required for practicing evidence-based medicine is the asking of well-built clinical questions (Oxford Centre for Evidence-Based Medicine, 2001). To benefit patients and clinicians, such questions need to be both directly relevant to patients' problems and phrased in ways that direct your search to relevant and precise answers. In medical practice, well-built clinical questions usually contain the four elements summarized

Table 1. Tips For Using Critical Appraisal in Child Trauma Treatment

	Client or problem	Intervention (A cause, prognostic factor, treatment, etc.)	Comparison intervention (If necessary)	Outcomes
Tips for Building	Starting with your client, ask "How would I describe a group of clients similar to mine?" Balance precision with brevity	Ask "Which main intervention am I considering?"	Ask "What is the main alternative to compare with the intervention?	Ask "What can I hope to accomplish," or "what could this adaptation really affect?
		Be specific	Again, be specific	Be specific
Examples	"In an adolescent with a chronic history of abuse who is triggered by traumatic reminders & engages in aggressive & risk taking behavior. . .	". . . would adding additional sessions on coping strategies for emotional and behavioral stabilization for present day problems. . . "	". . . before implementing narrative trauma work. . . "	"lead to a decrease in aggression, an increase in interpersonal functioning & greater sense of control? Is this worth the risk of delaying exposure or narrative techniques to address intrusions?"

Note. From Oxford Centre for Evidence-Based Medicine. (2001). Retrieved January 10, 2007, from www.cebm.net/focus_quest.asp. Adapted with permission of the Oxford Centre for Evidence-Based Medicine.

in Table 1 (Oxford Centre for *Evidence-Based Medicine,* 2001). To illustrate these elements, the medical example from the Centre for Evidence-Based Medicine Web site has been modified to reflect a trauma-specific example with an adolescent client.

As is specifically outlined in medicine, systematically and routinely forming specific questions as described above could also guide the search for information in one's clinical work in mental health. To do evidence-based practice, the practitioner must employ critical appraisal skills and critical thinking—of the research base, the treatment models, and their applicability to the specific, perhaps complex, scenario of their clients. *Critical appraisal* refers to the process of answering the question, "How good or strong is the evidence for that?" when evaluating evidence, which includes clinical observations, assessments, the literature, or other sources. *Critical thinking* is the ability and willingness to assess evidence, to seek contradicting and confirming information, to monitor one's biases, and to make objective judgments based on well-supported reasons (Gay, 1998; Last, 2001). Although the child trauma field is at a much earlier stage of scientific scrutiny compared to evidence-based medicine, it is nevertheless essential that clinicians have knowledge and understanding of a variety of treatment models and the range of evidence supporting them, so that they can indeed appraise them and thoughtfully apply them. Clinical textbooks, research studies, and the clinically wise, espouse the critical nature of solid assessment for treatment planning. Appropriate assessment measurement to use in child trauma is beyond the scope of this article. Nevertheless, critical thinking and critical appraisal skills about what intervention models to use should extend to the assessment. Complex child trauma histories demand a full understanding of the child's traumatic experiences, what Pynoos (personal communication, October 6, 2006) has described as the child's "trauma history profile." Children with multitrauma experiences, have symptom pictures that are influenced by multiple risk factors that also include the duration, dose, number, nature, and subjective experience of the trauma. Diagnostic considerations include, but extend beyond the severity of posttraumatic stress symptoms. This is particularly true in the case of abuse and neglect with consequential attachment disruption and multiple placements.

Health services effectiveness research has impacted the field with a growing demand for outcomes-oriented

practice using posttreatment evaluation, and more and more clinicians and community agencies are using posttreatment measurement to evaluate treatment success. Developmental impact should be addressed in considering pretreatment assessment. In looking to analogies to the approach of our colleagues in medicine, who monitor blood work and laboratory studies, is there analogous monitoring and assessment along the mental health treatment path? As clinicians working with complex clients, is this not the place where twists in the clinical case should most emphasize the need for tracking by monitoring? If so, are our assessment measures brief enough and sufficiently sensitive to change to allow clinicians the feedback they need to determine what aspects of treatment are working and what are not? Although it is the research field that must address these questions, we believe that community clinicians, in accepting or challenging the use of empirically based treatment models in the practice, should monitor treatment progress along the way. Because the current science cannot fully inform clinical choices, it becomes even more critical to monitor and assess outcomes throughout treatment.

CRITICAL APPRAISAL WITH ADOPTION & ADAPTATION IN COMMUNITY PRACTICE: IMPRESSIONS FROM COMMUNITY AGENCY CLINICIAN FOCUS GROUPS

Although the process has not yet been systematically captured and defined, NCTSN clinicians and their supervisors are actively engaged in critical thinking and critical appraisal skills to adopt and adapt treatment models in interesting ways. Community agencies and individual clinicians report that when faced with clients with complex clinical presentations there are a number of recommendations they might find necessary to make when applying many of the EBTs. Some of the suggestions include (a) initiating what they label as "prework" prior to the implementation of a specific EBT treatment; (b) expanding the treatment modules to incorporate other elements that may be necessary; (c) continuing to apply model components well beyond the processing of the trauma itself and its immediate consequences, and (d) adding/integrating other empirical treatment models into the treatment plan.

These recommendations may have emerged, in part, given there are several areas that are addressed less frequently or in less depth in many RCT treatments to date, including areas that focus on (a) emotion dysregulation with feelings of intense rage and shame, (b) behavioral dysregulation including aggression and risk taking, (c) attachment issues and the impact of attachment disruption, and unstable, chaotic relationships, (d) self-efficacy and self-perception, especially for adolescents, and (e) lack of purpose and meaning in life. Youth struggling in these areas of functioning often have severe dysregulation of self-systems that permeates their lives and significantly and repeatedly impacts their ability to engage in treatment and achieve a sense of stability and safety. The RCTs are hard pressed to include components that address the difficult, often time-consuming self-reflection, affective and behavioral regulation, and relationship navigation skills though a few have done so successfully (e.g., Lieberman et al., 2005).

Clinicians in the NCTSN focus groups noted that EBT models are particularly difficult to apply to their work with children who have neglect and abandonment histories as these children's trauma histories are often incomplete, lack a discrete event, and hence a narrative is hard to do. They found EBT model assumptions are sometimes problematic: They assume that a child can quickly learn strategies to self-regulate, that the caregiver is self-regulated or can get that way soon, that caregiver capacity and attachment issues will be adequately addressed by enhanced parenting skills or alternatively a referral to therapy for themselves, or that a child's innermost sense of safety (the kind that will enable him to sleep peacefully through the night) is addressed by a classic safety plan.

Adaptations for Chronic Emotional and Behavioral Dysregulation

Initiating a kind of prework that focus group members described with individuals coping with the complicated sequelae of chronic, interpersonal trauma actually has a long history that, Ford and his colleagues (2005) point

out, began with Pierre Janet and has been described as phased-based treatment in both the adult and child literature (e.g., Briere, 2002; Cloitre, Cohen, & Koenen, 2006; Cook et al., 2005; Ford & Kidd, 1998; Courtois, 1999; McCann & Pearlman, 1990; van der Kolk, Pelcovitz, Roth, Mandel, McFarlane, & Herman, 1996). Ford et al. (2005) outline three phases of treatment, each important components of the work; they include (a) engagement, safety, and stabilization, (b) recalling traumatic memories, and (c) enhancing daily living. Clinicians in the NCTSN focus groups, in describing what they meant by *prework*, gave several examples of strategies for Phase 1 stabilization they would use, most of which included adding several sessions to target self-regulation—perhaps using mindfulness, yoga, modules on biofeedback, or stabilization on medication.

Questions that clinicians raised in group discussions during the focus groups include "Sometimes it's hard to know when to move on to the next phase of treatment—do I expand each module till the client 'gets it' or just move on?," "Is it just our agency, or does everyone struggle with how to handle treatment components when a client experienced multiple traumas of varying intensities and duration?," and "When is good enough treatment in evidenced-based practice?" (see Acknowledgments). These clinicians debated when to use narrative models (exposure paradigm) versus nonnarrative models. Several clinicians described running a present-focused, nonexposure-based group EBT and adding individual treatment with narrative exposure for select clients they felt needed it.

Another set of strategies that many of the clinicians described was simply extending the duration of select modules beyond the normal time frame or expanding select modules with added components. A coping skills module that heavily emphasizes relaxation skills might be expanded to include additional exercises on mindfulness. As a prerequisite to facilitating trauma narration and cognitive processing, a therapist may feel a client would benefit from more intense autoregulation tactics in addition to basic feelings identification and coping skills. This is thoughtful application, adaptation, or augmentation of EBTs—and not what some might argue to be deviation. Perhaps most logical, but rarely discussed in writing by treatment developers, is the recognition by community clinicians that the more complexly traumatized children and families will continue to need model components applied well beyond the processing of the trauma and its immediate consequences. Many youth need additional time in treatment to support generalization of coping strategies, and affect regulation and application of adaptive cognitions and emotions. Interestingly, in her work with trauma therapists implementing several different treatment protocols, Najavitz et al. (2004) found that 68% of clinicians wanted treatment to be longer. Regrettably, treatment length and content can be driven by funding sources for research and trends rather than client needs.

Focus group clinicians described the importance of working with the child's caregivers to address their own dysregulated emotions and behaviors that significantly impair their ability to support the child. Focus group members also found success with pairing complimentary models by beginning one specific evidence-based model before the application of another model. Examples include completing dialectical behavior therapy or a parent management model prior to implementing a trauma-specific cognitive–behavioral model. Clinicians might use an attachment focused model, such as Real Life Heroes (Kagan, 2004), prior to using a trauma-processing model such as TF-CBT or Life Skills/Life Story (Cloitre et al., 2006).

Clinicians and their supervisors pointed out that therapeutic process variables like therapeutic alliance are often inadequately addressed by treatment developers. Hohmann (1999) has argued for research models to better operationalize these variables rather than allocate their effects to error variance. Researchers have demonstrated that the therapeutic alliance is directly related to treatment outcome. In a meta-analysis of 79 adult studies on therapeutic alliance (Martin, Garske, & Davis, 2000), the relationship between alliance and outcome was moderate and consistent, despite the influence of other variables. Although no studies to date have examined the relative importance of the therapeutic alliance in predicting positive outcomes for traumatized children, there is consensus by

researchers and clinicians that it is essential for successful treatment and a critical focus in training efforts. In point, treatment developers for a cognitive–behavioral treatment for sexual abuse expanded their discussions regarding engagement and therapeutic alliance into their manual and trainings based upon feedback from community clinicians (J. A. Cohen, personal communication, March 24, 2004). In addition, some treatment models discuss the therapeutic alliance as not simply a prerequisite, but also as a strategy for treatment intervention to assist the client with emotion regulation (see Ford et al., 2005; Miller, Rathus, & Linehan, 2006).

Although this array of strategies is usually applied on a case by case basis, some clinicians report their agencies (more than one) have actually systematized clients use of EBTs by offering two tracts upon client intake: (a) one tract for clients who are ready to begin an EBT from a preassessment set of criteria, and (b) another tract for clients not ready for EBT who require much more case management or attention to client stabilization and less-structured applied trauma treatment components than a strict protocol may allow. One site has developed a specific manualized treatment that systematizes this in an assessment-driven approach (Taylor, Gilbert, Mann, & Ryan, 2006). Notably, it is the models that clearly label complex trauma presentations as part of their target population, which are apt to have the stabilizing, emotion-regulating, often dialectical or alternatively attachment-oriented components that usually require a longer duration; whereas some of these models have an efficacious ranking behind them (Lieberman et al., 2005), many are newly developed promising practices still gathering an evidence base intent on filling the gaps in the current science base (e.g., ARC, Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005; integrative psychotherapy for complex trauma, Lanktree & Briere, 2003; Life Skills, Life Story, Cloitre et al., 2006; Real Life Heroes, Kagan, 2004; SPARCS, DeRosa & Pelcovitz, in press; TARGET, Ford & Russo, in press; trauma systems therapy, Saxe, Ellis & Kaplow, 2006; trauma systems therapy for adolescent substance abused, Suárez Saxe, Ehrenreich, & Barlow, 2006).

Balancing Fidelity and Adaptation: Using Critical Appraisal Skills

Although our field's very strong models, particularly those emphasizing trauma-specific cognitive–behavioral strategies and parent management training, are absolute critical tools for treating traumatized children in the community—including those with complex presentations, it is not surprising and is to be expected, that clinicians encounter scenarios these models cannot always fully address. The focus group discussions provide a window into the critical appraisal skills of seasoned clinicians educated in the EBT for traumatized children who creatively, thoughtfully, and routinely assess and evaluate what phase and treatment components best fit the needs of their clients. These clinicians stated that they were intrigued by the notion of evidence-based practice as a verb, and agreed that much of their struggle to discern the most appropriate course in treatment planning followed this rubric. However, individually and as a group, clinicians expressed a wariness about being too eclectic in defining what is evidence-based practice—fearing that a nonsystematic application of clinical knowledge to treatment would lead to less-effective outcomes. These clinicians, many of them senior leaders in their agencies with years of experience, were very supportive of evidence-based practice, and actively looked for systematic ways to integrate EBTs into day-to-day practice. When the most complex situations challenged this, they posed informed, specific questions, emphasized clinically savvy grounding, and were eager for scientific debate on what would be considered best practice in these scenarios.

These trauma treatment clinicians emphasize evidence-based practice in their work and as much as possible, utilize supervision, peer support, and fidelity checklists in treating clinical cases along a wide range of clinical complexity. Faced with the more complicated symptom picture of children with horrendous histories of abuse, community violence, and psychosocial adversity that includes nonconsistent caregivers and ever-changing chaotic environments, they must pull from a wide repertoire of knowledge and resources. Although not in favor of dismantling or

abandoning EBT models to treat complex cases, they propose that evidence-based practice may require expansion of modules, adjustment and tweaking, and pairing models with other evidence-based models, promising practices, and clinical strategies. They wonder, as the field should wonder, can clinicians, seasoned in EBTs, be able to conscientiously apply key aspects of key models and still be considered doing evidence-based practice?

Sackett's definition allows the individual clinician to make that determination; however, the literature begs these same questions be asked, be researched, and be answered, defining what is fidelity versus deviation. Nock, Goldman, Wang, and Albano (2003) make the case that EBTs can and should be flexible—that tailoring to a client's needs is not the same thing as modification of a treatment model. Lipman (2006) points out, "it is often forgotten that evidence based medicine is not the same thing as 'implementing the findings of research'" (p. 270). Najavits et al. (2004) found that although trauma therapists reported high satisfaction and comfort (71–93%) with implementing manualized treatment protocols, only 40% reported they were likely to implement the treatment again without modification. There is research to support that, as one would expect, a flexible approach, sensitive to the needs of the client yields better outcomes (see Levant, 2005). Nock et al. (2003) do emphasize the importance of follow-up assessment when modifying treatment protocol; they describe necessary modification as analogous to selective use of medications off-label. These recommendations are strikingly analogous to the mandate of the physician, who in encountering the complex medical presentation, may necessarily tailor or modify a given protocol given the medical needs of a patient, while conscientiously following concomitant bloodwork or lab studies to insure the progress of his or her patient.

CONCLUSIONS

Defining evidence-based practice (as a noun or verb) will evolve over time as the evidence itself evolves to catch up and understand how best to study real-world setting effectiveness and its many mediators and moderators that effect change in outcomes. Researchers, like Hohman (1999) are challenging health services clinical effectiveness studies to emphasize the importance of using active comparison groups to control for contextual factors (Jensen et al., 2005) like therapeutic alliance. Furthermore, clinical effectiveness research experts suggest that treatment developers must transition to view manual development as necessarily community research-based (instead of university-based) to best incorporate the clinical complex scenarios encountered in communities (Weisz, Jensen, & McLeod, 2005). New, exciting, effectiveness research methods such as the regression discontinuity design (Battistin & Retore, 2002; F. Putnam, personal communication, November 30, 2005) can be applied to our field's trauma treatment outcome comparison studies—differing from randomized or quasi-experimental strategies because its unique method of assignment does not require placing potentially needy individuals into a nonintervention comparison group.

Funding mechanisms will necessarily need to emphasize that researchers engage in more community partnerships so that intervention development and their manuals will be more effective in real-world settings (Chorpita, 2002, Chorpita, Daleiden, & Burns, 2004). Some of the best news from a clinical effectiveness research perspective is that some academic centers are responding to community partnerships and are beginning to address feasibility issues and additional treatment needs to enhance the content, approach, and application of child trauma treatments. These partnerships, such as those funded by SAMSHA's NCTSN, will also provide additional empirical support to move treatments and described promising practices up the ladder of evidence classification schemes. Our field will benefit from systematic assessment and operationalization of the ways in which EBT approaches are currently in practice. The NCTSN has adopted a learning collaborative model for training and implementation which brings treatment developers and community agencies together. Although its effectiveness in mental health is still being evaluated, this partnership and training approach appears to enhance not only training efforts and consultation, but also evaluation, dissemination, and adoption of evidence-based and promising practices (Institute for Healthcare

Improvement, 2003). This information and collaboration, in turn, has informed and arguably qualitatively increased the real-world effectiveness of the treatments themselves as developers revise and adapt their protocols based on clinician and consumer feedback.

Like our colleagues in medicine, as we engage in trauma-focused treatment with children and families, we must know the evidence and critically appraise what that evidence is and what that evidence is not. Similarly, we must have a thorough knowledge of our client's clinical presentation and treatment needs to determine the goodness of fit in applying a given treatment. In the field of child trauma, necessary assessment includes a comprehensive survey of the child's traumatic experiences, i.e., a trauma history profile (R. S. Pynoos, personal communication, October 6, 2006) that includes duration, dose, number, nature, and sequelae of these traumatic experiences. Diagnostic considerations, developmental implications, and client preferences, together will inform the clinician who must critically appraise the evidence base and indicators for a given treatment, as much as the field's state of knowledge will allow. And regardless of where along the continuum of complex clinical presentations we find ourselves, there needs to be a judicious and conscientious outcome-oriented monitoring of progress. This mandates that clinicians must understand their clients' specific treatment needs, the repertoire of treatment components that are available, the evidence-base behind them, and how and what to assess along the way.

Perhaps a clinician's rubric around use of EBTs could be, "Adhere when possible, adapt when necessary, assess along the way."

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