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Comments on "Evidence-Based Behavioral Medicine: What Is It and How Do We Achieve It?": The Interventionist Does Not Always Equal the Intervention—The Role of Therapist Competence

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Davidson et al. (1) provided the field of behavioral medicine a significant and timely service by outlining "do's and don'ts" regarding the design and reporting of randomized clinical trials (RCTs). Such a checklist helps researchers to guard against threats to internal and external validity and can advance evidence-based medicine by ultimately providing scientifically sound data regarding the efficacy of various psychosocial intervention strategies. Although these authors are to be commended for the general breadth of these guidelines, we wish to take this opportunity to expand on one issue that they noted, that of treatment integrity, not because of any disagreement, but because we believe they did not fully discuss the issue of the "therapist" as a Type I error concern.

Treatment integrity, in the psychotherapy outcome literature, refers to two major issues regarding a given treatment arm in an RCT—adherence and competence (2). *Adherence* refers to the degree to which a provider conducted treatment according to some external set of criteria, usually a therapy manual. *Competence,* although related, can greatly range in its degree of correlation with adherence. In this context, competence involves the degree to which the therapist conducts the treatment in a minimally effective manner. Therapists, even if adherent, can range in competence from *incompetent* (e.g., provider describes the rationale for the treatment in a hurried or incomplete manner) to *expert* (e.g., provider describes the treatment rationale comprehensively, in easily understood terms, and in a way that allows patients to better understand how this treatment is relevant for them). It is this range that represents the major threat to internal validity. In drug trials, it is correctly assumed that if a given pharmacological intervention is represented by accurate measurement or "pill counting" (i.e., each unit of a drug is the same), one can validly measure the impact of the drug. However, to assume that "all therapists are equally competent" is to ignore a potentially large degree of variance not accounted for by the treatment per se. In other words, *the intervention does not equal the interventionist.* As such, it becomes difficult to determine whether treatment effects (or lack of) are due to the hypothesized mechanism of action (i.e., the active ingredient within the intervention) or the treatment *provider* (3).

Although the impact of therapist competency on treatment outcome has only been recently addressed in a meaningful manner (4), initial results suggest that higher levels of therapist competency are significantly associated with improved patient outcome (5,6). As such, it behooves all researchers conducting RCTs that involve a psychosocial intervention in the future both to incorporate procedures to methodologically enhance therapist competence (e.g., detailed treatment manuals, use of "expert" providers, enhanced training protocols, sustained supervision of providers) as well as methods to systematically assess both adherence and competence (e.g., systematic assessment of therapist behaviors via audio- or videotape of actual treatment) and to determine whether either served to moderate outcome.

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