**The World Confederation of Cognitive and Behavioural Therapies (WCCBT)**

**Training Guidelines for Cognitive and Behavioural Therapies (CBTs)**

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## 1. Preamble

The World Confederation of Cognitive and Behavioural Therapies (WCCBT) is dedicated to the promotion of the health and well-being of the world's population through the development and implementation of evidence-based cognitive and behavioural therapies (CBTs; see the WCCBT Mission at https://wccbt.org/aims-and-mission). The WCCBT is comprised of regional associations, each of which has a general aim of advancing scientific knowledge and research in CBTs and promoting access to evidence-based assessment and intervention for health and mental health difficulties in their country or region.

The overarching aims of the WCCBT are as follows: (a) to support the global development and profile of CBTs; (b) to develop a worldwide network to share news, information, and issues relevant to CBTs; (c) to promote and advocate for mental health, CBTs, and evidence-based treatments for psychological disorders more broadly in order to improve well-being across the world; (d) to facilitate and support research in CBTs; and, most relevant to this document, (e) to develop and support effective implementation of CBTs through education and training.

To further the latter aim, a Training and Accreditation Committee (TAC) was formed in 2020, with the goal of developing guidance in terms of what knowledge and competencies are required to be a CBT practitioner. The current guidelines were written to describe training needed for someone who is able to provide cognitive and behavioral interventions for a variety of problems, and who grounds their interventions with assessment and case conceptualization. The Committee is comprised of the following members (in alphabetical order)[1]:

- **Andrea Ashbaugh**, PhD, CPsych, Previous President of the Canadian Association of Cognitive and Behavioural Therapies (CACBT), representing North America;
- **Julio Obst Camerini**, PhD, President, Latin-American Association of Analysis, Behavioral Modification, and Cognitive and Behavioral Therapies (ALAMOC), representing Latin America;
- **Jacqueline Cohen**, PhD, RPsych, President, CACBT, representing North America;
- **Helen MacDonald**, PhD, Chartered Psychologist, Senior Clinical Advisor, British Association of Behavioural and Cognitive Therapies (BABCP), Training Co-ordinator European Association for CBT (EABCT) representing Europe;
- **Firdaus Mukhtar**, PhD, Consultant Clinical Psychologist, President, the Asian Cognitive Behaviour Therapy Association (ACBTA), representing Asia;
- **Luis Oswald Perez Flores**, Ps Cl. Mg, Executive Committee member WCCBT, Chair TAC, and member of ALAMOC, representing Latin America; and
- **Mehmet Sungur**, MD, President, the Turkish Association for Cognitive and Behavioral Psychotherapies (TACBP), representing the International Association of Cognitive Psychotherapy.

[1] The TAC would also like to acknowledge the contributions of Gabriel Perez (Peru) and Joseph Inhaber (Canada).

### 1.1 Development of the Training Guidelines

The initiative to develop Training Guidelines arose for several reasons. First, as clearly identified by the World Health Organization (June 2022), “the need for action on mental health is indisputable and urgent” (see https://tinyurl.com/WHOMentalHealthAction). Effective interventions exist to promote psychological health as well as to address the needs of people with mental health conditions. Many of these interventions are explicitly cognitive and/or behavioural or have their roots in cognitive or behavioural theory. The call for worldwide dissemination of these evidence-based interventions speaks to the need for a clear and common articulation of the CBTs and what it is that CBT practitioners do.

Second, many of the WCCBT’s constituent organizations, as well as other organizations dedicated to the advancement of CBTs, have developed or are developing their own guidelines for training in CBTs. The purpose of this document is to recommend a set of minimum guidelines for the content and competencies that should be included in training to provide CBTs.

The hope is that these Training Guidelines will provide a set of definitions and standards that are broadly adopted by CBT organizations, thus providing a common understanding of the knowledge and competencies that characterize a CBT practitioner anywhere in the world. The ultimate goal is to promote CBTs globally by setting standards for CBT training and thus improving access to CBTs and other evidence-based psychological interventions.

The TAC met regularly between June 2022 and May 2023. The Committee began by reviewing already existing training guidelines, including those developed by the BABCP, the Improving Access to Psychological Therapies (IAPT) Program in the UK, the Malaysian Ministry of Health’s National Psychotherapy Task Force, the European Association for Behavioural and Cognitive Therapies Standards for Training and Accreditation of Cognitive and/or Behaviour Therapists, and the National Guidelines for Training in CBT developed by the CACBT. The certification recommendations developed by the Academy of Cognitive and Behavioral Therapies, the Australian Association for Cognitive and Behaviour Therapy, the BABCP, the Beck Institute, and the CACBT were also considered.

After articulating a definition of CBTs in summer 2022, the TAC worked to identify and group together common elements of training in CBTs – both in terms of knowledge bases and competencies. The resulting categories form the main content of this document. The TAC then divided into subgroups to develop a first draft of the Guidelines. The WCCBT Board Members reviewed the first draft, and their feedback was used to inform the current version of the Guidelines. This current version was presented in a symposium at the 2023 World Congress of Cognitive and Behavioural Therapies in Seoul, Korea. It was also be circulated to organizations involved in the CBTs in order to solicit feedback. The final document was approved by the WCCBT Board and membership in June 2023.

### 1.2 Assumptions

Given that the practice of CBT, and indeed, the application of psychological interventions more generally, is regulated by region- and country-specific legislation, one of the main assumptions of these Guidelines is that CBT practitioners have the appropriate licensure/registration to practice in their region/country. In some cases, this may mean having a license that enables the practice of psychotherapy (in some countries this might be as a physician, psychologist, or social worker, for example); in others this may mean having a specific certificate (e.g., as a CBT therapist).

In some regions/countries formal legislation and certification of practitioners does not exist and non-registered providers may provide aspects of CBTs, either autonomously after receiving training or under supervision. Regardless, these Guidelines assume they have the basic training and skills, as well as the appropriate qualifications to practice psychological interventions in their region/country. It is also recognized that CBT is delivered in unique formats and at different levels of intensity for different problems, and so the training needs to reach an appropriate level of complexity for each intended application These guidelines are not intended to preclude the training of practitioners for specific problems and applications.

The WCCBT recognizes that there are both generic therapeutic skills as well as skills specific to the CBTs, and that these skills vary across mental health conditions and populations. The Guidelines are based on the following assumptions: (a) that CBT practitioners already have generic therapy skills (e.g., developing and maintaining a therapeutic relationship, assessing and managing risk); (b) that CBT practitioners follow ethical and professional practice guidelines; and (c) that CBT practitioners will seek out the knowledge and skills to apply CBTs and other interventions to the specific problems and populations with which they work.

Another assumption is that cognitive and behavioural theories, models, and interventions will continue to evolve. It is incumbent on CBT practitioners to stay up to date regarding scientific and other developments in the field and to modify their interventions to reflect the best available evidence.

Moreover, the WCCBT recognizes that cognitive and behavioural models and interventions were, for the most part, developed and studied in sociocultural contexts and with populations characterized by relative privilege (in terms of factors such as race, ethnicity, heritage, socioeconomic status, education, gender, sexual identity, and abilities). There is a growing body of evidence speaking to the adaptation of cognitive and behavioural approaches to racially diverse, minoritized, and other marginalized populations (e.g., Indigenous, Black, Hispanic, and other People of Colour, sexual and gender minorities, people with intellectual disabilities, older adults). Yet more needs to be done to adapt and study these models and interventions across populations and contexts. It is assumed that CBT practitioners will inform themselves of the limitations of the evidence as it applies to the populations they serve and the problems they face, learn about and be responsive to cultural and individual differences, exercise cultural humility, and practice culturally responsive clinical care in their work with diverse, minoritized, or marginalized populations.

A final assumption of these Guidelines is that CBT practitioners have the capacity to use CBT skills themselves, and as such, they readily identify, examine, and question any attitudes that interfere with the effective application and practice of CBTs. They are also expected to be able to regulate their own emotions in their work with clients.

**1.3 Definitions**

There is considerable variability in how each of the following terms are defined in the literature. For the sake of clarity, several key terms that are used throughout the Guidelines are defined below.

**1.3.1 Cognitive and behavioural therapies (CBTs).** The WCCBT defines CBTs as a collection of empirically based treatment approaches that are based on cognitive, behavioural, and contextual theories and models of human experience. Although the acronym "CBT" might be used for the sake of simplicity, it is recognized that there are multiple models and methods encompassed within the overall field of CBTs. Collaborative empiricism is fundamental to the CBTs, especially given the emphasis of the field on the ever-evolving science of human behaviour. CBTs emphasize the role of

and responses to cognitions, behaviours, sensations, emotions, and life events, and their interrelationships in the development and maintenance of psychological well-being. The goals of the CBTs are to reduce distress, improve quality of life, and alleviate human suffering by increasing flexibility in thinking, improving capacity to experience, express, and regulate emotions, and enhancing functional behaviour. This definition will evolve with new empirical findings.

**1.3.2 CBT Practitioner.** Given the varying titles used to describe those who provide CBT (e.g., clinician, counsellor, mental health care provider, psychotherapist, therapist) across regions and countries, we use here the term CBT practitioner, believing this to be the most accurate and simple description of someone who applies CBTs in their therapeutic practice.

**1.3.3 Guidelines.** This document provides guidance about the content of training, minimum core knowledge, and clinical competencies that CBT practitioners should possess. It is not designed as a regulatory set of standards for CBT training. Rather, the hope is that it will be used to inform organizational standards, the development and evaluation of training programs, and – for individual practitioners – training decisions and self-evaluation.

**1.3.4 Training.** Training broadly encompasses activities that occur in the context of professional mental health programs, professional continuing education workshops, courses, certificate programs, supervision and consultation, and other delivery methods. This training can occur in the context of an integrated program of study, a stand-alone course, or a combination of different delivery methods.

**1.3.5 Trainer.** Different regions use different terms (e.g., clinical supervisor, lecturer, clinical consultant) to describe individuals who teach CBT knowledge and competencies. In the context of these Guidelines, a trainer is anyone who already possesses the knowledge and competencies to be a CBT practitioner and who teaches others (e.g., trainees, students, residents) the skills to develop their own knowledge and competencies in the application of CBT.

**1.3.6 Trainee.** In the context of these Guidelines, a trainee is anyone who is undergoing or receiving training to develop knowledge and competencies in the application of CBTs. CBT trainees can include students in formal healthcare professional training programs as well as practitioners who have decided to learn how to practice CBT or advance their training in the CBTs.

**1.3.7 Knowledge.** Knowledge refers to the understanding of human experience and human change processes based upon theory and scientific evidence. Knowledge will further accumulate over time as the field develops and evolves.

**1.3.8 Competencies.** Competencies are core sets of abilities, behaviours, or skills that a trainee should demonstrate by the end of training. Competencies are predicated upon core knowledge and the experience to know when and how to apply that knowledge. Competencies are not static; rather, they evolve over time and as the field develops.

**1.3.9 Adherence.** Adherence refers to the accuracy with which clinicians implement specific interventions (i.e., how closely they follow specific principles and protocols). Adherence is a key component in providing evidence-based treatment.

**1.3.10 Competence.** In contrast to adherence, competence refers to the effective implementation of specific principles and protocols.

**1.3.11 Diversity.** Diversity refers to differences across traits and social groups. Examples of areas of difference include yet are not limited to, race, ethnicity, heritage, language, culture, religion,

socioeconomic status, caste, education, gender, sexual orientation, relationship status, age, mental and physical abilities, weight, and appearance.

## 2. Fundamentals and Competencies

This section constitutes the main content of the Training Guidelines in that it outlines the knowledge and competencies that a CBT practitioner should know and be able to demonstrate by the end of their CBT training.[2]

First, the fundamentals of the CBTs and core CBT knowledge is listed (2.1). These lists comprise the core CBT knowledge that every practitioner is expected to know, as well as assessment, commitment building, and intervention strategies.

The second part of this section (2.2) focuses on CBT-specific competencies, that is, the abilities that CBT practitioners should be able to demonstrate by the end of their CBT training. This includes skills in the area of client engagement, assessment and case conceptualization, general intervention, and specific interventions. For clarity, the specific interventions are divided into strategies that are primarily behavioural, primarily cognitive, and primarily contextual in nature. The WCCBT acknowledges that there is overlap among these categories; further, there are multiple other ways to group them.

### 2.1 CBT Fundamentals and Core Knowledge

Trainees should know the fundamentals of the CBTs and core CBT knowledge as follows.

#### 2.1.1 CBT Knowledge

a. the development and history of CBT;
b. how to read and apply the scientific literature to practice, as well as how to remain up to date regarding advancements in CBT theory and practice;
c. principles and practice of evidence-based care;
d. CBT models describing the development and maintenance of clinical problems and psychopathology, including the following:
    i. evolutionary models of emotions;
    ii. behavioural theories of learning (including concepts such as classical and operant conditioning, observational learning, learning by experience, habituation, and inhibitory learning)
    iii. behavioural theories regarding the development and maintenance of mental health problems;
    iv. cognitive theories of the development of assumptions, beliefs, appraisals, interpretations, and values;
    v. information processing models;
    vi. contextual theories;
    vii. integrative models that emphasize the interdependence of cognitions and behaviours; and
    viii. goal attainment and functional improvement

#### 2.1.2 CBT Assessment

a. suitability and contraindications for CBTs;
b. assessment tools and interviewing skills (e.g., objective measurement, Socratic dialogue)
c. principles of CBT case conceptualisation and its implications for treatment;
d. case monitoring and evaluating outcomes (e.g., measurement-based care);

[2] The WCCBT recognizes that this is not a complete list.

e. adapting conceptualizations, models, and interventions for individual and cultural factors (e.g., gender, culture, faith, ethnicity, age, sexuality, sociodemographic status, education, occupation, neurodiversity) as well as their intersections;
f. considering the interrelationships among culture, psychological processes, and mental health problems;
g. adapting for co-occurring problems and complex presentations;

#### 2.1.3 Building Commitment to Engage in CBTs

a. role of the therapeutic relationship in CBT, including collaborative empiricism
b. awareness of common challenges in CBT
c. role of structure in CBT, including session structure and format.
d. assessing client engagement and readiness for change;
e. building motivation and commitment to the therapeutic process;
f. collaboratively determining treatment goals;
g. setting a treatment framework

#### 2.1.4 CBT Interventions

a. cognitive, behavioural, arousal reduction, acceptance-based, and experiential strategies;
b. the importance of generalizing principles and skills to daily life;
c. the role of reflective and deliberate practice in making and maintaining gains;
d. the effective use of between-session assignments and other homework;
e. CBT models for maintaining treatment gains and preventing relapse;
f. criteria for consultation with and/or referral to a specialist;
g. ending treatment in accordance with evidence-based principles

### 2.2 CBT-Specific Competencies

By the end of their CBT training, trainees should have attained the following CBT-specific competencies.

#### 2.2.1 Client Engagement and Collaboration

a. match client needs to treatment;
b. evaluate and enhance client’s motivation for treatment;
c. establish and maintain factors important to the therapeutic alliance (e.g., agreement on goals and therapeutic tasks);
d. establish and maintain a collaborative empiricist framework

#### 2.2.2 Assessment and Case Conceptualization

a. use empirically validated assessment tools (this might include self-report measures, interviews, observations, historical and collateral information, functional assessment of specific behaviours) to evaluate the following: the frequency, duration, and intensity of problems; precipitating and maintaining factors; coping strategies; and comorbidities
b. develop CBT case conceptualizations based on assessment;
c. collaboratively establish treatment goals that are specific, measurable, achievable, relevant, and time-bound (SMART);
d. evaluate and modify case conceptualizations as treatment progresses;
e. conduct progress and outcome monitoring’
f. evaluate and assess self-monitoring and self-management skills

#### 2.2.3 General Interventions

a. provide psychoeducation based on CBT models and conceptualization;

b. provide psychoeducation on physiology and neuroplasticity;
c. explain the rationale for CBTs;
d. collaboratively structure the session, including setting and following an agenda;
e. appropriately direct and pace sessions;
f. measure treatment progress and adapt interventions as needed;
g. conduct functional assessments of specific problems;
h. enhance motivation and commitment;
i. teach problem-solving skills and concepts;
j. identify, explore, and address rigid, inflexible and unhelpful thoughts, attitudes, beliefs, and assumptions;
k. identify and modify unhelpful behaviours;
l. attend to, validate, and manage emotions, including helping clients identify, understand, and effectively express, manage and respond to emotions;
m. develop in-session and between-session behavioural experiments, exposures, and other assignments;
n. collaboratively review and check-in on between-session assignments;
o. identify and problem-solve barriers to completing between-session tasks;
p. prepare clients for terminating therapy and develop relapse prevention plans;
q. adapt CBT to accommodate for individual and cultural factors;
r. adapt CBT to accommodate for comorbidities and complex presentations;
s. problem-solve challenges that arise during therapy

Trainees should be able to use some or all of the following specific strategies:

#### 2.1.4 Specific Interventions: Behavioural Strategies

a. contingency management, including stimulus control, identifying and integrating natural reinforcers, and shaping complex chains of behaviour
b. skills training, including social skills training, interpersonal effectiveness, and assertiveness training
c. exposure-based strategies, including developing hierarchies, pacing and graded exposure, in vivo, interoceptive, and imaginal exposure, response prevention, and targeting safety behaviours, escape, and avoidance;
d. behavioural activation, including mastery, pleasure, and pacing;
e. habit reversal
f. arousal management strategies, including breathing exercises, progressive muscle relaxation, mental and behavioural distraction, grounding and distress tolerance skills, and emotion regulation skills
g. problem solving, including identifying and defining problems, generating solutions, completing decisional balances, following through on action steps, and evaluating decisions
h. behaviour monitoring and change (e.g., sleep, diet, exercise)

#### 2.1.5 Specific Interventions: Cognitive Strategies

a. identifying cognitive content and processes, including Socratic dialogue, guided discovery, and thought monitoring
b. labelling and categorizing cognitive content, including identifying common helpful/effective and unhelpful/ineffective patterns of thinking, identifying and rating belief in thoughts; examining impact on emotions, sensations, and behaviours;
c. identifying, describing, and labelling emotions, understanding the components of emotions, and rating the intensity of emotions;

d. modifying cognitive content and processes through activity scheduling, behavioural experiments and surveys, enhancing psychological flexibility, identifying alternative thoughts, attentional retraining and modifying cognitive biases, imagery rescripting, and generating and rating new beliefs
a. Meta-cognitive strategies

**2.1.6 Specific Interventions: Contextual Strategies**

a. mindfulness-based strategies;
b. acceptance-based strategies;
c. compassion-based strategies;
d. cognitive defusion and distancing;
e. values identification;
f. committed action;
g. self-as-context;
h. development of resiliency and personal strengths

## 3. Training and Evaluation

Trainers should be aware of the background of their trainees and select only trainees that are qualified to provide mental health services in their region/country.

By the end of their training, a CBT trainee should be able to effectively apply the skills and competencies they have learned. CBT training should continue until the trainee demonstrates both adherence and competence.

Recommended training strategies to achieve adherence and competence are discussed first; then, recommended strategies to evaluate adherence and competence are presented.

### 3.1 Training Strategies

Training should be tailored to individual trainees to ensure they learn CBT techniques as well as how to apply them ethically and effectively. Existing research is insufficient to specify a minimum number of hours required to achieve CBT adherence and/or competence. Nonetheless, studies do speak to the importance of supervision in learning to apply CBTs adherently. There appears to be a dose response between training/supervising in CBTs and competence in that trainees who receive more training and engage in reflective, deliberate practice achieve greater competence.

While didactic strategies are important for teaching CBT knowledge, including the history, evidence base, and principles of the CBTs, applied training strategies (e.g., supervision, deliberate practice), are essential to training CBT skills. The supervision of CBT cases is considered an especially necessary part of CBT training. As such, the WCCBT strongly recommends that trainees receive supervision/consultation across a number of cases from varied populations and over time. If the trainee will be working with specific populations or in specific contexts, then supervision in working with these populations and in these contexts is essential.

The WCCBT recommends that training in CBTs includes all of the following:

- didactic strategies such as lectures, webinars, and readings;
- experiential strategies such as case conceptualization activities and role plays; and
- supervision of multiple (at least three) cases in which CBTs are applied and in which each case receives an adequate trial (at least six sessions) of the indicated treatment.

With regard to the final point (supervision), supervision should be provided by at least two different CBT trainers/supervisors. Moreover, the trainee should ideally see clients with a variety of presenting problems (e.g., anxiety, depression, trauma-related stress). Supervision can occur in a variety of formats (e.g., group, individual); however, it should include direct observation of the supervisee's work, discussion of the supervisee's clinical decisions and the supervisee's implementation of the CBT model that is being trained. Trainees should receive regular feedback on their strengths and areas for further development.

**3.2 Evaluation Strategies**

Evaluation should include not only evaluation of the trainee's CBT knowledge, yet also their competence in applying CBTs in clinical practice. Both adherence and competence should be evaluated by multiple (at least two) trainers.

The WCCBT recommends the following evaluation strategies.

- CBT knowledge may be assessed by means of multiple-choice tests, short- and long- answer essay questions, reflection papers, presentations, and summaries of the literature on a specific topic.
- Case presentations, written case conceptualizations, review of session notes, and peer supervision/consultation are helpful in evaluating the application of CBT strategies.
- The evaluation of a trainee's competence must include observing the trainee apply CBT (observation can occur live, through recorded sessions, or by role play). Elements that should be evaluated include skills in building the therapeutic relationship, CBT case conceptualization, structuring of sessions, application of a variety of CBT strategies, adapting CBT protocols while maintaining fidelity, and adapting interventions to ensure cultural responsivity.
- Moreover, it is strongly recommended that trainees be evaluated using a standardized rating scale. This might include a validated measure of adherence such as the Cognitive Therapy Rating Scale – Revised (Miller, 2022) or the Cognitive Therapy Scale – Revised (James, Blackburn, & Reichelt, 2001). Rating scales should be appropriate for the model of CBT being applied and the population being served.