Behaviour Change (2019), **36**, 192–199
doi:10.1017/bec.2019.18

CAMBRIDGE
UNIVERSITY PRESS

INVITED EDITORIAL

The Emergence and Development of Cognitive Behaviour Therapy in Australia: Observations from an Early Player

David James de Lancy Horne

Ramsay Health Care, Albert Road Clinic, Melbourne, Victoria, Australia

As a contribution to celebrating the 40th Annual Conference of the Australian Association for Cognitive Behaviour Therapy (AACBT), I would like to offer some reflections upon a number of the antecedents and early developments that led to the formation of, first, the Australian Behaviour Modification Association (ABMA) and subsequently its transformation into the AACBT.

In doing this I will briefly refer to my experiences as both an undergraduate student (University of Adelaide, 1960–1963), my postgraduate training at the Institute of Psychiatry, University of London (1964–1966), and my first postqualification post at Guy's Hospital, London (1966–1968). Reflecting upon these experiences will, I hope, provide some perspective on cognitive behaviour therapy (CBT) today.

I will then turn to historical developments in Australia from 1969 when I took up an academic appointment at The University of Melbourne, Department of Psychiatry.

The Adelaide years (1960–1964)

In 1960, the University of Adelaide had its first ever Professor of Psychology when Malcolm Jeeves arrived from Cambridge and appointed some young and enthusiastic staff.

It was also the year in which I started study for my degree at Adelaide. As preparation for this, I had read Eysenck's (1957) *Sense and Nonsense in Psychology*, which stimulated my interest in studying contemporary, experimental research into the nature of learning and behaviour.

At that time, Dr Sydney Lovibond, who was a senior lecturer at the University of Adelaide, immersed us, as students, in a profound understanding of contemporary learning theory.

It was Sydney, who when I expressed a desire to become a clinical psychologist, pointed me in the direction of The Institute of Psychiatry, University of London, at the Maudsley Hospital. At that time (1963) there were no postgraduate degree courses in clinical psychology in Australia. The one at 'The Maudsley' (as it was often simply referred to) was also the only one in the United Kingdom. Sydney had recently spent a sabbatical there writing his book on conditioning and enuresis (Lovibond, 1964), and was clearly impressed by what he had observed: an experimental approach to understanding psychopathology and developing the new psychological therapies, called behaviour therapy (BT).

Upon completing my honours year, I had a five-month interlude before leaving Adelaide for London (a six-week-long boat voyage, which was a real adventure). Through a casual inquiry to the South Australian Department of Health, I was appointed as a clinical psychologist to a large mental hospital at Glenside in inner Adelaide; an Honours degree alone sufficed to qualify for this!

Unbeknown to me at the time, a new (first) Professor of Psychiatry, William Cramond, had arrived from Scotland. He was also the State Director of 'Mental Hygiene' and was actively seeking the appointment of psychologists and social workers to mental health services as part of his major reform program. It was at Glenside Hospital that I had my first referral for BT, using systematic desensitisation (SD) for phobic anxiety. So, the psychiatrists were becoming aware, even in early 1964, that these new treatment modes existed.

© The Author(s) 2019

https://doi.org/10.1017/bec.2019.18 Published online by Cambridge University Press

The London Years (1964–1968)

At The Maudsley, Hans Eysenck had produced a Department of Psychology with a large number of PhD students and a uniquely influential scientist-practitioner clinical course where research into learning theory and BT was a core activity. An excellent review of this era can be found in a book by HB Gibson (1980).

Gibson makes an interesting observation (p. 146) that:

> *As far as I can determine, the term 'behaviour therapy' was first coined by Skinner and Lindsley in 1953. They used the term in a somewhat narrow sense referring to 'operant conditioning' procedures, but Eysenck developed the term, following Wolpe, more in the sense of Pavlovian 'classical conditioning'. It is hardly necessary, at this juncture, to explore the differences between these two types of conditioning. It should be noted that Skinner and Lindsley's report was published in the same year, 1953, as Eysenck's* Uses and Abuses of Psychology, *where in the chapter 'Psycho-analysis, Habit and Conditioning' he sets out in detail what was to be, for him, the whole basis of behaviour therapy.*

I undertook the two year MPhil course in 'Abnormal Psychology' (1964–1966). Dr Monte B Shapiro was the Reader and Director of the clinical course. Shapiro's focus on the meticulous analysis and understanding of each patient's issues, by means of The Personal Questionnaire he had designed and researched, provided an excellent basis upon which to develop and implement the new forms of therapy, called 'Behaviour Therapy' (Shapiro, 1961).

As clinical trainees we underwent an intense weekly program of lectures and seminars, plus closely supervised clinical practice, in many different settings. Of particular note for me, with regard to the development of evidence-based clinical practice, was the supervision I received.

From a contemporary perspective, it is interesting to reflect there were only 12 students a year accepted into the clinical training program.

After completing the MPhil, I was appointed to be the sole clinical psychologist in adult psychiatry at Guy's Hospital, a London University teaching hospital dating back to the 18th century. My appointment was the first time that a psychologist with a degree in clinical psychology had ever been appointed to that hospital. It was certainly an environment that was conducive to developing the practice of CBT; not only in the psychiatry inpatient and outpatient settings but also in the medical and surgical wards.

The Australian Years (1969–onwards)

While at Guy's Hospital I was offered and accepted an appointment as a lecturer in the Department of Psychiatry of The University of Melbourne, based at The Royal Melbourne Hospital, and I duly arrived in January 1969 (again via an enjoyable voyage on a classical passenger ship). Professor Brian Davies, who had appointed me, had taken up the inaugural Chair in Psychiatry in 1964, coming directly from the Institute of Psychiatry in London.

The Department of Psychiatry, under Professor Davies, was conducive to exploring and developing new therapies in psychiatry. While the main focus was on biochemistry and pharmacological research, there was ample scope for research in psychological therapies, particularly CBT. Thus, I started CBT in various areas of medicine and surgery, including traumatic injury, skin disorders and cancer, as well as with patients in both inpatient and outpatient psychiatric care (e.g., Horne, 1977; Horne, Taylor, & Varigos,1999; Horne, Varigos, & White, 1989; Horne & Watson, 2011).

The Beginnings of a National CBT Association

In 1978, the first Australian Behaviour Therapy Conference was held in Sydney, due primarily to the heroic efforts of young members of the Psychology Department at the University of Sydney; namely,

https://doi.org/10.1017/bec.2019.18 Published online by Cambridge University Press

Keith Johnson and his close colleagues. The conference was a resounding success, way beyond expectations, with over 400 delegates, including many of the leading psychiatrists of the day. Venues at the University of Sydney had to be changed. Plans for the conference dinner on a boat in Sydney Harbour had to be expanded and more coaches ordered, all at short notice.

Of course, Professor Sydney Lovibond, now at the University of New South Wales, was an important pioneer and influence on developments of BT in Australia. I recall spending time with him discussing the nature of what a future Australian society for BT should look like. He strongly advocated that such a society should be closely linked to clinical psychology, both at the university and professional practice levels.

So, immediately following the Sydney conference, an ad-hoc national committee was set up to organise a follow-up conference. A number of pioneers in BT in Australia from across the nation were on this committee.

The upshot was that South Australia, which had established its own society, The South Australian Behaviour Modification Association, undertook to host the conference for 1979. The South Australians wanted to affiliate with the USA Association of Behaviour Therapy rather than with the rest of Australia and the newly formed ABMA, at that time comprising Western Australia, Victoria, New South Wales and Queensland.

That conference duly took place in May 1979 and went well. However, at the end, the national ABMA committee resolved to hold the next conference in Melbourne and appointed me as president of the national body and convenor of the conference. This conference was held at the Melbourne State College of Education from May 24–28, 1980, and established the practice of inviting one or two internationally renowned speakers and convenors of workshops. The conference committee was enthusiastic, and the conference secretary, Neville King, had a key role in holding it all together.

To help obtain a perspective on who contributed in these early days to the newly formed ABMA, the key people are listed below.

Organisng Committee

Mr Gregory Murphy — Preston Institute of Technology
Dr Nancy McMurray — University of Melbourne
Dr Michael Bernard — University of Melbourne
Ms Judi Watson — Department of Community Welfare, Victoria
Mr Malcolm Press — Community Welfare Training Institute
Dr Connie Peck — LaTrobe University
Dr Bob Montgomery — Latrobe University
Mr Andrew Remenyi — Lincoln Institute
Dr Kim Halford — Lincoln Institute

Keynote Speakers (and Workshop Presenters)

Prof Edward Blanchard —State University of New York at Albany
Assoc Prof Ted Glyn — University of Auckland, New Zealand
Prof Syd Lovibond — University of New South Wales
Prof Aubrey Yates — University of Western Australia
Prof Wesley Baker — University of Oregon, USA

The proceedings were published in house, with the editors being Nancy McMurray and myself (Horne & McMurray, 1982). A copy of this publication is now held by the National Committee of the AACBT.

It is interesting to note the education theme to this conference. It was advertised as 'Teachers and Teacher Educators are invited to the 3rd Australian Conference on Behaviour Modification'. Nowhere did the words 'clinical' or 'therapy' appear.

https://doi.org/10.1017/bec.2019.18 Published online by Cambridge University Press

Another outcome of the 1980 Melbourne Conference was that the South Australian delegates agreed to become part of the ABMA. Thus, the Melbourne 1980 conference can be truly regarded as the first conference of the fully national association.

Around this time there was also great debate about what the fledging association should call itself. The 'radical' behaviourists preferred the term 'ABMA', but many of us, myself included, believed this to be too narrow a title and opted, successfully, to include both the terms 'cognitive' and 'therapy', and so by the late 1980s, the AACBT came into existence, via the efforts of the National Committee working with the state branches.

The Association's journal, *Behaviour Change*, produced its first issue in 1984, at which time the association was still the ABMA. Again, it is interesting to see who was involved in this new publication.

Editor: Neville King — Phillip Institute
Production Editor: Henry Jackson — Melville Clinic, Health Commission, Victoria
Book Review Editor: Gregory Murphy — Phillip Institute
Associate Editors (as listed in the journal):
Jay Birnbrauer (WA)
Mark Dadds (QLD)
Tony Floria (NSW)
Stan Ginsberg (NSW)
Ted Glyn (NSW)
Charles Hart (SA)
Paul Martin (WA)
Iain Montgomery (TAS)
David Horne (VIC)
Neville Owen (SA)
Andrew Remenyi (VIC)
Matt Sanders (QLD)
Chris Williams (TAS)
Peter Wilson (NSW)

The first edition of *Behaviour Change* (vol. 1, issue 1, 1984) had only three articles: (1) Neville King and Peter Miller: 'The birth of Behaviour Change: A call for articles on behavioural programming in Australia'; (2) Geoffrey N Molloy and Neville J King: 'Behavioural assessment: Basic principles'; (3) Henry J Jackson and David Tierney: 'On the relationship between psychiatric diagnosis and behavioural assessment'.

The major focus was on behaviour, with no reference to cognitive and emotional factors.

Also of note is the number of people from the early days who are still involved in CBT today.

The pioneer journal of BT, *Behaviour Research and Therapy (BRAT),* Editors HJ Eysenck and SR Rachman, preceded that of the Australian journal, *Behaviour Change*, by 21 years. In volume 1, number 1 (May 1963), the first four articles reflect the early links to BT in Australia: (1) HJ Eysenck: 'Editorial'; (2) S Rachman: 'Introduction to Behaviour Therapy' (3) SH Lovibond: 'The mechanism of conditioning treatment of enuresis'; (4) J Wolpe: 'Psychotherapy: The non-scientific heritage and the new science'.

In addition to the 1980 ABMA Conference in Melbourne, there were two other relevant conferences of note in that year, which I was fortunate enough to attend. Both of these reflected the change from seeing these new therapies as purely 'behavioural', to an explicit awareness of the role of 'cognitive' factors in influencing behaviour change. The first was the 1st World Congress of Behaviour Therapy in Jerusalem from July 13–17.

The conference mainly comprised Israeli and some Palestinian psychiatrists and psychologists and a lesser number of delegates from the United States, the United Kingdom, Australia and New Zealand. Other countries in the world, including those in Europe, were only just beginning to be interested in

https://doi.org/10.1017/bec.2019.18 Published online by Cambridge University Press

these new therapies, which challenged the rather more established adherence to psychoanalytical therapies. I learned that in some countries, such as Spain, not only was BT frowned upon but was actually forbidden in some departments of psychiatry.

The second 1980 Conference was that of the American Psychological Association's Annual Convention in Montreal, Canada, which I also attended. There was a plenary session in the form of a 'debate' between Hans Eysenck and the renowned US researcher of operant learning, BF Skinner. This was the only occasion where these two famous pioneers of BT ever actually met. The auditorium was packed out, with people crammed into the aisles. They both provided nice overviews of their theories and research, but there was little debate. Nevertheless, I think this meeting of those two eminent researchers in BT reflects that 1980 was, indeed, a pivotal year in the evolution of both BT and CT into CBT.

Putting Cognitions into the Emotion-Behaviour Question

Some of the earliest publications that indicated that changes were occurring are listed below.

The first example is two papers by Albert Ellis (1957 and 1962), where he begins to describe what became known as rational-emotive therapy (RET).

Second, Aaron T Beck (1967) presented his findings about the nature of cognitive distortions in people suffering from depression and showed how eliciting these distortions and counteracting them could be an effective means of treating depression.

Third, Michael J Mahoney (1974), who was a clinical psychologist at Pennsylvania State University in the United States and whose work was seminal at this time, published the first book to explicitly juxtapose the words 'cognition' and 'behavior' in its title, *Cognitive and Behavior Modification.*

Fourth, Donald Meichenbaum, in 1977, did a similar thing with his book titled *Cognitive-Behaviour Modification*. Meichenbaum argued that introducing cognitive processes into behavioural psychology brought about some redress of the effect of environmental events upon behaviour compared with the significance of how a person perceives and evaluates these events. To quote him, he said:

> *The theme is that behaviour therapy techniques, as originally conceptualised and implemented, have overemphasised the importance of environmental events (antecedents and consequences), and, therefore underemphasised and often overlooked how a client perceives and evaluates those events. Our research on cognitive factors in behaviour therapy techniques has highlighted the fact that environmental events per se, although important, are not of primary importance; rather what the client says to himself about those events influences his behaviour. (p. 108)*

Fifth, Albert Bandura's (e.g., Bandura, 1977) work on social learning has been seminal to CBT. He has explored in great detail the powerful effects of modelling on human behaviour, both when the modelling is concrete, in the form of an actual person, or symbolic as in film, video, puppet shows or cartoons. By 1977, his research was internationally recognised as equally important to that of Eysenck and Skinner (Gibson, 1980, p. 242).

But, it would appear that verbal cognitions are only part of the story. So, in order to redress the balance, I will make a few observations about the role of non-verbal cognitions in therapy.

Nature of Imagery in CBT

In this era, there were at least two major schools of thought about the nature of imagery: namely, the 'pictorialists' (e.g., Kosslyn, 1980) and the 'descriptionalists' (e.g., Pylyshyn, 1973).

Pictorialists emphasised the similarity between images and the objects they represent: viz. functional properties of images depend upon their pictorial qualities; for example, rotation of an object in imagery can easily be carried out by some people, because the image directly represents the actual object.

https://doi.org/10.1017/bec.2019.18 Published online by Cambridge University Press

Descriptionalists argued that the representation corresponding to a visual image is more like a description than picture.

Peter Lang, with a 'descriptionalist' starting point, made a major contribution to understanding the nature of imagery in emotional disorder and its use in CBT. He proposed that 'affective images (e.g. in depression) are conceptualised as propositional structures, rather than as re-perceived, raw, sensory representations' (1977, p. 863).

He argued for three elements in imagery: (1) stimulus aspects, (2) response aspects, and (3) aspects of imagery containing semantic propositions. For example, visualising a luxury car you would like to own has meaning: it provides a luxury form of travel and shows its owner to be a successful person, as well as having its own shape, colour, smell and sound.

Since the early days of BT (Wolpe, 1958, 1961) imagery, usually visual, had been incorporated into BT treatments such as SD. However, the scope of incorporating imagery has greatly expanded to work with trauma patients and other people with major mental health complaints (e.g., Hackmann, Bennett-Levy, & Holmes, 2012). Imagery can also be used to enhance relaxation responses, including in people with physical illnesses (e.g., Horne & McCormack, 1984; Horne et al., 1999).

One observation is that research using imagery in CBT has largely concentrated upon visual imagery, possibly because it is the one most readily accessed by most people and thus easily studied. However, mental imagery can occur in any sensory modality; for example, both smell and sound stimuli can elicit powerful emotions; both negative, as in posttraumatic stress reactions, and positive, as when recalling memories of past pleasurable experiences.

In this reflective review, I have deliberately not discussed the wider range of therapies that have evolved over the past 20 to 30 years, such as acceptance and commitment therapy, schema therapy, dialectical behaviour therapy, mindfulness, and so forth. This is because my aim has been to reflect upon the evolution of BT to CBT over the period of 1960 to the early 1980s.

Conclusions and Implications for the Practice of CBT Today

By way of conclusion, based upon my reflections about CBT over the past 55 years, I would like to add a few comments upon the current professional practice of CBT and pose some questions to consider.

Initially, the majority of BT practitioners were both educational and clinical psychologists. Now we have all sorts of psychologists and other health professionals acting as CBT therapists. How do we maintain quality control with such diversity?

In the United Kingdom there are well-established postgraduate courses in CBT (some based in universities, but many also in other organisations). They are increasingly being evaluated and accredited by the British Association for Behavioural and Cognitive Psychotherapies (Salkovskis, 2018). These are courses open to psychologists, psychiatrists, nurses and, indeed, any bona fide health professional, or even educational professional, who wishes to become a practitioner, and can afford, the training.

I am not aware of such accredited training courses being run in Australia. Also, the training that is offered mostly seems targeted to psychologists.

Government registration of CBT therapists may be approaching. But this raises questions about any health practitioner being able to use elements of CBT in their practice. Certainly, it is usually assumed clinical psychologists, at least, are able to practise CBT without specific further training. But, what about psychiatrists, social workers, occupational therapists, nurses and so on; should the AACBT take on an official role in accrediting training courses in CBT and even in encouraging universities to develop postgraduate courses in CBT that are open to most health professions?

Government and private health providers tend to like to pay the least they have to for a service; thus, it may be that more emphasis will be placed on funding CBT provided by non-clinically, health or counselling psychology trained therapists. How do we know these therapists are less effective than their postgraduate trained psychology colleagues?

It is also interesting to reflect that the first generation of CBT therapists are well on the way to retirement or have even passed on from the scientist-practitioner arena of life, or even life itself.

https://doi.org/10.1017/bec.2019.18 Published online by Cambridge University Press

If there are different levels of training and a varied groups of trainees, with varied experiences and expertise in CBT, will it still be relevant to base all training on the scientist-practitioner model of clinical training that has been at the core of training in university-based clinical psychology courses since the 1950s?

What is certain is that health professionals and the general public are aware that CBT exists and even believe that it is, or can be, an effective form of therapy. Thus, we can legitimately predict that CBT and its practitioners will be around for the foreseeable future. But, in 20 years' time, how closely will CBT resemble that practised today? Already it is useful to think of a 'family' of CBT therapies (Hallam, 2013). Will these family members remain related to each other or will they evolve into very different tribes of therapists, possibly with each claiming superiority over the others and fighting for the limited funds to support their own tribe?

I would argue that any drift away from developing therapies not linked to core research in psychology, in its broadest sense, would lead to a 'belief' in a therapy rather than a critical examination of both core theoretical underpinnings of therapy and of the techniques used. Let us remember that what initially differentiated BT from its arch, and much more established rival: namely, the family of psychodynamic and psychoanalytical therapies was its basis in experimental psychology and the study of normal psychological process, such as learning plus also focusing on measurable outcomes, whereas these earlier psychodynamic therapies developed their theories and treatments from the study of relatively few people already suffering from problems of anxiety, depression, trauma and psychosis.

It was the development of BT that initially advocated 'objective' evaluation of outcomes rather than being overly focused upon processes. As BT matured it became CBT and did begin to heed the importance of process of change as well as outcome. This trend continues and is certainly broadening the scope of what cognitive-behavioural therapies include as valid aspects of human behaviour to investigate and treat. At the same time, the psychodynamic therapies have become interested in measureable outcomes as well as the processes that underly outcomes; leading to such interventions as brief psychodynamic therapy (BPT). Does this indicate a rapprochement between these two major approaches to relieving human suffering (e.g., Roth & Fonagy, 2005)? I do not have any answers but I hope this paper has provided an interesting perspective upon the early evolutionary change from BT to early CBT, and may help understand some of the reasons for the emergence of the third wave of cognitive-behavioural therapies.

References

Bandura A (1977). Self-efficacy: Toward a unifying theory of behavioural change. *Psychological Review*, **84**, 191–215.

Beck AT (1967). *Depression: Causes and treatment*. Philadelphia, PA: University of Pennsylvania Press.

Ellis A (1957). Rational psychotherapy and individual psychology. *Journal of Individual Psychology*, **13**, 38–44.

Ellis A (1962). *Reason and emotion in psychotherapy*. New York, NY: Stuart.

Eysenck HJ (1957). *Sense and nonsense in psychology*. Harmondsworth, UK: Penguin Books.

Gibson HB (1980). *Hans Eysenck: The man and his work*. London, UK: Peter Owen.

Hackmann A, Bennet-Levy J and Holmes EA (2012). *Techniques of imagination in cognitive behaviour therapy*. Weinheim, Germany: Beltz.

Hallam RS (2013). *Individual case formulation*. Oxford, UK: Academic Press.

Horne DJ de L (1977). Behaviour therapy for trichotillomania. *Behaviour Research and Therapy*, **15**, 192–196.

Horne DJ de L and McCormack H (1984). Behaviour psychotherapy for a blood and needle phobic patient receiving adjuvant chemotherapy. *Behavioural Psychotherapy*, **12**, 342–348.

Horne DJ de L and McMurray N (Eds) (1982). *Behaviour Therapy in Australia: Proceedings of the Third Australian Conference on Behaviour Modification*. Melbourne, Australia: Australian Behaviour Modification Association.

Horne DJ de L and Watson M (2011). Cognitive behavioural therapies in cancer care. In M Watson and D Kissane (Eds), *Handbook of psychotherapy in cancer care* (pp. 15–26). New York, NY: Wiley Blackwell.

Horne DJ de L, Taylor M and Varigos G (1999). The effects of relaxation with and without imagery in reducing anxiety and itchy skin patients with eczema. *Behavioural and Cognitive Psychotherapy*, **27**, 143–151.

Horne DJ de L, Varigos GA and White A (1989). A preliminary study of psychological therapy in the management of atopic eczema. *British Journal of Medical Psychology*, **62**, 241–248.

Kosslyn SM (1980). *Image and mind*. Cambridge, MA: Harvard University Press.

https://doi.org/10.1017/bec.2019.18 Published online by Cambridge University Press

Lang PJ (1977). Imagery in therapy: An information processing analysis of fear. *Behaviour Therapy*, **8**, 862–886.
Lovibond SH (1964). *Conditioning and enuresis*. Oxford, UK: Pergamon.
Mahoney MJ (1974). *Cognition and behaviour modification*. Cambridge, MA: Ballinger.
Meichenbaum DH (1977). *Cognitive–behaviour modification*. New York, NY: Plenum Press.
Pylyshyn ZW (1973). What the mind's eye tells the brain: A critique of mental imagery. *Psychological Bulletin*, **80**, 1–24.
Roth A and Fonagy P (2005). *What works for whom? A critical review of psychotherapy research* (2nd ed.). New York, NY: Guilford Press.
Salkovskis P (2018). From the President: Being strategic as a special interest group and professional organisation. *CBT Today*, **46**, 3.
Shapiro MB (1961). The single case in fundamental psychological research. *British Journal of Medical Psychology*. **34**, 255–262.
Skinner BF and Lindsley OR (1953). *Studies in behavior therapy* (Status Report 1, Naval Research Contract N5 on 7662). Washington, DC.
Wolpe J (1958). *Psychotherapy by reciprocal inhibition*. Palo Alto, CA: Stanford University Press.
Wolpe J (1961). The systematic desensitisation treatment of the neuroses. *Journal of Nervous and Mental Diseases*, **132**, 189–203.

Cite this article: Horne DJdeL (2019). The Emergence and Development of Cognitive Behaviour Therapy in Australia: Observations from an Early Player. *Behaviour Change* **36**, 192–199. https://doi.org/10.1017/bec.2019.18

https://doi.org/10.1017/bec.2019.18 Published online by Cambridge University Press