Chapter 4
Cognitive Behavioral Therapy in Australia

Michael Kyrios, Ross Menzies, and Nikolaos Kazantzis

Overview of Australia

Australia is the world's sixth largest country by area, the world's thirteenth largest economy (heritage.org) but with a population of approximately 26 million (abs.gov.au) it does not rank in the top 50 as for population. The Commonwealth of Australia is comprised of the Australian continent, the island of Tasmania, and a number of smaller islands (https://www.cia.gov/the-world-factbook/countries/australia/). The country is highly urbanized with most population centres located on the eastern seaboard. Prior to the arrival of Dutch explorers in the seventeenth century, Indigenous Australians inhabited the continent (Clarkson et al., 2017). In 1770, Great Britain claimed the East Coast and named it New South Wales and a penal colony was set up. As the population of Australia grew, additional colonies were set up, and in January 1901, the six colonies formed the Commonwealth of Australia. Australia has six states and ten territories and has a democratic political system. Of note, immigrants account for 30% of the population (abs.gov.au).

M. Kyrios (✉)
College of Education, Psychology and Social Work, Flinders University, Adelaide, Australia
e-mail: michael.kyrios@flinders.edu.au

R. Menzies
Graduate School of Health, University of Technology Sydney, Ultimo, Australia

N. Kazantzis
Cognitive Behaviour Therapy Research Unit, Melbourne, Australia

Beck Institute for Cognitive Behavior Therapy and Research, NY, USA

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History of Psychotherapy in Australia

Australia has been a loyal and reliable advocate in the science, practice, dissemination, and upscaling of cognitive behavior therapy (CBT). The science underpinning CBT in Australia has been grounded on experimental psychology from the 1950s onwards, while its dissemination has been advanced by the advent of accredited clinical psychology training in the scientist-practitioner model, with both research and practice supported by resilient professional bodies that have also stressed the importance of a strong evidence base to clinical practice. Furthermore, the upscaling and dissemination of CBT throughout health, mental health, community, and educational settings has been supported by public policy that gives particular prominence to a strong evidence base.

The best example of this in recent years was the embedding and, hence, upscaling of CBT into the Australian national health system through the provision of government rebates for CBT when treating mental health disorders. The following sections detail the significant factors and events that have impacted the development and dissemination of CBT in Australia.

Researchers and Universities Providing the Evidence Base

Despite an early focus on army, school and inpatient psychiatric contexts, and a history characterised by psychoanalytic theory and psychotherapy, the focus of Australian mental health practice has transferred to primary care and community settings and cognitive behavioral interventions in recent decades (Byrne & Reinhart, 1990). Through that journey, Australian universities and, specifically, psychology departments have been particularly influential in the provision of research findings on human behavior.

In their social history of behavior modification in Australia, Winkler and Krasner (1987) outline that, reflecting Australia's colonial history, psychology in Australian universities grew out of philosophy, with the first professors coming from Britain with roots in the intellectual philosophies of nineteenth century Britain. Winkler and Krasner further identified the University of Melbourne Psychology Department of the early 1950s as the birth place of Australian behavior therapy. In support, Lovibond (1993) outlines that the initial force at the University of Melbourne came in 1952 and 1953 from a select group of Honours students and staff who aimed to understand behavioral problems by utilising the fundamentals of normal behavior. Spence (2016), on the other hand, emphasizes that a variety of state-based groups of researchers and practitioners across Australia with interests in behavior change emerged somewhat independently.

Notably, seminal research in the 1950s and 1960s on classical conditioning and applications to behavior change brought an initial focus on evidence-based interventions (Winkler & Krasner, 1987). Over time, from the 1950s and 1960s onwards,

universities introduced experimental clinical psychology and evidence-based practice into their programs in clinical and applied psychology, although unlike today it was not required by formal course accreditation standards introduced by the Australian Psychological Society (now independently evaluated by the Australian Psychology Accreditation Council, a standards organization). Interestingly, course subjects highlighting the link between the basic discipline of psychology and clinical practice were not specifically characterized as behavior therapy; rather, they were labelled experimental clinical psychology (Lovibond, 1993), stressing that translational science was at the heart of cognitive-behavior therapy in Australia from the very outset.

In the late 1960s and 1970s, operant conditioning research and applied behavior analysis followed, while the 1970s also saw the advent of clinical psychological research findings being applied to a diverse range of psychological and behavioral problems (Spence, 2016), such as childhood, anxiety, mood, and behavioral disorders and problems. There was a particular uptake of CBT in educational and disability services during this period.

The 1980s and 1990s saw the beginning of the cognitive revolution in Australia. Although it is not possible to pinpoint the specific impetus, it most likely occurred as a result of Aaron T. Beck's theory of psychopathology, research trials, and practice guides such as *Cognitive Therapy of Depression* published in 1979. (La Trobe University, situated in Melbourne, Australia awarded Dr. Beck a Honorary Doctor of Science Degree for his contributions to the profession.) The integration of behavioral and cognitive interventions broadened the focus to a greater range of issues and disorders, including psychosis, and obsessive-compulsive, trauma-related and personality disorders, as well as chronic health conditions. These developments were supported by research on psychopathology, psychosocial determinants of health, and clinical trials. By the 2000s and 2010s, the arrival of a new wave of cognitive and behavioral therapies was making great impact across the board, while randomized control trials were impacting advances in public mental health policy. In particular, digitally delivered CBT interventions were being developed in the hope of upscaling the dissemination of CBT, particularly to those who had little access to specialist clinical services.

Such developments were dependent on the university sector, particularly clinical psychology and public health researchers. Cognitive rehabilitation interventions, post-rational and narrative approaches, acceptance and commitment therapy, dialectical behavior therapy, eye movement desensitization and reprocessing (EMDR) therapy, and mindfulness-based interventions were also spreading rapidly amongst practitioners, although it took a little longer for researchers to take an interest or to be funded for investigating the efficacy of such interventions. By the 2000s, the advent of the third wave of cognitive-behavioral interventions and the positive psychology movement also saw their expansion into the educational, health, primary care, and other domains (Kazantzis et al., 2010). Such advances were supported by the university departments of psychology, education, population health, medicine (especially psychiatry), occupational therapy, social work, and other allied health,

supporting the notion that CBT has now extended its spread and impact into a range of professions and disciplines beyond psychology.

Relevant Organisations and Regulations

The Australian Psychological Society and the Australian Association of Cognitive Behavior Therapy (AACBT), inclusive of its predecessor the Australian Behavior Modification Association (ABMA), have been particularly influential in the promotion of CBT and CBT-related research. These organisations have provided national and international linkages, provided mentorship and professional practice standards, ethical standards and codes of conduct, and promoted the inclusion of CBT in national health and mental health policies. We focus here on the contributions of the APS and AACBT but acknowledge that many psychologists in Australia hold memberships with partner organizations, such as the Association for Behavioral and Cognitive Therapies (ABCT), The British Association for Behavioral and Cognitive Psychotherapies (BABCP), European Association for Behavioral and Cognitive Therapies (EABCT), the International Association for Cognitive Psychotherapy (IACP), and, more recently, the Association for Contextual Behavioral Science with its emphasis on Acceptance and Commitment Therapy. Australian psychologists have also sought specific accreditation in the practice of CBT via the Academy of Cognitive Therapy, a multidisciplinary certifying organization.

(i) The Australian Psychological Society (APS)

The APS has been a distinct force in the emergence of cognitive behavior therapy in Australia. Its strong ties from the outset with universities and teachers' colleges, and its emphasis on evidence in the training of psychology practitioners, are still reflected in current national accreditation and registration requirements in Australia (Cooke, 2000).

Established in 1944, with 44 members, as the Australian Branch of the British Psychological Society (BPS), members voted to become the independent APS – the organisation coming to fruition in 1966. The APS, with a current membership of around 24,000, has functioned as a national body representing psychologists through state groups, regional branches, a series of divisions representing academic and practitioner arms of the society, and public interest and professional special interest groups. In 2017, the APS voted on a new governance structure, consisting of a representational Board and Council. The APS advocates for the profession and discipline of psychology, publishes three main journals (*Australian Psychologist, Clinical Psychologist,* and *The Australian Journal of Psychology*), holds numerous conferences and a congress, undertakes several activities around the issues of public interest, provides psychology practitioners with evidence-based practice guidelines, runs a training institute (the APS Institute), maintains standards and the professional code of conduct, and participates in course accreditation processes which impact on national professional registration and endorsement.

One of the great achievements of the APS was to directly advocate and succeed in embedding government-funded rebates for evidence-based therapy, and particularly CBT, within the Australian national universal health system (see section below on the policy context in Australia which describes the "Better Access to Mental Health Care" initiative). Through this initiative, consumers have been able to access rebates for CBT services, greatly increasing access, particularly to mental health experts delivering focused psychological interventions such as those embedded within CBT.

The APS has also established excellent linkages and collaborations with other professional groups representing medical practitioners, allied health and mental health, consumers, indigenous health practitioners, and others. For example, the APS Institute, together with the Australian Association of Social Workers and Occupational Therapy Australia, developed the first online training course in CBT for Australian mental health professionals (*CBT Fundamentals: Processes and Techniques in Cognitive Behavior Therapy*), funded by the Australian Government Department of Health and Ageing (DoHA) to support the Better Access to Mental Health Care initiative. The course has now successfully trained over 7000 mental health professional across Australia.

(ii) The Australian Association of Cognitive Behavior Therapy (AACBT)

According to Birnbrauer (1994), the Australian Behavior Modification Association (ABMA), the first official entity aimed at representing behavior modification or behavior therapy in Australia, was set up following an informal meeting of relevant individuals from various states at an APS conference in 1974. Initially led by Victoria in the early 1970s, the ABMA constituted a relatively loose grouping of state branches that were incorporated locally. The recognition of the cognitive revolution in psychology led to a name change for the organization and in 2010 the AACBT was formed as a national body. "Broadly speaking, the AACBT is concerned with the application of behavioral and cognitive sciences to understanding human behavior, developing interventions to enhance the human condition, and promoting the appropriate utilization of these interventions" (King, 2016, p. 266). It is a multidisciplinary association with membership open to psychologists, psychiatrists, teachers, counselors, coaches, occupational therapists, social workers, other tertiary qualified health professionals, and other groups interested in using the cognitive behavioral approach "to help bring about emotional, cognitive, and behavioral change" (King, 2016, p. 266) across all aspects of health care. It is a particularly inclusive organization, attempting to disseminate research findings from all branches of cognitive and behavioral therapy (e.g., behavior therapy, cognitive therapy, CBT, acceptance and commitment therapy, mindfulness-based CBT).

AACBT currently organizes conferences (its first national conference was in 1978, while it has hosted over 40 conferences) and workshops with national and international experts, facilitates local professional development activities, publishes a journal (*Behavior Change*, first published in 1984 by the Victorian Branch), provides professional awards to recognise researchers and practitioners in cognitive behavior research and therapy, and has a national website and social media presence

(e.g. a Facebook page with over 9000 followers in 2016 and now over 12,000; Menzies, 2016), which it uses to update members and followers on news, research, and facilitates professional and networking opportunities. AACBT has established links with the major umbrella organisations representing cognitive and behavioral work internationally (including ABCT, EABCT, Asian Cognitive Behavioral Therapies Association [ACBTA], and IACP), and has representatives on the Committee of the World Congress of Behavioral and Cognitive Therapies. From the outset, ABMA/AACBT demonstrated its intentions for global outreach (see later section on Global Reach), with the Queensland Branch hosting the 4th World Congress of Behavior Therapy on the Gold Coast in 1992 and Melbourne hosting the 8th World Congress of Behavioral and Cognitive Therapies in 2016. Conference proceedings and papers emerged from those conferences (Menzies et al., 2016; Sanders & Halford, 1992) highlighting the quality and range of research in cognitive behavior therapy emanating from Australia and the world.

The Policy Context in Australia

While CBT is practiced mainly by psychologists in Australia, particularly as most clinical psychology postgraduate training programs provide foundational knowledge in CBT (Kazantzis & Munro, 2011), numerous other health and mental health professionals and paraprofessionals are also trained in or practice CBT. This is reflected in the multidisciplinary membership of AACBT and training opportunities provided by the APS Institute. Despite the wide acceptance and practice of CBT, there are currently no formal certification requirements within Australia, although the AACBT has recently introduced an accreditation system for members that is similar in its requirements to that of the BABCP. Despite the absence of certification of practitioners in the past, CBT has permeated Australia's nationalized healthcare system that provides specified rebates via the Medicare Benefits Schedule for a wide range of healthcare services, with primary care as a centrepoint. Patients present to their general medical practitioner (GP) and, should more specialised care be required, patients can be referred on. Traditionally, such referrals have been limited to specialist medical practitioners but, in recent years, the importance of a multidisciplinary approach to many health problems has been acknowledged. In particular, the contribution of psychologists and allied health practitioners to mental healthcare has been recognized by policy makers. In 2006, and of particular relevance to mental health and CBT, a national program termed "Better Access to Mental Health Care" was introduced, specifically targeting mental health presentations within primary care.

Better Access allows GPs with specific training to develop mental health plans and refer on for ongoing care which encompasses CBT (Kyrios, 2014). In addition to GPs, referrals can also be made by psychiatrists and paediatricians to generalist and endorsed clinical psychologists or social workers and occupational therapists for rebatable focused psychological treatments based on CBT. While the initial policy

allowed for up to 18 sessions of individual therapy in addition to the same number of group sessions per year, the uptake by the public was so great that budget overspend considerations led the federal government to limit the number of sessions to only up to 10 individual and 10 group sessions per year. The COVID pandemic provided an impetus to increase the number of sessions and to introduce telepsychology sessions. Referrals are initially made for a maximum of 6 sessions with a GP assessment required to determine whether the additional sessions are needed. While the limited number of sessions compromises the quality of care for certain conditions (obsessive compulsive disorder, posttraumatic stress disorder, hoarding disorder, psychosis, etc.), some additional service provision models have been developed that can be accessed through primary care networks and non-government organisations. The bulk of Better Access referrals are to psychologists, with endorsed clinical psychology sessions making up around half of those. (A similar emphasis on CBT exists in New Zealand, though there is a different training and healthcare context, [Kennedy-Merrick et al., 2008]). The impact of CBT and the role of psychologists in particular have also led to impacts in specialist mental healthcare and to health contexts such as rehabilitation, pain, diabetes and cardiac care, migraines and headaches, sleep disorders, etc. Since the advent of Better Access, there have been enormous increases in the number of individuals with a mental disorder receiving CBT and significant decreases in levels of distress, depression and anxiety (Pirkis et al., 2011).

A review of the Medicare Benefits Schedule has been undertaken that may change the funding framework again. While a number of challenges have been identified with respect to unplanned impacts of Better Access on the profession, training courses, and equity (Gilmore et al., 2013), the major point to consider, however, is that CBT was purposely chosen to be the cornerstone of mental health care within primary care in Australia because of its evidence base. Other criticisms of the Australian system include the lack of local CBT certification and, possibly reflected in cost blowouts, the lack of a nationwide stepped care approach to mental healthcare. GPs can make a referral anytime, with no evidence required that the particular professional receiving the referral has specific levels of expertise in CBT.

While almost all clinical psychology programs in Australia are now CBT-based, a large proportion of psychologists maintain an eclectic or psychoanalytic approach to their practice. Furthermore, referrals are generally made without specific reference to the severity of the disorder which, in many international contexts, is linked to the "intensity" of treatment. For instance, in the United Kingdom, a stepped care approach is utilized in the delivery of low- and high-intensity psychological interventions (IAPT, 2012). The UK's Increasing Access to Psychological Therapies (IAPT) program aims to facilitate access to psychological treatment for people with high prevalence mental health disorders (e.g. depression and anxiety) through the provision of four levels of stepped care that are based on guidelines by the National Institute for Health and Care Excellence (NICE), an independent public body providing national guidance and advice aimed at advancing care in the United Kingdom.

Albeit with some significant differences, the IAPT framework has formed the basis for the development of the *beyondblue* New Access program in Australia, a pilot which was exclusively funded by a non-government organisation. To date, a

higher intensity component in stepped care has not been incorporated into New Access. Furthermore, New Access could accept direct self-referral via telephone and social media, rather than following a GP referral. Moreover, New Access training was not overseen by a relevant professional body (i.e. the APS), as it had in the United Kingdom by the British Psychological Society. While Cromarty et al. (2016) reported that initial recovery rates and the economic viability of New Access were promising in a non-independent pilot evaluation, a stepped care framework has not yet been established formally in Australia. Stepped care was particularly important in the success of the United Kingdom's IAPT program where higher reliable recovery rates were associated with a higher average number of therapy sessions, higher step-up rates among individuals who started with low-intensity treatment, larger services, a larger proportion of experienced staff, and NICE recommended treatments (Gyani et al., 2013). Nonetheless, there are moves towards stepped care models in Australia with a number of alternatives being developed, inclusive of the use of digitally delivered CBT.

A salient feature of CBT is its suitability for adaptation into interventions that can be delivered and disseminated via digital means (e.g. online, smartphone apps) in automated, therapist-assisted, or multimodal formats (Bakker et al., 2016). There is now a large body of research supporting the acceptability, feasibility, and efficacy of digital delivery of mental health resources in assessing and using cognitive behavioral principles and strategies to treat psychological disorders (Andersson & Carlbring, 2017), although uptake and engagement fluctuate widely (Fleming et al., 2018). Digitally delivered interventions span the spectrum from those for mental health literacy, help seeking, public health/health promotion, at risk/early intervention, and treatments, either automated self-help or therapist-assisted, for specific symptoms, high prevalence psychological disorders, serious mental illness, and suicide prevention.

The Australian government has invested in the development of digital CBT mental health interventions for high prevalence disorders. Australia has led the great developments over recent years in the online dissemination of CBT, inclusive of the integration of online CBT into the national mental health policy (Australian Government Department of Health and Ageing, 2012). The Australian government's e-mental health strategy (Australian Government Department of Health and Ageing, 2012) has supported the development and maintenance of various online and remote psychological treatment services, while embedding these within the national health and mental health system in a formal capacity and developing staged models of care is the next priority. An online repository of CBT-based mental health interventions has been developed inclusive of a portal (Head-to-Health; see https://headtohealth.gov.au), a website designed to help people with mental health conditions or challenges link to trustworthy online information and resources, most of which are CBT-based. There is ongoing development of such digital supports, inclusive of the further development of quality indicators so that consumers and professionals can differentiate quality products, the training of professionals to incorporate such resources into their work, and the facilitation of

access to such resources to community-based service providers (Reynolds et al., 2015).

Global Reach of CBT in Australia

A number of international conferences have been held in Australia where CBT has taken a central role. In 2014, the APS hosted the 27th International Congress of Applied Psychology in Melbourne. Within that conference, there were a multitude of CBT researchers presenting keynotes, symposia, and papers. More significantly, as mentioned above, the 1992 World Congress of Behavior Therapy was hosted by the Queensland Branch of ABMA on the Gold Coast and, in 2016, the AACBT hosted the 8th World Congress of Behavioral & Cognitive Therapies in Melbourne. Over 2300 delegates from more than 50 countries attended that event that had been 10 years in the planning. One emphasis was to showcase research from emerging economies and in regions where CBT had not been the dominant treatment modality in the past. The AACBT introduced a free registration scheme for delegates from emerging nations, which saw attendees come to Australia from the Sudan, Congo, Ethiopia, Uganda, Zimbabwe, Nigeria, Sierra Leone, Indonesia, Papua New Guinea, and many other nations. The theme of the 8th WCBCT was "Advances and Innovations in the Behavioral and Cognitive Therapies Across the World" (see Menzies et al., 2016). A second emphasis of the event was to attract delegates from beyond the traditional disciplines of mental health. Applications of the cognitive and behavioral sciences in experimental psychology, clinical psychology, psychiatry, nursing, social work, psychiatry, primary care, and a range of related areas in allied health and health policy were presented. This was in keeping with the multidisciplinary nature of the host organization, the AACBT.

The Future of CBT in Australia

CBT is currently firmly entrenched within the Australian health and mental health system. Professionals, paraprofessionals, educators and peer supports are using CBT and CBT-based frameworks to: (a) impart information and treatment strategies that empower individuals affected by health and mental health challenges to manage their symptoms and lives and/or (b) to educate youth and adults so as to better manage or prevent difficulties and build resilience. With respect to the latter, the return of CBT at a broader level to primary and secondary educational contexts is an exciting development.

Furthermore, digitally supported CBT has made a significant impact on the broader Australian community. While various models and resources have been developed to help clinicians integrate digitally supported CBT into their practice, few training programs or supervision arrangements support the development of

requisite skills. A part of the future of CBT and its dissemination lies in the development of training programs to facilitate the integration of e-based CBT skills into the arsenal of practitioners. Technological developments will further facilitate the utility of CBT. For instance, technology can facilitate access to individualised content chosen on the basis of client preferences or algorithms that integrate information from structured online assessments. Exposure-based interventions will be advantaged by augmented and virtual reality capabilities. The use of avatars in online programs has already begun (Rehm et al., 2016). With such opportunities come challenges, inclusive of ethical and legal concerns, keeping up with technological advances, developing viable business models to support digital services, and adjusting models of interdisciplinary and professional-peer interactions (Kyrios & Thomas, 2014; Kyrios et al., 2015).

Finally, the role of our Australian CBT professional bodies in supporting developments in emerging nations in our region is only beginning to be explored. The AACBT is playing a significant role in current planning for a World Confederation for Behavioral and Cognitive Therapies. The new organisation has the support of many of the largest international CBT associations and has been developed by the World Congress Committee of the WCBCT. It is a global organisation to represent CBT activities and influence policy making in mental health. One of its aims is to overcome regional barriers and provide support for emerging nations with little current access to specialist CBT services. Australia is well placed to support emerging economies in the Pacific region to gain access to CBT services. This may, of course, critically involve the use of e-therapies described above. CBT has not only had a golden past in Australia but Australian CBT researchers and practitioners will continue to impact globally.

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