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原著論文（実践研究）

Pilot Trial of Classroom-Based Brief Cognitive Behavior Therapy (BCBT) for Japanese Pre-Adolescent Students as Compared to the FRIENDS CBT program

Yuki Matsumoto (School of Human Life Sciences, Tokushima Bunri University)
Yuma Ishimoto (Teacher Education Center, Tottori University)

Abstract: Cognitive Behavior Therapy (CBT) has been shown to be effective in children with various behavioral and emotional problems. Given that schools can act as a suitable space for prevention and early intervention for mental health problems, CBT can be adapted to the school setting and can be useful in enhancing students' social and emotional skills. Unfortunately, the rigorous Japanese school curriculum currently limits the available time for the implementation of CBT in schools.

The aim of the present research is thus to examine the efficacy of a Brief Cognitive Behavior Therapy (BCBT) program for pre-adolescent students developed by the authors and to compare the results with a CBT program (FRIENDS). The BCBT program consisted of six 20-minute sessions in the after-school period delivered by a volunteer homeroom teacher, whereas the CBT program was delivered by two homeroom teachers for ten 45-minute sessions during the class period. Students completed a questionnaire sheet at pre-, post-, and follow-up periods under the supervision of their homeroom teacher. Significant positive changes were found in anxiety and behavioral difficulties for both the BCBT and CBT programs. The results indicate the feasibility of using BCBT in a Japanese school setting.

Keywords: Brief Cognitive Behavior Therapy, Cognitive Behavior Therapy, Mental health services in schools, Child mental health, Japanese school

The prevalence rates for childhood mental health problems in Japan have been found to be anywhere from 8.7 to 15% of the childhood population (Tanaka, Terashima, Borres, & Thulesius, 2012). Moreover, according to the Ministry of Education, Culture, Sports, Science, and Technology (MEXT, 2016), the rate of nonattendance in primary and junior high schools was estimated to be at 1.26% of the total student population. This absenteeism was explained by several related factors, including: emotional problems such as anxiety (30.6%), lethargy (30.2%), and difficulties in relationships with peers (17.2%). Despite recent laws to provide various opportunities for flexible learning, the total rate of nonattendance increased to 1.69 % in 2018 (MEXT, 2019).

Findings from an international comparison study showed that Japanese 14-to15-year-old students reported more difficulties in interpersonal relationships and more feelings of powerlessness than their Korean and Chinese counterparts (Houri, Nam, Choe, Min, & Matsumoto, 2012). Furthermore, children who were diagnosed with a mental health problem have been found to be more likely to continue through adolescence with the disorder, or to develop a new psychiatric problem (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003). Given these findings, preventive and early intervention should be offered in childhood or early adolescence.

Since there are existing barriers to accessing mental health services, including a lack of professional services in communities and the parental stigma associated with clinical settings, the school has a significant role to play in addressing children's health problems. Research has demonstrated the efficacy of school-based preventive programs (e.g., universal, selective, and indicated preventive programs), most of which are based on Cognitive Behavioral Therapy (CBT) components (Neil & Christensen, 2009). CBT with children has shown to be effective in its application to various problems, including anxiety and depression (Silverman & Hinshaw, 2008). CBT can also fit well in the school settings as components such as psychoeducation, skill-building, between-session work, and progress monitoring already exist as common services within the school, and thus teachers can more easily accept the approach (Mennuti, Freeman, & Christner, 2006). The effective application of CBT in schools can aid schools in preventing psychological problems through early interventions by reducing stigma, giving access to treatment, and helping students to sustain their acquired competencies (Mychailyszyn et al., 2011).

Findings from different research on school-based preventive programs have shown a variation in effect sizes highlighting the importance of mediating variables such as adherence to program fidelity, and levels of participation (Stallard et al., Taylor, Anderson, Daniels, Simpson, Phillips, & Skryabina, 2012). In terms of differences in the effectiveness of preventive programs between countries, these too can be explained by differences in the school system, cultural norms and values, and the socio-economic characteristics of the participants (Kösters, Chinapaw, Zwaanswijk, Wal, Utens, & Koot, 2012). In the Japanese school system in particular, teachers have reported difficulties in implementing preventive programs due to various reasons, including: a lack of knowledge and skills, acceptance at school, time restrictions, limited budgets, and/or adjustment by students (Miyake, Yoshikawa, & Takada, 2008). Thus, to implement CBT in schools, there is a valid need for adaptation to fit the specific school context.

Brief CBT (BCBT) has been developed to overcome barriers for treatment including the length of treatment, costs, and access to services (Beidas, Mychailyszyn, Podell, & Kendall, 2013). BCBT could be a valuable resource in school settings because of its short duration, access to both clinical and at-risk children, and the availability of experiential learning via in vivo exposures (Crawley et al, 2013).

BCBT reduces the average 12 to 20 CBT sessions into 4 to 8 sessions with specific

treatments for a limited number of the client's problems. The exact length of treatment is thus determined by identifying factors relevant to the participants and treatment settings (Cully & Teten, 2008). BCBT is composed of two main parts: psychoeducation and practicing skills (Beidas et al., 2013). Hence, BCBT in schools can adapt to school schedules and its contents in psychoeducation and skill training to specific school needs. Examples of suitable problems for BCBT could include for example, anxiety, depression, assertiveness, exercise, and social isolation (Cully & Teten).

The current research was a preliminary trial of a BCBT program using a CBT program as a control group. The aim of the study was to develop a BCBT program suited to Japanese school contexts, including the following: curriculum integrated (using short before- or after-school homeroom periods), teacher taught (using stress-free manual sheets), and shorter sessions (approximately 15 to 30 minutes). The program efficacy was evaluated by examining students' behavioral, emotional, and interpersonal problems.

METHOD

BCBT program

A Brief CBT program was developed for the present study to reduce the emotional, behavioral, and interpersonal problems in students. The program consisted of six 15- to 30-minute sessions as part of a structured group intervention in a classroom gathering. The program consisted of skill training based on CBT, including attention training, relaxation, and self-control (see Table 1).

Each session was composed of a learning component (psychoeducation) and an activity component (skill training) such as discussion and/or role-plays with peers. For example, in the fifth session, the psychoeducation component involved positive and negative attention patterns (i.e., individual patterns of paying attention to positive or negative things), the usefulness of positive attention, and the introduction of attention training. In the activity component, the students were then encouraged to talk about their attention patterns and share examples of their positive attention.

The present program was grounded on Social Learning Theory (Bandura, 1977) and Ecological System Theory (Bronfenbrenner, 1979) in which teachers are regarded as supporters for students. Teachers thus provide students with a wide range of support for growing their competence in various skills, including: building positive relationships, promoting positive behaviors, handling their

Table 1
CBT and BCBT's session contents

	CBT	BCBT
1	Developing a sense of self	Assertion: Clear words and warm talk
2	Awareness of feelings	Attention Training: Finding happy things
3	Relaxation: Breathing, Muscle relaxation, and meditation	Peer Praise: Attending preferable behaviors
4	Cognitive restructuring: Red and Green thoughts	Relaxation: Breathing and Muscle relaxation
5	Cognitive restructuring: Challenging red thoughts	Preventive Approach: Setting fair class rules
6	Coping Step Plans	Regulation: Self-time-out
7	Role Model and Support Networking	
8	Problem Solving	
9	Review and Practice9	
10	Cerebration	

emotions, and solving interpersonal problems. Thus, this program teaches views and skills which are beneficial for all students while providing opportunities for normalization, social interactions, modeling, and peer and group feedback.

The program sessions were conducted by a homeroom teacher with a session guidance sheet structured into four parts: (1) session purposes and main points, (2) psychoeducation, (3) activities including role-playing and discussion, and (4) sharing reflections and comments. Depending on the available time, teachers could increase or decrease the number of activities.

CBT program

The FRIENDS for Life for Children (Barrett, 2010) program was developed in Australia, and is a school-based CBT program that aims to reduce anxiety in children aged eight to 11 years old. The revised version of FRIENDS for Children (Barrett, Lowry-Webster, & Turner, 1999) has been studied internationally, and the World Health Organization endorsed it as an evidence-based program effective through universal, indicated, and targeted formats in reducing anxiety in children and adolescents (WHO, 2004). The program is a structured, ten-session program that has three main components based on CBT including learning behavioral, cognitive, and emotional components, and physiological responses. The aim of the program is to teach skills that are beneficial for all students and encourages participation in group activities in all sessions.

Participants

A total of 30 students (13 females and 17 males) participated in the BCBT group aged 9 to 10 years old from a primary school in a local city area. In the CBT group, 45 students (22 females and 23 males) aged 10 to 11 years old from 2 primary schools in another local city area participated. The students belonged to regular classes, and none of the students were found to have any diagnoses of mental health problems.

Procedure

After the university's Ethical Board approved the study, schools were invited to the project through the Education Board. The authors held a three-hour workshop where 56 teachers learned CBT approaches for classroom management such as how to teach students relaxation, the relationships between thoughts, feelings, and behaviors, and problem solving. Participants in the study were then recruited after explaining study purposes, methods, and ethical considerations.

Three homeroom teachers voluntarily participated in the study: one allocated to the BCBT program, and the other two to the CBT program based on the available time in the school setting. The principals sent parents a consent form with an information sheet about the project which was collected before the commencement of the study. The students' consent was obtained by the teachers in class. The BCBT program was held continuously for over two weeks in the after-school homeroom (KAERINOKAI). The CBT program was implemented over two and a half months (one session per week) during the periods for integrated studies (SOGO NO GAKUSHU), moral education (DOTOKU), and special activities (TOKUBETSU KATSUDO). The students in both groups were invited to lively group activities in all the sessions encouraging

them to share ideas and comments with the whole class.

The students completed self-report questionnaires in their classroom administered by the teachers both pre-, and post-program in 2014, as well as in a follow-up period in 2015: Time 1 (June), 2 (September), and 3 (February) respectively. The follow-up was conducted before the school year ended in March. To test the hypothesis, scores were analyzed using a two-way mixed ANOVA to examine the effect size. The teachers were asked to give feedback about session contents to estimate the acceptability of the program also.

Measures

The Spence Children's Anxiety Scale- Child Report Version (SCAS; Spence, 1998)

This four-point rating scale with 38 items (0 = never, 1 = seldom, 2 = occasionally, and 3 = often) provides an overall measure of total anxiety, as well as 6 subtype scores which correspond to DSM-IV-TR anxiety disorder categories: separation anxiety, social phobia, obsessive-compulsive, panic attack and agoraphobia, general anxiety, and fears of physical injury. This self-report measurement targets children and adolescents between 8 and 16 years of age.

The scale has demonstrated high internal consistency and concurrent validity with other measures of child and adolescent anxiety scales, as well as adequate test-retest reliability (Spence, Barrett, & Turner, 2003). The SCAS has been regarded as a useful measure to assess child anxiety symptoms in different countries, including non-Western and non-English speaking countries (Ishikawa, Sato, & Sasagawa, 2009). A Japanese version of the SCAS can be obtained on the author's website which has demonstrated a good reliability and validity with Japanese samples (Ishikawa et al., 2009). In the present study, the scale showed good reliability with a reported Cronbach alpha coefficient of .88 at the pre-program.

The Depression Self-Rating Scale for Children (DSRS-C; Birleson, 1981)

The DSRS is an 18-item self-report scale rated on a three-point scale (0 = never, 1 = sometimes, and 2 = mostly) used for children from seven to 13 years of age. The Japanese version (Murata, Shimizu, Mori, & Oshima, 1996) has demonstrated a good reliability and validity with Japanese samples: Cronbach alpha=.77, test-retest reliability=.73. In the present study, the scale showed good reliability with a reported Cronbach alpha coefficient of .71 in the pre-program testing.

The Strengths and Difficulties Questionnaire (the Student 11-17 version) (SDQ; Goodman, 1997)

The SDQ is a 25-item questionnaire rated on a three-point scale, which measures perceptions of behaviors in children aged two to 17 years of age. The scale has child, parent and teacher versions including five subscales of five items each: emotional symptoms, conduct problems, inattention/hyperactivity, peer problems, and prosocial behaviors. The score of total difficulties (TD) is calculated by adding the scores of four subscales except for prosocial behaviors.

This study used the student version for participants aged 11 to 17 years old, although it must be noted that the participants in the current study were from nine to 11 years old. This measurement was chosen on the ground that a study with 5072 children (Noda, Ito, Harada, Nakajima, Takayanagi, & Someki, 2013) used the student version and produced

the normative data of Japanese children and adolescents nine to 15 years of age. In this study, the SDQ in pre-program testing showed a Cronbach alpha of .69 which is reasonable or adequate (Taber, 2017).

RESULTS

Two-way mixed ANOVAs were conducted to compare the scores of both groups (BCBT and CBT) at three points in time: Time 1 (prior to the intervention), Time 2 (after the intervention), and Time 3 (a follow-up period). The teachers' feedback was also submitted to the Education Board, which was then forwarded to the authors.

The scores on the SCAS and the DSRS-C prior to the intervention were found to be in the normal ranges, that is, students' anxiety and depression levels were found to be normal (see https://www.scaswebsite.com/; Denda, Kako, & Sasaki, 2004). In regards to the SDQ scores, the pre-scores on the five subscales were slightly below or exceeded the normative data (Noda et al., 2013), which reported each mean score and SD for male and female students respectively: Emotional symptoms 3.00 (2.28) and 3.68 (2.56); Conduct problems 2.62 (1.63) and 1.97 (1.35); Hyperactivity 4.65 (2.05) and 4.09 (2.12); Peer problems 2.70 (1.71) and 2.45 (1.64); Pro-sociality 5.36 (1.99) and 6.20 (1.98); and Total difficulties 12.93 (5.47) and 12.15 (5.37).

Initial support for BCBT

The pre- and post-scores were used to evaluate the program efficacy in alleviating students' emotional, behavioral, and interpersonal problems. Table 2 shows the results on the SCAS and the SDQ (including sub-scores) at the pre- and post-periods (Time 1 and 2) along with the F-value, p-value and effect size (Hedges' adjusted g). Table 3 presents the scores of the DSRS-C at pre- and post-periods (Time 1 and 2) along with the t-value, p-value and effect size (Hedges' adjusted g).

In regards to emotional problems, the SCAS total anxiety score and its five subscales (Separation Anxiety Disorder, Social Phobia, Obsessive-Compulsive Disorder, Panic Attack and Agoraphobia, and Generalized Anxiety Disorder) indicated a significant improvement with an effect size between .30 and .55. The DSRS-C also showed a significant positive change with an effect size of .29. These effect sizes can be estimated as small to medium.

Regarding behavioral problems, the SDQ TD (the total score of emotional symptoms, conduct problems, hyperactivity and peer problems, excluding pro-sociality) was found to have a significant improvement. The Hedges' adjusted g was found to be .39 suggesting the

Table 2
Pre- and post-scores on the SCAS and SDQ in BCBT group

	Pre (T1)		Post (T2)		F	p	g_{adj}
	M	*SD*	*M*	*SD*			
SCAS (n = 25)							
SAD	4.08	3.95	2.88	3.82	9.19	.006	.30
SP	4.52	3.63	2.72	2.78	20.25	.000	.55
OCD	3.84	3.39	2.48	2.95	6.62	.017	.42
PA & A	3.96	4.14	1.96	3.60	7.55	.011	.51
PIF	3.76	2.98	3.04	2.56	2.37	.136	.26
GAD	2.24	2.15	1.36	1.63	5.76	.024	.45
TA	22.40	15.40	14.44	13.36	18.38	.000	.54
SDQ (n = 29)							
ES	2.69	2.36	2.10	2.41	3.82	.061	.24
CP	2.38	1.21	1.79	1.40	3.44	.074	.44
HA	3.62	2.16	3.24	2.21	1.41	.245	.17
PP	3.28	1.83	2.83	1.61	1.68	.206	.26
PS	6.10	1.93	5.79	1.88	1.85	.184	.16
TD	11.97	4.74	9.97	5.24	7.73	.010	.39

Note. SAD: Separation Anxiety Disorder; SP: Social Phobia;
OCD: Obsessive-Compulsive Disorder;
PA & A: Panic Attack and Agoraphobia;
PIF: Physical Injury Fears;
GAD: Generalized Anxiety Disorder;
TA: Total Anxiety; ES: Emotional Symptoms;
CP: Conduct Problems; HA: Hyperactivity;
PP: Peer Problems; PS: Pro-Sociality;
TD: Total Difficulties

Table 3
Pre- and post-scores on the DSRS-C in BCBT group

n = 29	Pre (T1)		Post (T2)		t	p	g_{adj}
	M	*SD*	*M*	*SD*			
DSRS-C	9.38	4.51	8.00	4.86	3.34	.002	.29

Note. DSRS-C: Depression Self-Rating Scale for Children

effect size was between small and medium. Each of the subscales, however, displayed no significant changes.

As to interpersonal problems, the results were found to be mixed. Whereas the social phobia (SP) subscale of the SCAS which included six items (e.g., "I feel afraid that I will make a fool of myself in front of people" and "I am a good person") was found to have a significant positive change ($p = .000$ and $g_{adj} = .55$), the peer problems, pro-sociality and hyperactivity subscales of the SDQ showed no significant difference between Time 1 and 2.

Comparison between BCBT and CBT

Tables 4, 5, and 6 present the outcomes of the comparison analyses between the three scales in the two groups using a partial eta squared (p-η^2) as a measure of effect size. The number of students in the two groups varied from Time 1 (pre-program period) to Time 3 (follow-up period) because of the absence of data over the three-time periods. No significant group difference was found between the two groups with small effect sizes (the partial eta squared between .04 and .00).

Teachers' feedback

The teachers gave their feedback about the program to the Education Board whose representative then forwarded the feedback to the authors. The teachers in both groups were found to have appreciated the psychoeducation and skills based CBT practices. The teacher in the BCBT highlighted that the program was easy to deliver in a brief time session, and made positive changes in the class. He liked the short length and explicit purposes in the sessions

Table 4
SCAS Scores in BCBT and CBT Groups

	BCBT (n = 24)						CBT (n = 29)						Time x Group			Time			Group		
	T1		T2		T3		T1		T2		T3										
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*	*p*	*p-η2*	*F*	*p*	*p-η2*	*F*	*p*	*p-η2*
SCAS																					
SAD	4.17	4.01	2.96	3.88	3.63	4.74	3.45	4.44	2.59	2.97	2.90	3.26	.12	.866	.00	3.13	.054	.06	.40	.533	.01
SP	4.67	3.63	2.83	2.78	4.54	5.41	3.72	4.25	2.93	3.03	3.21	2.96	1.61	.206	.03	5.50	.006	.10	.62	.434	.01
OCD	4.00	3.36	2.58	2.96	4.04	3.72	3.79	4.21	2.55	2.80	2.86	3.24	.80	.425	.02	3.81	.037	.07	.39	.534	.01
PA & A	4.00	4.22	2.04	3.65	3.46	6.00	2.34	5.14	1.41	1.92	1.72	1.93	.56	.516	.01	3.13	.066	.06	2.27	.138	.04
PIF	3.83	3.02	3.00	2.60	3.46	3.48	4.21	3.41	3.86	3.08	3.90	2.93	.24	.756	.01	1.19	.305	.02	.58	.450	.01
GAD	2.33	2.14	1.42	1.64	3.21	4.90	3.00	4.16	2.28	2.49	2.28	2.85	1.58	.214	.03	1.61	.208	.03	.10	.753	.00
TA	23.00	15.43	14.83	13.50	22.33	26.36	20.52	22.79	15.62	13.45	16.86	12.95	.90	.389	.02	4.08	.028	.07	.32	.572	.01

SAD: Separation Anxiety Disorder; SP: Social Phobia; OCD: Obsessive-Compulsive Disorder; PA & A: Panic Attack and Agoraphobia; PIF: Physical Injury Fears; GAD: Generalized Anxiety Disorder; TA: Total Anxiety

Table 5
SDQ Scores in BCBT and CBT Groups

	BCBT (n = 29)						CBT (n = 22)						Time x Group			Time			Group		
	T1		T2		T3		T1		T2		T3										
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*	*p*	*p-η2*	*F*	*p*	*p-η2*	*F*	*p*	*p-η2*
SDQ																					
ES	2.69	2.36	2.10	2.41	2.45	2.86	2.14	2.53	2.64	2.80	1.77	2.14	1.77	.179	.04	.43	.638	.01	.16	.695	.00
CP	2.38	1.21	1.79	1.40	2.48	1.33	2.50	1.68	2.64	2.04	2.45	1.63	1.60	.208	.03	.57	.562	.01	.99	.325	.02
HA	3.62	2.16	3.24	2.21	3.00	2.25	3.86	2.36	3.32	1.81	3.18	2.02	.05	.947	.00	3.06	.054	.06	.10	.750	.00
PP	3.28	1.83	2.83	1.61	2.66	2.09	3.05	1.86	3.00	1.63	3.18	1.82	1.25	.291	.03	.69	.494	.01	.13	.720	.00
PS	6.10	1.93	5.79	1.88	5.66	2.06	5.45	3.40	5.32	3.34	4.91	3.46	.11	.894	.00	1.42	.246	.03	.85	.361	.02
TD	11.97	4.74	9.97	5.24	10.59	6.04	11.55	6.14	11.59	5.85	10.59	4.09	1.16	.317	.02	1.57	.214	.03	.10	.756	.00

ES: Emotional Symptoms; CP: Conduct Problems; HA: Hyperactivity; PP: Peer Problems; PS: Pro-Sociality; TD: Total Difficulties

Table 6
DSRS-C Scores in BCBT and CBT Groups

	BCBT (n = 29)						CBT (n = 29)						Time x Group			Time			Group		
	T1		T2		T3		T1		T2		T3										
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*	*p*	*p-η2*	*F*	*p*	*p-η2*	*F*	*p*	*p-η2*
DSRS-C	9.38	4.51	8.00	4.86	8.00	5.79	10.28	4.83	9.28	4.68	9.31	5.18	.09	.903	.00	3.20	.048	.05	1.01	.319	.02

DSRS-C: Depression Self-Rating Scale for Children

which made it feasible to implement the program. Also, he advised that the program could have additional sessions depending on the students' needs, and be recommended to any teachers who are needing help in classroom management. The teachers that were part of the CBT program, on the other hand, had some difficulties with time management in implementing all of the sessions, as well as with preparing the session plans.

DISCUSSION

One of the aims of the present study was to address the difficulties in the implementation of CBT programs in Japanese schools due to school time restriction, teachers' concerns about knowledge and skills, and curriculum integration. Although the mixed results do not provide conclusive evidence for the efficacy of BCBT, the comparison with the CBT program (FRIENDS) found no group difference in the scores between BCBT and CBT which is promising for the future of BCBT programs.

Impact on emotional problems

After the completion of the BCBT program, the students were found to have a reduction in emotional difficulties. The improvement was found in the SCAS total anxiety scores and the DSRS-C depression scores. The results were consistent with research on CBT, more specifically, the FRIENDS program (e.g., Briesch, Sanetti, & Briesch, 2010). Researchers have argued that anxiety symptoms in childhood precede the onset of depressive disorders in adolescence (Chopita & Daleiden, 2002). The current findings with pre-adolescent students may indicate usefulness of BCBT in preventing the development of future emotional problems.

Impact on behavioral problems

The SDQ TD score was found to have reduced after the program which suggests that the BCBT program improved students' behavior in school. This is consistent with the teacher's feedback about positive changes in the classroom. Compared to the recent Japanese normative data on the SDQ (Noda et al., 2013), the slightly higher pre-scores found in this study for conduct and peer problems reduced after the program. The results may indicate that the participants who displayed behavioral difficulties and needed some kind of intervention benefited from the treatment.

Interpersonal problems

The reduction in the SCAS SP subscale was found to be significant. Research findings regarding the SCAS indicate that Japanese children tend to select the SP items more frequently (e.g., "I worry what other people think of me"; Ishikawa et al., 2009). The current findings may indicate that anxiety related to interpersonal relationships decreased after the program. On the other hand, no significant difference was found in the SDQ peer problems subscale (e.g., "I would rather be alone than with people of my age"), as well as the pro-sociality subscale (e.g., "I try to be nice to other people. I care about their feelings"). These results indicate that the development of interpersonal competency may involve various factors such as time to practice, and the environment to perform.

Program acceptability

The teacher's positive comments about the BCBT program indicated that the program was acceptable for the school setting. The program

seemed to be easy to deliver and was found to be useful to help students. Researchers in the United Kingdom investigated teachers' views of the CBT program and found that a lot of the content and passive learning factors were less evaluated despite the program's usefulness (Skryabina, Morris, Byrne, Harkin, Rook, & Stallard, 2016). The positive acceptability of the BCBT program in the present research seemed to relate to factors pertinent to an education setting (e.g., the reduction of the program contents and time). As the feedback was from only one individual, future studies should have more participants to confirm teachers' acceptance and positive regard for the program.

CONCLUSION

The BCBT program examined in the present study was composed of six short sessions which aimed to facilitate the implementation of CBT in classroom settings, and to help students with the management of emotional, behavioral, and/or interpersonal difficulties. The study indicated the possibilities for BCBT to be implemented in Japanese schools where teachers in the past have had difficulties in implementing traditional CBT programs despite acknowledging them as useful. Since the study utilized a small number of participants, future research using a randomized control trial design should be conducted with a larger number of schools.

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