

Evidence-Based Practice in Child and Adolescent Mental Health

ISSN: 2379-4925 (Print) 2379-4933 (Online) Journal homepage: www.tandfonline.com/journals/uebh20

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To cite this article: Erica Mazzone, Chalita Antommarchi, Gabriela Bagnara, Hannah Jutzy, Abby Alido & Maya Boustani (2024) School-Based Opportunities for Adolescent Recovery (SOARing): The Acceptability and Feasibility of a DBT Skills Training Program for At-Risk Adolescents, Evidence-Based Practice in Child and Adolescent Mental Health, 9:1, 45-59, DOI: [10.1080/23794925.2023.2224113](https://doi.org/10.1080/23794925.2023.2224113)

To link to this article: <https://doi.org/10.1080/23794925.2023.2224113>



Published online: 30 Jun 2023.



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School-Based Opportunities for Adolescent Recovery (SOARing): The Acceptability and Feasibility of a DBT Skills Training Program for At-Risk Adolescents

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ABSTRACT

Adolescents from disadvantaged backgrounds are disproportionately at-risk for experiencing chronic stressors, which often decreases their ability to emotionally regulate and negatively impacts their psychological well-being. Effective prevention and early intervention programming that addresses emotion dysregulation is vital for improving mental health outcomes in these populations. School-based dialectical behavior therapy (DBT) offers a promising avenue for bolstering socioemotional health in at-risk students by emphasizing the development of four core skills: emotion regulation, mindfulness, interpersonal effectiveness, and distress tolerance. The purpose of this investigation is to describe the rationale for, and development of, a school-based DBT skills program for students attending a continuation high school in an underserved area, known as School-Based Opportunities for Adolescent Recovery (SOARing). Although it is not the first project to implement school-based DBT, SOARing is among the first to devise a 12-session, group intervention protocol through formative testing and evaluate its preliminary potential. Field note data from a pre-pilot trial were collected in order to determine the program's feasibility and acceptability. Results from these field notes and student satisfaction questionnaires indicate that the intervention was positively received, with constructive feedback from the students successfully incorporated as modifications to the program. These findings have since informed the protocol refinement of a larger randomized proof-of-concept trial that will test the effectiveness of SOARing in improving psychological outcomes.

A school environment offers an accessible option for delivering prevention and early intervention programming designed to promote adolescent mental health. In particular, schools reduce logistical barriers to mental health services, such as lack of insurance and transportation, and are also more convenient for recruiting and working with youth as compared with other environments (Masia-Warner et al., 2006). Schools are the largest providers of mental healthcare to children and adolescents (Bains & Diallo, 2016) and are often one of the few consistent mental health resources available in low-income communities (Atkins et al., 1998). Several meta-analyses have demonstrated the effectiveness of school-based universal, selective, and indicated prevention programs in improving mental health outcomes in youth (Calear & Christensen, 2010; Durlak et al., 2011; Stockings et al., 2016; Werner-Seidler et al., 2017).

Improving access to care becomes even more crucial when working with youth who have been designated as at-risk. Though “at-risk” is a broad term, it generally describes youth experiencing psychosocial vulnerabilities, such as school deviance, depression, and other problematic behavioral and emotional outcomes, that stem from adverse early environments and later negatively impact what is considered to be a healthy and typical adjustment to adulthood (Eggert et al., 1994). Stressors associated with poverty explain many community-level risk factors in these youth populations, including barriers to affordable care, family difficulties, separation from adult caregivers, substandard housing, food insecurity, inadequate school resources, and frequent moves and transitions (Atkins et al., 2006; Santiago et al., 2013; Slopen et al., 2010). In youth, each stressor increases the risk that internalizing problems will develop, while

also decreasing their ability to emotionally-regulate and employ coping strategies (Evans & Kim, 2013; Santiago et al., 2013). School-based interventions provide an accessible and affordable option for supporting at-risk youth in coping with these challenges (Masia-Warner et al., 2006), with programs based on cognitive behavioral therapy demonstrating strong support for improving mental health outcomes, such as depression and anxiety (Calear & Christensen, 2010; Neil & Christensen, 2009). However, since adolescents with multiple chronic stressors may have more difficulty employing coping strategies, prevention programs that emphasize improving emotion dysregulation may have even greater applicability for this population.

Dialectical Behavior Therapy (DBT)

Dialectical Behavior Therapy (DBT) is a cognitive-behavioral form of therapy that aims to address patients' emotion regulation difficulties more comprehensively than other modalities by incorporating both acceptance and change strategies into its treatment methods (Linehan, 1993). DBT was originally developed for individuals with chronic suicidality, borderline personality disorder, and emotion regulation problems, and has since been adapted to treat other mental health problems across different settings (Feigenbaum, 2007; Linehan et al., 2006). One of DBT's main foundational principles is to find a balance between acceptance and change by encouraging patients to develop skills within four core modalities: (1) emotion regulation and (2) interpersonal effectiveness are known as the change-based strategies while (3) mindfulness and (4) distress tolerance are known as the acceptance-based strategies. Emotion regulation refers to one's ability to the ability to monitor, evaluate, and modulate their affective state, while interpersonal effectiveness entails the balance of maintaining positive relationships (respect for others) while also using assertiveness to meet one's own needs (self-respect; Linehan, 1993; MacPherson et al., 2013). Mindfulness involves increasing self-awareness, becoming less judgmental, and gaining control of one's attention (Mazza et al., 2016). Distress tolerance focuses on both crisis survival (i.e., techniques for distracting, self-soothing, and re-framing cognitions) as well as acceptance (i.e., experiencing their current situation

nonjudgmentally as to decrease the suffering that comes from being unwilling to process it; Linehan, 1993). This balance between acceptance and change, along with validation from the clinician are central to both treatment and the therapeutic alliance and forms the basis of what "dialectical" signifies in the modality's name. Indeed, dialectics are a frequent theme of DBT in general, where clients are encouraged to use "and" rather than "but" in between seemingly contradictory statements to validate that the two experiences (or feelings) can be true at once (Dimeff & Linehan, 2001). For example, a statement such as "this task is really hard, but I can finish it" can be modified to "*and* I can finish it" in order to avoid dismissing the truth of the task's difficulty, leading to a more balanced and self-compassionate perspective.

A version of DBT for adolescents, or DBT-A, was introduced in 1999 (Miller et al., 2000). As with adult clients, DBT-A was first used to treat suicidal ideation and symptoms of borderline personality disorder in adolescents. Following these initial promising results, later investigations determined that DBT-A was effective for treating other youth mental health problems in a variety of settings, including but not limited to suicidal and self-injurious behavior (Cook & Gorraiz, 2016; Fleischhaker et al., 2011), bipolar disorder (Goldstein et al., 2007), eating disorders (Safer et al., 2007; Salbach et al., 2007; Salbach-Andrae et al., 2008), substance use (Beckstead et al., 2015), and trauma-related symptomology (Geddes et al., 2013). A review of DBT for several of these psychiatric disorders concluded that DBT is particularly beneficial for adolescents that struggle with emotion dysregulation and disorders that share a common underlying dysfunction in abilities to regulate emotion (MacPherson et al., 2013). Schools provide a promising setting for delivering DBT. Findings from a study investigating a DBT skills group intervention for youth attending a Disciplinary Alternative Education Program (DAEP) revealed that youth who participated reported significantly reduced indicators of behavioral distress, such as aggression and conduct problems (Ricard et al., 2013). In traditional school settings, DBT skills training groups have been shown to be effective in reducing risky health behaviors (Burckhardt et al., 2018) and improving subjective ratings of emotion regulation abilities

(Zapolski & Smith, 2017). Additionally, a recent social – emotional learning curriculum for educators was developed in 2016 to facilitate teaching DBT skills in schools (Mazza et al., 2016). The manual, called Skills Training for Emotional Problem Solving for Adolescents (DBT STEPS-A), provides 30 lesson plans for teaching DBT skills to students from grades 6–12. However, there remain two significant gaps in the adolescent DBT literature. First, there are a limited number of studies that have examined school-based DBT interventions like DBT STEPS-A, and second, school-based DBT interventions have been primarily investigated in traditional school settings as part of universal prevention programs. Therefore, further research is needed to determine whether these interventions are appropriate for both youth in nontraditional, underserved school settings as well as those who are at increased risk for emotion dysregulation due to experiencing multiple chronic stressors.

Overview of Project SOARing

School-Based Opportunities for Adolescent Recovery (Project SOARing) was derived from DBT STEPS-A's core component lessons. However, rather than implementing its 30-lesson curriculum, the current study aims to develop a condensed protocol of 12 sessions to better fit the accelerated academic schedules of a continuation high school setting. As continuation high schools offer shorter “blocks” rather than semesters or quarters to help students more efficiently compensate for prior academic credit deficiencies, the research team was tasked with paring down the DBT STEPS-A curriculum to the most necessary and relevant components for this particular youth population. Our aim was to adapt elements from the manual under a community-based implementation lens. As research into the effectiveness of DBT STEPS-A is beginning to reveal promising findings (Chugani et al., 2021; Flynn et al., 2018; Gasol et al., 2022; Martinez et al., 2022), efforts should be made to ensure that youth from historically underrepresented backgrounds are included within this body of literature. Adapting and applying these materials within school mental health settings also creates an accessible option for reducing mental health disparities in youth who have experienced adverse childhood experiences (ACEs). Project SOARing therefore

seeks to determine how well school-based DBT interventions address the needs of these adolescents, the underserved schools which they attend, and their larger communities. Additionally, Project SOARing focuses on a Tier 2 rather than universal population of adolescents, with elevated levels of emotion dysregulation incorporated as an inclusion criterion. As prior investigations have focused on primary prevention with universal samples, this study will be the first to examine an adaptation of DBT STEPS-A's preliminary acceptability for use with Tier 2 adolescent populations.

Current study

The goal of this paper is to describe the development and formative testing of SOARing and determine whether SOARing is *feasible* and *acceptable* for delivery in an underserved high school, as a Tier 2 intervention. “Feasibility” refers to the extent to which an intervention can be successfully carried out despite the constraints present in the destination context while “acceptability” reflects the direct experiences that participants have as part of the intervention, and whether they find it agreeable, palatable, or satisfactory overall (MacPherson et al., 2013). We hypothesize that qualitative results from field notes and satisfaction surveys will demonstrate that the intervention is sufficiently feasible and acceptable to support future larger trials implemented within the same setting and population.

Method

Setting

This study takes place at a continuation high school for youth with academic credit deficiencies located in Southern California. Students attending this school are considered to be at-risk of not graduating, and as the school is located in a historically underserved area, many members of the student population face additional socioeconomic challenges to both academic success and psychological well-being. In addition to addressing their mental health needs, these students would also benefit from improved access to physical health resources and expanded social services.

Understanding the needs of its student population, this school launched its own on-campus Wellness Center, offering access to the nurse's office, telehealth visits with a physician assistant or nurse practitioner, guidance counselors, program specialists, mental health services, and referrals to other community-based services. This initiative supports students' physical health, mental health, and social service needs, with the understanding that many students often present with multifaceted problems requiring a combination of services. School-based healthcare programs therefore offer a promising solution for filling these resource gaps and improving physical and mental health disparities. In fact, evidence suggests that both closely linked school and community health systems, as well as fully integrated school/community child health systems, can be integral contributors to the health and well-being of children (Lear, 2002). For the present study, guidance counselors from the Wellness Center facilitated the identification and recruitment of students with increased mental health needs. This research, including all community-initiated recruitment and University-facilitated consent procedures, was conducted in accordance with APA Ethical Guidelines, and with full approval by the University's IRB, and the school district's research office (IRB #5190320).

Participants

Participants were recruited from a continuation high school in Southern California. Upon admission to the school, every youth enrolled completed a self-report mental health survey developed by the school's team of guidance counselors to identify whether they had been exposed to trauma or presented with symptoms of depression and anxiety. The survey also assessed risk factors such as homelessness, grief, parental psychopathology, and foster care involvement by having students select either yes or no responses. Students who endorsed any of these risk factors were flagged by the school counselor for potential risk of mood and emotion regulation difficulties. The lead school counselor then conducted a brief interview with these students to assess whether they appeared to be struggling with emotion dysregulation. If the lead counselor determined that they were at-risk, she asked for consent to share

their contact information with our research team. If they agreed, the students were approached by the research team and asked whether they were interested in participating in group therapy sessions. Students were excluded if they presented with psychosis, active suicidal ideation, or developmental delays. Additionally, the Revised Child Anxiety and Depression Scales (RCADS) was completed at baseline to support the lead school counselor's findings that the students chosen were at increased risk for these challenges. At baseline, participants had average RCADS *t*-scores of 61 ($SD = 17.39$). According to Chorpita et al., *t*-scores of 65 or higher indicate scores at the borderline clinical threshold, while *t*-scores of 70 or higher indicate scores above the clinical threshold (2000). As the scores for this sample approached this borderline clinical cutoff, we can conclude that study participants did have slightly elevated levels of depression and anxiety.

This selection process yielded five participants for our first SOARing group, all of whom were male. In terms of demographic information, participants were able to select multiple ethnic categories, with two selecting Latino, two were Native American and Latino, two were White, and two selected Other. Additionally, four of the participants were 17-years old, one participant was 18-years old ($M = 17.20$, $SD = 0.45$), and all of the participants identified as cisgender and heterosexual. In terms of psychosocial stressors, 60% of participants endorsed each of the following on the school's mental health survey: history of abuse or abandonment, below average academic functioning, family history of mental illness, and family history of substance use. Full demographic information is presented in Table 1.

Data sources

Framework

Our adaptations described in this manuscript were guided by Wiltsey-Stirman and colleagues' FRAME (Framework for Reporting Adaptations and Modifications – Expanded; Wiltsey Stirman et al., 2019) and are summarized in Figure 1.

Field notes

Descriptive field notes were compiled by doctoral student clinicians implementing the intervention at

Table 1. Participant demographic information ($N = 5$).

	<i>n</i> (%)
Age ($M = 17.20$, $SD = 0.45$)	
17	4 (80%)
18	1 (20%)
Gender	
Male	5 (100%)
Ethnicity (Multiple Selections Allowed)	2 (40%)
Hispanic/Latin	
Native American and Latin	2 (40%)
White/European American	2 (40%)
Other	2 (40%)
Sexual Orientation and Gender Identity	
Heterosexual, Cisgender	5 (100%)
Psychosocial Stressors	
History of Abuse or Abandonment	3 (60%)
Below Average Academic Functioning	3 (60%)
Family History of Mental Illness	3 (60%)
Family History of Substance Use	3 (60%)

the end of each of the 10 sessions. These field notes were informal, qualitative observations intended to assess the feasibility and acceptability of the intervention and record any challenges with its implementation. Verbal feedback collected at the end of each session from the students attending the group was also incorporated into these field notes in order to document which of the activities delivered were perceived as most engaging and valuable by the students. As one of the goals of this study was to condense a 30-lesson curriculum (DBT STEPS-A) into a shorter, targeted intervention, only some of the activities that were piloted would be selected for larger trials in the future. To this end, doctoral

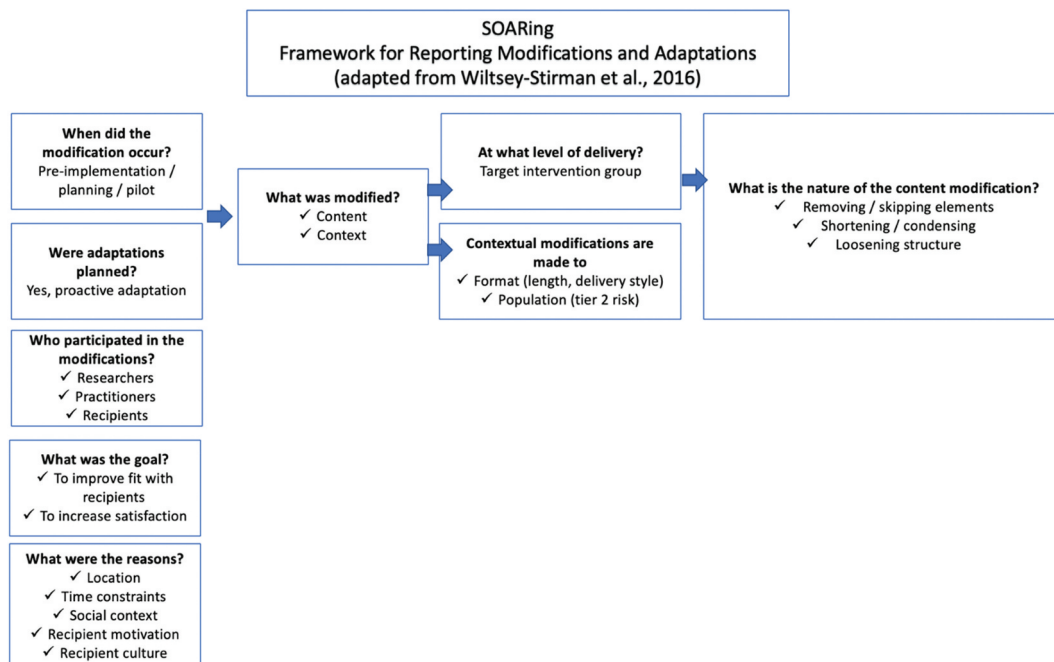
student researchers and the study investigator met to review the feedback on each activity and reach consensus on which were the best-received and most appropriate for inclusion in the final protocol.

Post-Session Evaluation Questionnaire

Post-Session Evaluation Questionnaire was used to collect satisfaction data following the end of every other session. The survey was comprised of 11 questions, including eight on a four-point Likert scale and three short-answer. The Likert scale questions asked participants to indicate whether the sessions were clear, informative, enjoyable, and presented well, with responses ranging from a score of 0 = Strongly Disagree to 4 = Strongly Agree. Examples of these items include, “The activities encouraged my participation,” and “Overall, I enjoyed today’s workshop.” Higher scores indicated greater overall satisfaction. The three short-answer questions that followed asked participants to specify one thing that they did not like about that day’s workshop, one thing that they liked best, and something new that they learned, respectively. The Post-Session Evaluation Questionnaire is included as [Appendix](#).

Revised Child Anxiety and Depression Scales (RCADS)

Participants were administered the Revised Child Anxiety and Depression Scales (RCADS) in order

**Figure 1.** SOARing framework.

to assess anxiety and depression symptoms at baseline (Chorpita et al., 2000). The RCADS is a 47-item self-report questionnaire that asks participants to rate how often they experience internalizing thoughts and behaviors on a four-point Likert scale, with responses ranging from a score of 0 = Never to 3 = Always. The total questionnaire also yields six subscales, including separation anxiety disorder, social phobia, generalized anxiety disorder, panic disorder, obsessive compulsive disorder, and major depressive disorder. For all subscales, higher scores indicate more severe overall symptoms, with *t*-scores of 65 or higher indicating scores at the borderline clinical threshold. The RCADS has demonstrated good reliability across all subscales, with Cronbach's alpha values ranging from 0.71 to 0.85 (Chorpita et al., 2000).

Procedures

Protocol development

The research team referenced existing DBT STEPS-A materials in developing the intervention used in the study protocol (Mazza et al., 2016). Part of the adaptation involved scaling down the 30-lesson DBT STEPS-A curriculum into a 12-session intervention to fit the natural school block schedule. In California and in other states, continuation high schools historically serve students who are aged 16 or older who are at risk of not graduating from high school. Because these students have fallen behind in academic credits and may have time-intensive obligations outside of school, such as work or with their families, most continuation high schools are designed to offer flexible, accelerated schedules (Sperling, 2019). The decision to condense the 30-lesson DBT STEPS-A curriculum into a 12-session intervention was therefore based around the time constraints of this school's particular accelerated schedule, as students who meet their credit requirements have the opportunity to graduate at the end of each block (there are six blocks per academic school year). In deriving a condensed protocol of 12 lessons, the plan was to pilot several of the activities in the manual and note which ones were best received by the students. Formative testing for this pre-pilot would occur over the course of 10 weeks, with the understanding that two additional lessons would be added to the final 12-session

intervention, which would serve as orientation and debriefing sessions, respectively.

Facilitator training

The pre-pilot was facilitated by two clinical psychology graduate students trained in delivering DBT skills. Prior to leading the intervention, both students had completed an online DBT foundations training led by DBT experts from Behavioral Tech LLC, and participated in a graduate level course on delivering DBT skills. They also received close supervision and consultation with the study's principal investigator, a licensed clinical psychologist who was both trained in DBT skills and DBT STEPS-A specifically by the intervention's developers, Drs. Mazza and Mazza. During weekly meetings, they reflected on adaptations needed and discussed logistics for future larger investigations. As these meetings continued throughout the pre-pilot, they also allowed the team to review field notes, address challenges they encountered, and brainstorm modifications to the protocol. The principal investigator was also available to the trainees outside of these meetings for more urgent consultations, as needed.

Informed consent

Students who met study eligibility criteria were approached by the study team to determine their willingness to participate in group therapy sessions and the current study. Informed consent procedures were then conducted with students who expressed interest. Students aged 18 or older were able to provide both verbal and written informed consent for research purposes, while students under the age of 18 provided written and verbal assent, and the Parent Consent form was signed by a parent or guardian.

Intervention implementation

The intervention is based on core components from the DBT Skills in Schools: Skills Training for Emotional Problem Solving for Adolescents (DBT STEPS-A) manual (Mazza et al., 2016). Each of the manual's activities is designed to help adolescents develop skills in one of the four core domains, including emotion regulation, interpersonal effectiveness, distress tolerance, and mindfulness. The team could not pilot every activity in the DBT

STEPS-A manual given that the SOARing intervention was created to have fewer than half as many sessions based on the block schedule time constraints of this particular continuation school setting. Therefore, six activities each were selected from the emotion regulation, interpersonal effectiveness, and distress tolerance skills, while brief mindfulness exercises were utilized in all sessions. The activities were selected based on recommendations from the developers of DBT STEPS-A on activities to prioritize in briefer, time-sensitive lesson plans. Additionally, the research team aimed to streamline the existing 30-session curriculum and reduce redundancy by selecting one skill for each of the given module's aims, as the DBT STEPS-A manual includes multiple skills that can be used for similar purposes (Mazza et al., 2016). The students met with the study team a total of 10 times between April and June of 2019, in-person at the school's wellness center, with each session occurring weekly during the same 50-minute class period. The first meeting served as an orientation used to establish ground rules, explain the confidential nature of group therapy, and provide an introduction to DBT. The team decided that the second session would teach the students mindfulness techniques to then be incorporated into each subsequent session, reinforcing the idea that mindfulness is a skill that should be continuously practiced. Over the course of the next seven sessions, the study facilitators piloted activities that reinforced the three remaining DBT modules. These sessions also included time set aside for group discussion, questions and feedback, and the Post-Session Evaluation Questionnaire. The final session served as a debriefing, intended to summarize all of the skills and information that the students learned throughout the intervention.

Analyses

Descriptive statistics were used to assess for instances of dissatisfaction and disengagement from the material, using the Post-Session Evaluation Questionnaire. The eight Likert-scale questions were averaged into an overall satisfaction score. The three open-ended questions from the satisfaction survey were transcribed for study team review. As the aims of this pre-pilot were exploratory, qualitative student feedback on this

survey were not systematically coded or analyzed. Instead, they were reviewed informally and discussed by the study team following each session and were documented in field notes. To compile the field notes, the team met weekly to record their observations and feedback, being careful to note any barriers to implementation, challenges with participation, and modifications needed. The study team examined field note and satisfaction survey information simultaneously when possible, in order to compare the two data sources and gain a cohesive understanding of the participants' perspectives. Based on student feedback, activities that were not received well would be removed from future iterations of the intervention.

Results

Acceptability

Student responses to the Post-Session Evaluation Questionnaire were used to determine protocol acceptability and overall satisfaction with the intervention. These evaluations were collected every-other session at five time points throughout the intervention between April and June of 2019, in total producing 26 complete (86.7%) responses. Results revealed that the intervention was consistently positively received over time. For the eight Likert scale items, where higher scores correspond to greater overall satisfaction and engagement, the mean score for each item was equal or greater to 3.5 (on a scale from 1 to 4). Means and standard deviations for each item are reported in Table 2. Additionally, the three short-answer qualitative questions provided valuable satisfaction information as well. The majority (75%) of students who answered the item, "One thing I did not like about

Table 2. Mean response (from 1 to 4) and standard deviations for questions in the post-session evaluation questionnaires.

Item	Mean	SD
1. Overall, I enjoyed today's workshop.	3.62	0.57
2. My SOARing coach was well-prepared.	3.65	0.49
3. The activities/information was presented well.	3.69	0.47
4. The activities encouraged my participation.	3.69	0.55
5. If I had any questions, they were answered clearly.	3.50	0.58
6. The session handouts were clear.	3.77	0.43
7. There was enough time for discussion.	3.66	0.56
8. I have greater knowledge of the topic covered today.	3.62	0.57

On average, participants responded between a 3 (agree) and a 4 (strongly agree) across items.

today's workshop was," indicated that they did not dislike anything about the sessions. Of the four constructive comments, a participant at one session stated that they disliked "talking in front of others," and another indicated that they disliked a mindful noticing activity. The other two constructive comments concerned feeling tired at session and disliking the snacks available. Responses to the item "One thing I liked the best about today's workshop was," were consistently positive, with one student stating, "I always like how everything is always discussed in a way I understand" and another stating "I like how in here we talk about our feelings and what to do with how we can control them." Specific activities that were referenced as things students liked best included mindfulness, the IMPROVE (Imagery, Meaning, Prayer, Relaxation, One thing at a time, Vacation, Encouragement) skill, and the mindful noticing activity (Mazza et al., 2016). Responses to the item "Something new I learned in today's workshop was," included "that it's okay to express emotions," "being mindful," and "ice can calm you down," with the latter referencing the "TIP" (temperature, intense exercise, paced breathing) skill.

Feasibility

Feedback

Results from the field notes recorded after each session indicated that the doctoral students were able to effectively deliver the intervention over the course of 10 weeks. However, the research team decided that it would be beneficial for future iterations of the intervention to include a total of 12 twice-weekly sessions rather than 10 weekly sessions in order to better match this particular school's 6-week block schedule. This change would also allow future facilitators to designate time during the first and last sessions for orientation and debriefing, respectively, as well as collect pre- and post-assessment measures. In this final iteration of the protocol, a single new skill would be introduced each week during sessions 2–11, providing ample time for practicing the skill, questions, and group discussion. During the weekly consultation meetings with the study principal investigator, the team was able to reflect on each session and determine its success based on verbal feedback from the high school students and observations

based on their reactions, as well as reviewing of the satisfaction surveys. It was determined that the team was able to complete delivery of the entire protocol, including teaching each of the chosen activities, despite some barriers to implementation, which were addressed based on youth feedback. The weekly field notes also captured feedback from the students regarding which delivery methods worked best for them. In general, the students displayed less engagement with the activities when a traditional "lecture style" approach was used. In response, the team quickly adapted to make the sessions more interactive and limit didactic instruction. The students also asked that leaders sat in a circle with them rather than write, stand, and present in a classroom-style setup. Sitting in a circle as part of a group not only encouraged additional participation, but also made the environment feel more collaborative, with the leaders more visibly positioned as therapists rather than as teachers. They also requested more hands-on and game-like activities and appeared to appreciate movement around the classroom and interaction with objects. In particular, the students appeared to prefer mindfulness activities that were modified in this way. Additional feedback included wanting more space for conversation about their experiences and how they would be able to utilize each skill in their daily lives. Many students also responded well to the leaders sharing their own experiences and examples of how the skills could be applied. Observations revealed that the students also appeared to retain information about each skill better when space was made to review the previous skill at the beginning of each week, which helped to consolidate learning. Finally, the team noted that the students often felt averse to paper handouts and questionnaires, with some students even referring to them as "homework." In response, the team began to utilize a white board as opposed to giving individual sheets of paper to each student. Though field notes were collected at every session, collecting paper questionnaires at every other session was ascertained to be an appropriate interval based on this student feedback, and in order to reduce participant burden.

Challenges

The main challenges associated with implementing the protocol included attendance, disruptive behavior, and engagement with the material. Some of

the school instructors were initially reluctant to allow students to leave class to attend group. However, collaboration with the lead school counselor resulted in the creation of paper passes that teachers more readily accepted. Additionally, students would also forget about group or would otherwise be hesitant to attend, resulting in them needing to be called out of class. In response, the team maintained a prize box and snacks to reward students for consistent attendance, often soliciting feedback from the students for what rewards to include. Adolescent-friendly prizes often consisted of technology accessories (e.g., headphones and phone chargers), journals, art supplies, and various self-care items (e.g., stress balls, scented hand lotions, and fidget toys). A challenge associated with attendance that was more difficult to troubleshoot was students not showing up for school. Many students in this setting face barriers to consistent attendance. Student disruptions presented another area of difficulty. These not only had the potential of negatively impacting the group, but also may have indicated when certain students needed more individualized therapy attention. In response, the leaders utilized foundational behavioral principles to actively ignore unrelated side comments or distracting behaviors and subsequent extinction bursts. A limit on phone use in sessions was also introduced to decrease distraction. Facilitators also consulted with the guidance counselor about students who would potentially benefit from more individualized support, which was readily available at the school's wellness center.

Modifications

The most significant modification made to the protocol during the pre-pilot was that the format of the sessions was changed from a lecture-style to group discussion, given that students tended to disengage when exclusively presented with psychoeducation. This change was possible as these targeted intervention groups included 6 to 8 students, rather than 30 students as is more typical in a classroom where DBT STEPS-A as a universal intervention might be implemented. In making this change, the team was able to add more experiential examples and exercises and fewer didactics, which allowed for more interaction and participation from the students. Group discussions were effective

in facilitating student participation and engagement, as determined by instructor observations and relevant items of the satisfaction survey. The team also determined that they could encourage further participation with activities such as a bag of affirmations, which involved the students writing anonymous, encouraging phrases to each other as an interactive method of practicing the GIVE skill and promoting positive relationships. While most of the activities that were chosen elicited positive feedback from the students, some were removed from the protocol based on poor reception. For example, guided meditations were preferred as mindfulness activities over those that involved singing out loud. Additionally, as the three chosen emotion regulation skills (opposite action, purpose of emotions, and coping ahead) were perceived to be more helpful by students, ABC PLEASE was subsequently dropped, though its message of practicing adaptive health behaviors could still be incorporated within the module. Some of the activities from the DBT STEPS-A manual were also modified to be more engaging and relevant to the students in this population. For example, the DEARMAN (Describe, Express, Assert, Reinforce, be Mindful, Appear Confident, Negotiate) interpersonal effectiveness skill acronym was adjusted to be more culturally appropriate for interactions between children and their guardians in primarily low-income, Latin households, by acknowledging that “assert” can be substituted with “ask,” and “reinforce” may be changed to “reward.” These modifications were made during the investigation in response to feedback from the students, who expressed discomfort with the idea of incorporating behaviors that corresponded to the original, stronger verbs in their interactions with parents, which they expressed they found inappropriately assertive for their culture. Altering this skill did not significantly change its content but did aim to make it more palatable to students who may consider respect for parental authority an important cultural value (Halgunseth et al., 2006). Finally, the leaders found that it was necessary to incorporate additional space after discussions on emotionally distressing topics, as students may be processing emotions that warrant more time and reflection, like sadness and grief. These modifications to the manual would then be

Table 3. DBT STEPS-A activities and modifications.

DBT STEPS-A Skills	Included in SOARing	Modifications
Principles of Dialectics/How to Think/Act Dialectically	Yes	Emphasis on exploring emotion dysregulation
Mindfulness Wise mind	Yes	Condensed to include following two items in same lesson
Mindfulness “What” skills	Yes	Added penny activity based on these skills
Mindfulness “How” skills	Yes	Added mindfully listening to music as an activity based on student interest
Distress Tolerance Intro. to crisis survival, ACCEPTS	Yes	Emphasis on coping ahead
Self-soothe and IMPROVE	Yes	Incorporated “5-4-3-2-1” exercise as self-soothing
TIP Skills	Yes	
Distress Tolerance Pros and cons	No	Discussed briefly during dialectics lesson
Intro. to reality acceptance and radical acceptance	No	Added to debriefing lesson
Turning the mind and willingness	No	Added to debriefing lesson
Mindfulness of current thoughts	Yes	
Goals of emotion regulation; functions of emotions	Yes	Combined with describing emotions lesson
Describing emotions	Yes	Emotion volcano activity added to express emotion through art
Checking the facts and opposite action	Yes	
Problem solving	Yes	Included in Interpersonal Effectiveness skills
A of ABC PLEASE	No	Being mindful of positive experiences included in mindfulness lesson
BC PLEASE of ABC PLEASE	No	Connection between health behaviors and emotions included with emotion regulation
Wave skill—mindfulness of current emotions	No	Concept included as part of describing/identifying emotions
Interpersonal Effectiveness Goal setting	No	Concept included as part of DEARMAN lesson
DEAR MAN	Yes	Participants could replace “assert” with “ask” and “reinforce” with “reward”
GIVE	Yes	Gave validation skill part of its own lesson, taught GIVE and FAST together
FAST	Yes	Incorporated “bag of affirmations idea”
Evaluating options	No	Discussed briefly during FAST and GIVE

Some activities in the original 30-lesson curriculum were condensed and re-ordered (Mazza et al., 2016).

implemented in future iterations of the intervention. A table listing all activities from the DBT STEPS-A curriculum, along with the modifications made for the current study, can be found in Table 3. Approximately 91% of the original key activities were preserved despite the condensed format, often by combining less time intensive but related skills, such as FAST and GIVE, into a single session.

Final manual and procedures

Based on the activities of this pre-pilot feasibility trial, the intervention now occurs twice weekly for six weeks to better match the high school students’ unique block schedule, with approximately 10 participants per block. The first session serves as an orientation meeting, and the second session teaches the students mindfulness techniques. Each of the subsequent sessions begins with 10–15 minutes of mindfulness exercises, reinforcing the idea that mindfulness is a skill that should be continuously practiced. For the next nine sessions, the intervention program is designed to cover interpersonal effectiveness, distress tolerance, and emotion regulation components three times each, with every session devoted to one particular component on a rotating schedule. The purpose of the rotating schedule was to allow participants to continuously

practice each component throughout the course of the intervention and to aid with their learning retention. Each of these sessions begins with 10 minutes of recap of the previous session, followed by 10–15 minutes to teach the skills training component of the week. They then conclude with approximately 10–15 minutes of group discussion, and up to five additional minutes for questions and feedback. The twelfth session continues to serve as a debriefing session, providing a conclusion that ties all of the skills that the students have learned together. A more detailed schedule of the final intervention can be found in Table 4. The final list of activities selected were the ones that were best received by the students in the current study, based on feedback on their satisfaction surveys and post-session discussions.

Discussion

Results of this pre-pilot trial indicate that Project SOARing demonstrates sufficient acceptability and feasibility. The satisfaction survey responses indicate that the intervention was well received by the students, while feedback and field note observations provided support for several meaningful modifications to the protocol. Additionally, qualitative information

Table 4. Soaring DBT skills group manual.

Week	Theme	Session Outline
1	Orientation	Names/Introduction Overview, icebreakers, and limits to confidentiality Review/Develop Rules Orientation to Group Structure/Timing Every Week
2	Mindfulness	Mindfulness Exercise - Starburst/Chocolate exercise - look, feel, texture, smell, taste Review - Rules Skill - Wise Mind (Page 376) - Three States of Mind - reasonable mind (what I THINK to be), emotion mind (what I FEEL to be), and wise mind (what I KNOW to be) - Emotion Volcano Drawing Activity
3	Interpersonal Effectiveness	Mindfulness Exercise - Guided meditation (2 minutes) Review - Wise Mind Skill - Validation (Page 470) - Validation: show that you understand your or another person's feelings or opinions. Be nonjudgmental out loud
4	Distress Tolerance	Mindfulness Exercise - Five Senses – 5 you can see, 4 you can feel, 3 you can hear, 2 you can smell, 1 you can taste Review - Validation Skill - TIP (Page 396–397) - Explanation of emotional arousal with examples - TIP: Temperature, Intense Exercise, Paced Breathing - Breathing meditation with plastic ice cubes
5	Emotion Regulation	Mindfulness Exercise - Guided Meditation (2 minutes) Review - TIP Skill - Purpose of Emotions (Page 421–422) - List emotions with action indicated, how we communicate it, function of emotion
6	Interpersonal Effectiveness	Mindfulness Exercise - Mindful Seeing - switch one item on body and see who notices what is different Review - Purpose of Emotions Skill - DEARMAN (Page 467–469) - DEARMAN: Describe, Express, Assert, Reinforce, be Mindful, Appear confident, Negotiate
7	Distress Tolerance	Mindfulness Exercise - Guided meditation (3 minutes) Review - DEARMAN Skill - IMPROVE (Page 392–394) - IMPROVE: Imagery, Meaning, Prayer, Relaxation, One thing at a time, Vacation, Encouragement
8	Emotion Regulation	Mindfulness Exercise - Leaves on a Stream - guided meditation for 3 minutes Review - IMPROVE Skill - Opposite Action (Page 435–436) - Opposite Action: acting opposite to the action urge when the emotion is doing more harm than good
9	Interpersonal Effectiveness	Mindfulness Exercise - Penny Exercise - mindful seeing Review - Opposite Action Skill - FAST and GIVE (Page 470–474) - FAST: be Fair, no Apologies, Stick to values, be Truthful - GIVE: be Gentle, act Interested, Validate, use an Easy manner
10	Distress Tolerance	Mindfulness Exercise - Body Scan - toes to top of head Review - FAST and GIVE Skill - ACCEPTS (Page 388–390) - ACCEPTS: Activities, Contributing, Comparisons, Emotions, Pushing away, Thoughts, Sensations
11	Emotion Regulation	Mindfulness Exercise - Guided Meditation (3 minutes) Review - ACCEPTS Skill - Cope Ahead (Page 451) - Cope Ahead: cope ahead of time with emotional situations by rehearsing a plan ahead of time so you are prepared
12	Debrief	Mindfulness Exercise - Guided Meditation (3 minutes) Review – Cope Ahead Brief Discussion – Radical Acceptance - Acknowledging the reality of our lives for problems that cannot be solved in the long term Final check-in, questionnaires, and feedback

suggests that the intervention is feasible and can be effectively delivered within this setting. Overall, the findings of this pre-pilot are

promising and provide the rationale needed for continued investigation into the protocol's potential effectiveness.

Future directions

The qualitative data collected from this pre-pilot support the research team's plans to conduct larger investigations based on this protocol. Following the current study, an IRB proposal was approved for a randomized, waitlist-controlled trial in the same setting, which is currently underway. Outcomes collected during the randomized trial will include similar qualitative data sources in addition to quantitative measures administered at pre- and post- assessment, including validated scales for assessing possible improvements in mental health symptoms (e.g., depression and anxiety) and the four DBT skill targets (i.e., emotion regulation, interpersonal effectiveness, mindfulness, and distress tolerance). This new study uses a revised manual that has incorporated changes based on the results of this pre-pilot. Consistent with previous iterations, sessions are led by psychology doctoral students from Loma Linda University under supervision of the same licensed psychologist. The wellness center where this study was conducted is a practicum placement for doctoral students to receive clinical training. As such, there will continue to be opportunities for doctoral students to administer the DBT group should the school wish to continue the partnership. In addition, these preliminary investigations earned the support of both school administrators and the school district (Boustani et al., 2020). The school district's satisfaction with this initiative has resulted in the allocation of funds for an intensive, 4-day DBT skills training for all mental health and wellness staff, in order for them to infuse DBT skills into their treatment as usual. Should the findings from our waitlist control indicate improved mental health outcomes, we will work with the school's leadership to collaboratively explore future directions in terms of expanding the program both in terms of campuses (i.e., can SOARing be implemented at other high schools in the district?) and in terms of workforce (i.e., can mental health staff employed by the district implement SOARing?).

Limitations

As a feasibility study, a large sample size and a control condition was out of scope. However, it would have been helpful to collect some preliminary clinical outcome measures to determine any trends

indicative of preliminary effectiveness. We are hopeful that our pilot trial which is currently underway will provide sufficient data regarding the promise of SOARing as a school-based intervention. Due to the small sample size and nature of the qualitative data (write-ins as part of satisfaction surveys and field notes), we did not conduct a rigorous qualitative data analysis. This would have greatly strengthened our findings. As part of our ongoing pilot trial, we are conducting semi-structured interviews with each participant to further our understanding of youth satisfaction with the intervention. These interviews will go through a rigorous qualitative analysis procedure. Finally, due to the real-world constraints of working in a continuation school with 6-week blocks instead of semesters, we had to condense a 30-lesson DBT skills manual down to 10 sessions, and then expand slightly to 12 to accommodate an orientation and debrief session. Although the team wanted to conserve as much of the DBT STEPS-A manual as possible, some modifications were unavoidable due to the shortened timeframe and the needs of this particular at-risk population. It will be interesting to see if our briefer version of the intervention is as effective as the full version implemented in traditional schools. Finally, it should be noted that the revisions we made were consumer-driven and may not be applicable to different settings with different age and racial groups or community contexts.

Conclusion

By merging the strong evidence base for DBT with the unique needs of youth in our context, we expect that SOARing will be an effective school-based intervention. Our approach allowed us to hear directly from the consumers of the intervention – the youth – and make revisions based on their recommendations and preferences. We believe that this bottom-up process provides a more tailored program with a higher chance at sustainability. SOARing is currently undergoing a pilot trial, including semi-structured interviews with participants, which may inform future adjustments and provide us with information about the effectiveness of the intervention. Whenever possible, we recommend that research teams adopt such a collaborative approach in order to ensure that programming meets the

specific needs of the population where the program will be implemented.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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Appendix

Post-Session Evaluation Questionnaire

SOARing Post-Session Evaluation Form



Strongly Disagree
1



Disagree
2



Agree
3



Strongly Agree
4

Please answer the following questions using the scale above.

1.	Overall, I enjoyed today's workshop.	1	2	3	4
2.	My SOARing coach was well-prepared.	1	2	3	4
3.	The activities/information was presented well.	1	2	3	4
4.	The activities encouraged my participation.	1	2	3	4
5.	If I had any questions, they were answered clearly.	1	2	3	4
6.	The session handouts were clear.	1	2	3	4
7.	There was enough time for discussion.	1	2	3	4
8.	I have greater knowledge of the topic covered today.	1	2	3	4

9. One thing I did not like about today's workshop was

10. One thing I liked the best about today's workshop was

11. Something new I learned in today's workshop was
