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When Silence Feels Safer: Challenges and Successes of Delivering a School-Based Cognitive Behavioral Intervention to Central American Unaccompanied Immigrant Youth

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Abstract

Objective: To explore cultural and immigration-related factors, among Central American unaccompanied immigrant youth (UIY), affecting the safety and acceptability of Cognitive Behavioral Intervention for Trauma in Schools (CBITS), a group intervention designed to treat trauma symptoms. ***Method:*** Thematic analysis of data from grounded theory study of group interventions to support resilience in UIY, consisting of interviews with 10 key stakeholders (5 CBITS facilitators) and 16 UIY (6 CBITS participants) from El Salvador, Guatemala or Honduras, interviews conducted in Spanish, English or Mam. ***Results:*** Five themes emerged from interviews with CBITS facilitators and UIY: 1. *Todo está bién*: Self-protective silence about trauma and symptom denial, 2. *Chisme* goes around: Personal risks of disclosure, 3. Marginalizing the language and world view of indigenous youth, 4. "CBITS didn't really quite land for them": Adapting the curriculum and delivery, 5. "I learn to appreciate things": Benefits of the CBITS group. CBITS facilitators endorsed skill-building aspects of the groups and expressed concerns about a curriculum relying on written homework and parental support for youth with limited home country schooling, currently living with distant relatives. CBITS participants endorsed hearing about other youths' stories and learning coping skills.

Conclusions: Models for group intervention that emphasize coping skill development and group support, while de-emphasizing the trauma narrative, should be explored and tested. Group intervention leaders should consider the impact of differences in gender, country of origin and native language on group dynamics.

Keywords: Adolescent, unaccompanied immigrant youth, Central America, thematic analysis,

group interventions, cognitive behavioral interventions.

Clinical Impact Statement:

Adolescents who migrate alone from Central America to escape pervasive violence arrive with trauma histories. School-based interventions increase access to care for immigrant youth, and cognitive behavioral trauma therapy can decrease post-trauma symptoms. A manualized 10-week group, Cognitive Behavioral Intervention for Trauma in Schools (CBITS) was implemented with unaccompanied newcomers from Central America and evaluated for safety and acceptability through interviews with youth, group facilitators and other stakeholders. Central American newcomers were reluctant to disclose their stories in the group, fearing for family members' and their safety, but appreciated group support, learning coping skills and feeling less isolated.

When silence feels safer: Challenges and successes of delivering CBITS to Central American Unaccompanied Immigrant Youth

Since 2014 at least 300,000 unaccompanied immigrant youth (UIY) have migrated to the United States (U.S.) from Central America (U.S. Customs and Border Protection, 2020), to escape pervasive violence and extreme poverty (Restrepo & Garcia, 2014). UIY arrive with significant histories of psychological trauma and trauma-related symptoms, behaviors, and adjustment difficulties (Estefan et al., 2017; Franco, 2018). Most UIY attend school after they are settled with sponsors in the U.S., and schools have been identified as a primary provider of mental health services for Latinx immigrant youth (Franco, 2018; Kataoka et al., 2003). This study addresses the safety and acceptability of a group intervention, Cognitive

Behavioral Intervention for Trauma in Schools (CBITS) (Jaycox et al., 2018), to treat trauma symptoms among Central American UIY. We will consider the impacts of history, culture, and ongoing trauma on our participants from Guatemala, Honduras, and El Salvador, including Mayan youth from Guatemala. We will report on the advantages and challenges of delivering this evidence-informed, manualized group intervention to newcomer immigrants, adaptations we made in recruiting, screening, and delivering CBITS to newly arrived UIY, and implications for future research and clinical care of this population.

Background

The history of civil war and government repression in Central America, especially the Northern Triangle countries of El Salvador, Guatemala and Honduras, has resulted in enduring violence in the region (Cruz, 2011; De Jesus & Hernandes, 2019), placing these countries among the 10 nations with the highest murder rates in the world (Pariona, 2020). These sociopolitical events have also led to genocide and disenfranchisement of indigenous populations (Burrell, 2013; Cruz, 2011). This massive social disruption and displacement allowed criminal gangs with transnational ties to flourish in all three Northern Triangle countries, most prominently Mara Salvatrucha or MS 13 and Calle 18, collectively known as *las maras* (InSight Crime & Asociación para una Sociedad más Justa, 2015; Viswanathan, 2018). Gangs have increased their ranks using coercion and violence toward ever-younger youth and their extended families, resulting in mass flight of targeted youth from cities and rural indigenous communities (Pariona, 2020; Viswanathan, 2018).

Youth fleeing overland from Central America through Mexico are at risk for assaults, kidnapping and extortion from criminals and corrupt law enforcement officials (Gonzalez,

2019). Before 2020, UIY would seek apprehension by the U.S. Customs and Border Protection in order to file an asylum claim and await adjudication at federal migrant centers in the U.S. During the COVID-19 pandemic, the Trump Administration blocked entry of asylum seekers and increased deportation of youth and families, regardless of dangers in their home country (Dickerson & Semple, 2020). At the time of writing, some asylum-seeking youth are being admitted to the U.S. under special circumstances (Meyer, 2021) and broadened admissions criteria under the Biden Administration.

Additional traumas and adverse experiences after apprehension include detention in *hieleras* (ice-cold, harshly lit structures), physical or sexual abuse at the hands of U.S. Customs and Border Protection or other detainees, resettlement with sponsors who are relative strangers and may not provide economic or emotional support, adjustment to unfamiliar schools in a new language, continuing news of violence at home, and fear of deportation (Estefan et al., 2017).

Youth who migrate to the U.S. without their parents have experienced high levels of psychological and physical trauma, often with enduring complex trauma symptoms (Cleary et al., 2018; Murray et al., 2008). Symptoms may first be detected in the school setting, where the stresses of acculturation are felt most acutely and where immigrant students interact closely with caring adults, such as teachers, social workers and coaches. However, historical events and cultural factors specific to their home countries combined with the disruption in bonds of family attachment and communication typical of immigrants fleeing violence (Burrell, 2013), have contributed to a reluctance on the part of many Central American UIY to disclose personal histories and their reactions to trauma to their caregivers and mental health clinicians.

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

Schools have been identified as ideal sites for providing mental health services to

immigrant youth (Franco, 2018; Kataoka et al., 2003). One evidence-informed model is CBITS, a manualized group intervention that was designed to reduce symptoms and increase coping skills in trauma-exposed youth (Jaycox et al., 2012; Jaycox et al., 2018; Stein et al., 2003). CBITS has been implemented in multiple languages, including Spanish, and adapted for use with Latinx and Native American groups (National Child Traumatic Stress Network, 2012). The intervention consists of ten group sessions, individual sessions and parent and teacher education sessions (Jaycox et al., 2018). Each individual session builds on the previous one, culminating in a personal "trauma narrative" that the student shares with the group. Sessions provide the framework of trauma psychoeducation and coping skills, and the trauma narrative serves as an exposure/habituation exercise to address the primary symptoms of trauma. The final sessions focus on social support, problem-solving and relapse prevention (Jaycox et al., 2018). This school-based intervention allows clinicians to serve student populations that do not regularly receive mental health services due to a range of barriers including cost, transportation, stigma and guardian availability for mental health care (Allison & Ferreira, 2016).

Local setting

The primary site for our study was a Federally Qualified Health Center (FQHC) located in the San Francisco Bay Area of northern California that includes eight school-based health centers (SBHCs) (Garcia et al., 2021), six of them located in a school district of 50,000 students. Most students speak a language other than English at home, with 33% speaking Spanish and 3% speaking Mam, a Mayan language spoken in Guatemala and Chiapas, Mexico (Oakland Unified School District (OUSD), 2020). During the 2018-19 school year, the district counted 2,547 newcomer youth, defined as immigrant students who have been enrolled in the district for less than three years, of whom 648 were UIY (OUSD, 2020). In the same year, these SBHCs

provided 5000 behavioral health visits to over 1200 students with a full time equivalent of 6.5 clinicians, using a mix of individual and group visits to extend capacity (Geierstanger et al., 2020).

The FQHC has focused on improving services for newcomer youth since 2014 through targeted registration drives, medical services, and referral to behavioral health (Garcia et al., 2021; Schapiro et al., 2018). Federal funding through a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) and technical assistance from the Unaccompanied Children Task Force of the National Child Traumatic Stress Network (NCTSN) were used to expand behavioral health services.

The FQHC had successfully implemented CBITS with English-speaking youth, including immigrant youth from Mexico and Central America, for over five years. Group facilitators were trained by certified CBITS trainers and met in a learning collaborative to review implementation and fidelity to the CBITS model. These facilitators noticed that newcomer students had experienced high levels of trauma and disrupted education, were not being served by English language CBITS groups, and wanted to offer them the chance to participate in this group intervention. We chose to study CBITS for newcomer UIY to see if an intervention that was effective for immigrant students more acculturated to the U.S. health and education systems would be safe and acceptable for newcomers with limited literacy and less time in the U.S. During the grant period, the FQHC conducted twelve CBITS groups in English and three CBITS groups in Spanish, targeting recent immigrants and UIY.

Method

The CBITS study was part of a larger constructivist grounded theory (GT) study of factors promoting resilience among UIY from Central America. GT is a qualitative research

method in which theory is inductively and deductively generated from systematic data collection and analysis, allowing the incorporation of multiple perspectives and larger domains of social interaction (Charmaz, 2014). We utilized thematic analysis to highlight emerging themes while analysis of all the data was continuing (Braun & Clarke, 2006).

Institutional Review Board (IRB) approval was obtained through University of California, San Francisco (UCSF), and a local Children's Hospital with an affiliated SBHC. The quality improvement committees of two community-based organizations gave permission for conducting research at their sites. We used verbal study consents for both Key Stakeholders and UIY participants with IRB approval. Youth participants were treated as mature minors for this low-risk behavioral research and parent/guardian consent was waived to protect the safety and confidentiality of the participants.

Institution-Wide Adaptations to Screening for CBITS

The FQHC therapists made two adaptations in the CBITS screening process for newcomer groups: 1) Replacing the symptom portion of the University of California, Los Angeles Post-Traumatic Stress Disorder (PTSD) Reaction Index screen (Steinberg et al., 2013) with the Maya Toolkit Health Screener (Czerwinski et al., 2011), and 2) replacing classroom-based screening with individual screening of youth referred by school staff. The Maya Toolkit screener focused on somatic symptoms, which were most prominent in the FQHC's practice and endorsed in research about newcomers who have experienced complex trauma (Betancourt et al., 2017). We changed to individual screening by therapists because our newcomers were in linguistically mixed classrooms and their low literacy levels made a paper screen impractical.

Participants

We interviewed 16 UIY from Central America ages 14-19 (see Table 1). Another four

youth were interviewed, but did not meet study criteria, as they revealed during the interview that they had migrated with a parent. We interviewed 10 key stakeholders with diverse roles and backgrounds (See Table 2). Our research staff consisted of two Spanish-speaking European-American doctoral-trained clinicians and researchers, one from an immigrant family, and two bilingual, bicultural Latinx research staff, consisting of a coordinator and a student intern.

Recruitment

UIY participants were recruited through trusted health care providers and staff at SBHCs, case managers at their connected schools, and a clinic at a local homeless youth shelter. Stakeholders were recruited through emails, at local presentations and meetings. In GT, data collection and analysis are conducted simultaneously, and purposive sampling allowed for recruitment of new participants as questions were raised in the data.

Study procedures and data collection

Data were collected through semi-structured interviews by the PI and RA, through field notes and participant observation. Key Stakeholders were interviewed in English or Spanish in person or over the phone. UIY interviews took place in SBHCs or in adjacent classrooms, in Spanish or Mam, using a Mam interpreter. All participants gave permission to be audiotaped and received a $25 gift card after the interview. Interviews were professionally transcribed, with bilingual transcripts for Spanish language interviews. Mam transcription was not available. Audiotape files were deleted after carefully comparing with their transcripts.

Data Analysis

All interviews were coded by the PI, co-PI and RA using Atlas ti v 8 software, developing open codes and then more focused coding (Charmaz, 2014). The PI and RA

developed a joint list of codes, compared then narrowed down redundant codes and consulted on coding groups. Emerging themes were discussed with the research staff (PI, co PI, RA, intern) and additional co-authors. When we interviewed several Mam-speaking teens who spoke little Spanish but declined use of a Mam interpreter, we interviewed two Mam interpreters to increase our understanding of this phenomenon (see Findings), and then successfully strategized the use of a trilingual interpreter who was introduced to Mam-speaking youth together with the research team. For the CBITS evaluation, we pulled emerging themes from the larger study to report here.

Results

Most youth defined trauma as something that was painful to remember and difficult to forget. Many defined healing from trauma as having a positive attitude and “trying to forget what you've experienced in your home country.” CBITS facilitators focused on the challenges they experienced in helping UIY develop and tell their trauma narrative, and the adaptations they made in the delivery of the CBITS curriculum. UIY who participated in CBITS groups endorsed difficulties they had in telling those stories, yet they appreciated hearing the narratives of others and learning coping strategies. The concept of silence was woven through interviews with UIY and key stakeholders, as a safety mechanism, functional coping tool and part of a resilience strategy. Below are five major themes that emerged from these interviews.

1. “Todo está bien:” Self-protective silence about traumas and a denial of symptoms

Some participants said they had been taught by family members that speaking of or dwelling on difficult experiences would increase their burden and acknowledging difficult feelings would make them worse. They were taught that it was better to “*Dejarlo atras*,” or leave the past behind, and look toward the future. Therefore, they would deny symptoms of distress they might

be experiencing. As a Mam interpreter explained, “a family member, probably they would be like, ‘Oh, leave it behind. Forget about it.’ Or, like, ‘It already happened but try to forget about it.’ But they never think how it's physically or mentally affecting the person.” When another Mam interpreter was asked if she had interpreted for groups, she noted that the group setting made already-difficult disclosures of violence even less safe, which led participants to deny rather than endorse enduring symptoms in front of strangers: “They think, ‘There are more people around me, I better not say anything. I’m fine.’”

Even youth who endorsed the value of speaking with a counselor stated that the goal was to forget the past:

> If something happens to you, it stays in your mind as a trauma. You can’t concentrate because you are always thinking about what happened… I’ve had many friends here that used to tell me that, and I would tell them to forget about it, that here, it is a new story, that they should start forgetting little by little because if they keep thinking about that trauma, they will never get over it, they will always have that in their minds, and they will always be scared, everywhere they go.

CBITS group leaders found that youth being screened for CBITS tended to underreport both trauma exposures and their impact. One CBITS leader remembered asking a youth if he still thought about what happened to him, and he replied, "No, no, I don't think about it anymore. It's all in the past, I'm doing well.” However, when she asked him “a lot of very specific questions, like, ‘Do you have memories or anything coming to your mind? Do you have nightmares about it? Do you experience this?’ Then he answers, ‘Yes’ to a lot of those specific questions.”

2. *Chisme* goes around: Personal risks of disclosure

In addition, youth were worried about *chisme* (gossip), the risk that information about them would spread in a small community. One interpreter noted, “If someone leaves the country, all the people notice it and say, ‘Oh, he left,’ if someone arrives to the country, everyone is aware, ‘Oh, he arrived, and he came from such place.’” According to one CBITS facilitator:

> I definitely had people say it to me, “It’s not safe to talk about” or, “I don’t want to talk about certain parts of it” and, at first, I thought about that like, “Oh, they don’t want to talk about the really traumatic parts” but it wasn’t, it was typically, “I don’t want to tell the whole story because it might give away pieces that would be not safe to disclose.”

An interpreter stated that individuals in Guatemala would not even speak with religious leaders about their trauma: “When we go to church, we can only speak with ourselves, and everyone else does the same because if you tell someone, that person can tell other people and, in the end, everyone finds out about your situation.” These sentiments were echoed by a youth from Guatemala:

> In my country, you tell something, and they start gossiping. That’s not all right. Sometimes, we have problems, and we can’t count on anybody. It stays within the family, and sometimes, you can’t even count on them. That’s why sometimes the people that come here are afraid. They don’t know if they can count on other people.

Another reason for youth reluctance to disclose traumatic events was fear of being teased, judged, or disbelieved about what had happened to them, or how they had acted in a difficult situation. One youth stated that he freely discussed being robbed at gunpoint in his group, but did not want to disclose being sexually harassed, even though he found the incident quite upsetting.

The fear of *chisme* came up again related to using interpreters, in such a small community.

One interpreter stated that even the fact of using an interpreter could spark *chisme* and speculation about the personal reasons the interpreter was needed for the family: “They're going for the lawyers, or they're going for clinic.”

3. **Marginalizing the language and world view of indigenous youth**

Both UIY and Mam interpreters talked about the teasing and bullying they faced in Guatemala and the U.S. because of their limited ability to speak Spanish as a second language or because of their accents. One youth stated, “at school, they spoke more Spanish than K’iche’, so since we didn’t speak Spanish fluently, they made fun of us.” An interpreter said, “people do make fun of you in the way, ‘Oh she speaks Mam, or she wears these cultural clothes.’” She stated that, as a result of the “negative thinking that comes up in your mind,” she was very quiet in school, and only began to speak up when she realized that she needed to advocate for her family. A key stakeholder who was a soccer coach stated:

> I feel like a lot of other cultures look down on the indigenous groups as well… I had a kid from Guatemala that said he didn't know how to speak K’iche’, he would always only speak Spanish, but sometimes when his mom would call him on the phone he was speaking in K'iche', and those little things -- I feel like that's another challenge for them.

Early in the research, we interviewed two Guatemalan youth whose Spanish was clearly limited, and who declined a chance to be interviewed with a Mam interpreter, one stating that there were so many different dialects of Mam that the interpreter might not understand her. As discussed above, we next interviewed two Mam interpreters, one of whom denied that this was a major barrier, stating that she just had to adjust her accent. However, they noted other barriers to using interpreters. “It’s very difficult to let them know that I will speak in Mam the first time

because in Guatemala, we are forced to speak in Spanish, so they think that speaking in Spanish with someone here is like being on a superior level.” The other interpreter noted that they think, “probably the interpreter is gonna make fun of them,” as her own family had experienced.

Although our youth participants did not directly endorse bullying or discrimination as an issue affecting their participation in CBITS groups, CBITS group facilitators observed that youth who were bilingual in Spanish and an indigenous language spoke less than other youth in the groups. One facilitator spoke about a session in the CBITS curriculum, that asks participants to identify problematic thoughts, followed by their feelings and actions. When a participant was pressed to name the feeling, such as anxiety or sadness,

> [we] kept saying: “what would be the emotion? what would be the emotion?”…They were like, “well I´d be sweating and I´d feel panicky, and my stomach would hurt…” So they were really able to talk about the somatics of it but the naming of the emotion was just not familiar to them.”

Other students in the group would say: “you’d be nervous,” attaching a Westernized label to this student’s experience of somatic sensations. To some observers this could be seen as being helpful, but in this context, it had the effect of marginalizing the language and world view of the indigenous group member.

4. “CBITS didn’t really quite land for them:” Adapting the curriculum and delivery

CBITS facilitators followed the schedule and weekly topics of the intervention, sometimes spending more than one week on a topic due to language issues or lack of familiarity with the concepts. They noted two major difficulties in delivering Spanish-language CBITS to UIY and other newcomers: the exposure portion and trauma narrative of the CBITS curriculum

and applying the CBT thoughts-feelings-actions triangle. One therapist noted that, despite "lively discussion" about the trauma narrative, "in the end, they mostly felt, it's still probably good to avoid things." She felt it was not productive to push them to talk about their worst experiences if they were not ready. Another therapist noted that "everyone across the board had experienced at least four traumas." Not wanting to push them to disclose, she opted for a different strategy:

> it became really clear to me that, if we talked about the traumas that one could experience, that we would gain a lot more traction, and so what we ended up doing was shifting things up at the beginning instead of people disclosing their own personal situations. We talked about what one could experience on a personal level, what one could experience on a community level, what one can experience like the country level.

Facilitators described improvising adjustments to engage youth and pulling exercises from other trainings, or that had been shared informally by colleagues, emphasizing coping skills and addressing acculturation stress over disclosure of trauma (See Table 3). Another adaptation utilized by facilitators was balancing negatively charged memories with positive ones "so that they feel like not all the memories from their home country are bad" and that "we get to pay some attention to the good ones as well."

Two CBITS facilitators from different institutions used the phrase, "it didn't really quite land for them," in describing the difficulties they had in applying the model to newcomer groups with a high proportion of UIYs. One found herself moving away from CBT and using an intervention from her own culture:

> Like the skills, you really have to twist how you present or how you teach them because for me... it has been more effective to sit with a group of students from Guatemala and burn sage than talk about the CBT triangle.

Another therapist added, “I would say there was a little bit more of a tendency to focus on the actions than on the thoughts.”

5. “I learn to appreciate things”: Benefits of the CBITS group

One young man, whose best friend had been murdered, stated, “Since I started the groups, I feel my nightmares don’t get to me as often. I feel a bit safer.” Although he was reluctant to share in the group, just listening to other stories was helpful. The theme of deriving comfort from mutual support and shared circumstance surfaced repeatedly during interviews, with participants drawing on other UIY’s stories to give them strength:

> For me, it was good because they shared things about their lives, and you can learn from another person. I thought I was all alone, but there are other people who are alone too, without their parents, but with the help of another person sometimes, we are able to keep going.

Peer support helped participants feel less stressed and fearful. “I cannot focus in school if I think about the assault, but then I go to the group… it helps me release stress, to forget what happened.” Although reluctant at first as they feared confidentiality breaches, once they trusted group rules, they found comfort in sharing at least some of their story. One youth stated he preferred to talk about some issues alone with a therapist, then added: “There are other things that I prefer to talk about in a group to at least encourage another person.”

Therapists and youth particularly praised the skill-building aspects of the CBITS curriculum, including learning relaxation and other coping tools. “I gave them some lavender eye-pillows to use for sleeping and they also really liked them.” A group participant agreed: “Sometimes, we did exercises that helped you sleep, or [group leader] would bring these

things that you put over your eyes, and you'd relax. She'd use things like that, and we'd talk." Some participants gained a feeling of expertise in the group and wanted to share this newfound knowledge with their peers: "I learn to appreciate things, and they taught me how to give advice to other people."

Discussion

Initially, we assumed that the CBITS framework could be adapted with minimal changes to treat newcomer Central American UIY. We thought their collective experiences as immigrants and the group process that had been successful in other CBITS interventions would overcome their initial reluctance to share their trauma stories. Instead, we found that a multigenerational history of violence and repression, and deeply held notions of privacy, suffering, and shouldering one's burdens alone (Burrell, 2013), could not be overcome for newcomers in a 10-week CBITS group. This reluctance was noted especially when the trauma histories involved targeted violence and threats against youth and their families. Therefore, the culture of sharing stories and mutual support that is fundamental to a CBITS group (Jaycox et al., 2018), might be experienced as antithetical to the silence they have had to maintain to keep themselves and their families safe from harm.

Although educating group members about strict confidentiality is a core component of the CBITS curriculum, UIY students voiced a particularly critical concern about the potential for gossip, living in tight-knit communities and interacting with people who might know their families in their home countries. We learned that the local Mam-speaking community comprised many small communities, divided by village of origin and religion, and that *chisme* (gossip) was a powerful means of enforcing silence about participants' trauma histories.

UIY could not fill out the standard symptom screener recommended by the CBITS

manual in class (Jaycox et al., 2018), due to interrupted schooling and low Spanish-language literacy levels, lack of familiarity with psychological terms, and underreporting of symptoms and events that they later disclosed in conversations with the CBITS facilitators. This is consistent with other reports about service delivery to UIY (Cleary et al., 2018). Both the Refugee Health Screener (Hollifield et al., 2013) and the Mayan Health Screener (McGrew, 2011), which was used by our CBITS facilitators, were developed for use with refugee populations and focus on somatic symptoms. Nightmares, the somatic symptom and benchmark for recovery most endorsed by youth in our study, are assessed on the Mayan Health Screener, but not the Refugee Health Screener, which has a general question about sleep difficulties. Future validation studies for both screeners should include refugees from Latin America, including indigenous youth.

We also found that some CBITS group participants from indigenous communities struggled with psychological concepts about labeling and confronting anxiety and negative cognitions. Even Spanish-speaking UIY who were more familiar with Western psychotherapy endorsed denial of symptoms to others and willed “forgetting” of traumatic experiences, focusing instead on a better future, and leaving the past behind. These findings affected every aspect of CBITS, from screening to group interactions, to delivery of portions of the CBITS curriculum. Health professionals from non-Western cultures have critiqued mind-body separation and assumptions about the superiority of psychological to somatic symptom descriptions as primarily Western constructs (Wong & Tsang, 2004). Western psychiatry has also tended to exclude the political and structural issues that have reinforced silences around symptoms and traumatic events, such as those in Central America (Gangamma & Shipman, 2018).

The CBITS curriculum teaches skills on a weekly scripted schedule, with limited

flexibility as to what elements are rolled out and when (Jaycox et al., 2018). However, the psychological safety of the group depended on trusted relationships with the group leader and other group members, and this trust took longer to develop for some UIY. CBITS developers acknowledge that cultural adaptations are important, and that low-literacy youth may need to spend more than one week on particular topics (Jaycox et al., 2012). Recent literature on trauma-informed care reinforces the necessity of developing trusted relationships to enable healing (Brown et al., 2017), and literature on Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), a non-manualized intervention, emphasizes longer and flexible time periods to teach coping skills and reinforce safety (Cohen & Mannarino, 2019; Cohen et al., 2012).

Traumas for UIYs persist in the intersection of U.S. immigration policies and the traumas that drove them from their home countries: physical and psychological assault compounded by legal and financial precarity in the U.S., and messages from some in the media and government agencies that their existence here is unwanted and illegitimate (Menjivar & Abrego, 2012). In addition, many UIY were living with parents they had not seen since early childhood or with other caregivers who were not involved in the treatment. Cohen and colleagues (2011) note the risks of offering treatment predicated on past, discrete trauma to youth experiencing ongoing risks to safety. CBITS is considered to be most effective for young people who have experienced a past trauma and are now in a safe environment, with a supportive caregiver (Jaycox et al., 2018; Santiago et al., 2016). However, it was difficult to gauge the level and timing of trauma exposure and symptoms while screening for the newcomer CBITS groups, given the silence and underreporting discussed above. CBITS facilitators had to assist newcomer youth to differentiate between their response to past and ongoing traumas, and to gauge whether they could realistically count on the youth's ongoing physical and psychological safety in carrying out the

curriculum.

As noted above, the CBITS facilitators made both ad hoc and borrowed adaptations to the group exercises. Both the STRONG curriculum (Hoover et al., 2019) and Fuerte (Martinez et al., 2020) focus on coping skills, cultural adaptation, and journey narratives instead of direct trauma exposure exercises. Both are currently being tested and neither were entirely open access at the time of data collection, so it is possible that CBITS leaders borrowed earlier versions of these promising interventions. It's worth noting that even though the developers of new interventions may justifiably limit their dissemination while they are being evaluated, clinicians working with immigrant youth may still be informally exchanging these resources with colleagues.

Strengths and weaknesses

We relied on individual youth interviews from our larger study of factors supporting resilience in UIY, in which 5 of the 16 youths interviewed had participated in CBITS groups. Although we retrieved rich data from the youth we interviewed, a formal interview may not be the best modality for indigenous participants, and other more youth-driven modalities, including photovoice (Wang, 2006) or focus groups, may inform future studies of resilience in this population, adjustment to life in the US and individualized choice, timing and impact of telling or not telling one's trauma story.

We interviewed very few designated females and relatively few youths in Mam, due to our focus on UIY, as most of the young women and monolingual Mam speakers who volunteered for interviews migrated with a parent, excluding them as participants. A previous newcomer study in a high school served by our sponsoring FQHC found few differences in mental health needs between UIY and children migrating with a parent (Schapiro et al., 2018),

and we also found in our current study that some youths were reluctant to state to clinic staff whether or not they had come with a parent. In future research, we will continue to focus on UIY but will not exclude children who migrated with a parent, in order to include more young women and indigenous youth and to respect the privacy of youth who decline to specify their migration circumstances.

As a qualitative study, our results cannot be generalized, however we feel that we have met criteria for trustworthiness, with rich documentation and multiple voices. Qualitative studies of this population are especially important, as existing quantitative measures of trauma and recovery may not be a good fit for Mayan populations, and the perspectives and insights we have gathered may help to develop more culturally responsive interventions.

The strengths of our study include the ability to recruit youth in trusted school-based settings and to incorporate the insights of school staff and community members. We acknowledge the important contributions of the Mam interpreter key stakeholders to our study. With their help we were able to elucidate and overcome barriers to using interpreters, thereby incorporating the voices of Mam-speaking youth and adults. Our study contributes to the literature on interventions with UIY, and helps to understand the historical, structural, and personal components of silence in trauma-exposed Central American youth and families.

Conclusion: Clinical implications and next steps

Our research team, key stakeholders and youth participants have all expressed pride in the strength, adaptability and optimism of the UIY with whom we have interacted. Through the study, we have learned that a manualized school-based intervention that has been very successful for more acculturated Latinx youth with more family involvement (Allison &

Ferreira, 2016; Kataoka et al., 2003), has some limitations when applied to UIY, and that developing relationships of trust and teaching coping skills were highly endorsed, even by youth who were relatively silent during the group process. Models for group intervention that emphasize coping skill development and group support, while de-emphasizing the trauma narrative, should be explored and tested with newcomer UIY in the SBHC context. We also recommend careful attention by group leaders to the impact of differences in gender, country of origin and native language on group dynamics. The COVID pandemic and clinic restrictions have given us the opportunity to explore virtual CBITS and other group interventions, which might allow for an indigenous language group drawn from multiple schools. We are preparing manuscripts on youth definitions of healing and the role of schools as social supports for immigrants, which was brought into sharper focus by school closures during earlier stages of the COVID pandemic. We are also exploring which youth would benefit most from individualized trauma-focused therapy (Cohen et al., 2011) or other modalities.

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Table 1: Youth participants

Country of origin	Total	Cis-Male	Cis-Female	Identify as Indigenous	Interview in Spanish	Interview in Mam
Guatemala	9	6	3	6	8	1*
El Salvador	6	6	0	0	6	0
Honduras	1	1	0	0	1	0

*2 additional youth were interviewed in Mam, but did not fit study criteria

Table 2: Key Stakeholders

Role	Immigrant, 1st or 2 gen	Cis-Male	Cis-Female	CBITS facilitator
Family therapist	X		X	X
Program manager	X		X	
Coach/case manager	X	X		
Lead clinician NP	X		X	
IBHC in SBHC, LCSW			X	X
Mam interpreter	X		X	
Mam interpreter	X		X	
IBHC in SBHC, LCSW			X	X
School case manager	X	X		X
School SW			X	X

Table 3. Adaptations to CBITS

Adaptation	Description	Source
Referral	Individual through teachers, school staff, case managers	Ad hoc adaptation
Screening	Individual screening using somatic-based tool with simplified Likert scale	Maya Health Toolkit screener[a]
River of Life map	Youth draw experiences from significant points of their life along a depiction of a river	Fuerte[b] curriculum with roots in Narrative therapy
Memory Pairing	Difficult memory paired with a positive memory	CBT Techniques
Use of general/universal topics vs specific trauma-related events	Use general trauma themes as examples of avoidance vs using actual traumas experienced by participants	Ad hoc adaptation, following the ways youth talked about avoidance
Focus on somatic experiences vs. emotion-naming	Incorporate descriptions of somatic experience as alternative to naming specific emotion (ie: heart racing vs anxious)	Somatic-based Techniques
Focus on actions vs thoughts	Discuss actions/steps to take with different scenarios more frequently than focusing on thoughts about scenario	Problem-Solving Therapy
Physiology of trauma	Discussing fight-flight-freeze	Seeking Safety curriculum[c]
Life journey	Youth draw out quadrant of events that represent their life journey including: 1) life in home country 2) journey to US 3) current life 4) hopes for future	STRONG curriculum[d]
Potential/general traumas instead of specific individual traumas	Discuss traumas that could happen to an individual, a family and a community without disclosing individual traumas in group setting	Seeking Safety curriculum[c]
Forecasting/anticipating triggering events	Identify potentially triggering shared future events (i.e.: immigration court hearing) to rehearse coping skills	CBT Techniques

a. Czerwinski et al., 2011
b. Martinez et al., 2020
c. Najavits, 2002
d. Hoover et al., 2019