Supporting Latina Mothers After Child Sexual Abuse: Lessons from a Bilingual Parent Group Model

Aileen Torres, PhD, ABPP; Nicole Guevara, MA; Karyn Smarz, PhD

Abstract

This article describes the development and implementation of the Bilingual Integrative Trauma Treatment (BITT) Parent Group, a 12-week intervention designed for Latina mothers of children who experienced sexual abuse. Conducted in Spanish, the group provided a culturally responsive space emphasizing *personalismo*, *familismo*, and *simpatía* (see Table 1 below). Sixteen participants reported reduced psychological distress and improved coping, supported by both quantitative measures and qualitative reflections. Key strategies included relaxation, mindfulness, psychoeducation, and collaboration with legal and immigrant-rights agencies to reduce fear and mistrust. The BITT model highlights the importance of addressing caregiver trauma as central to child recovery and offers a feasible, community-centered framework for engaging underserved Latina caregivers within child abuse treatment settings that warrants current replication.

Keywords: *bilingual trauma treatment; Latina mothers; child sexual abuse; culturally responsive care; group psychotherapy; immigrant families*

When a child discloses sexual abuse, the immediate priority is the child's safety and recovery. Yet the non-offending caregiver, most often the mother, also faces intense emotional, cultural, and systemic pressures (e.g., loss of income, loss of a caregiver, change of residence, and limited community support; Goslin et al., 2013; Letourneau et al., 2018; Pittenger et al., 2017). Many Latina mothers struggle with guilt, fear, and shame while navigating complex systems in a second language. Cultural norms such as *familismo* (family loyalty) and *simpatía* (the wish to maintain harmony) can both sustain resilience and silence distress.

Research suggests that Latino/a caregivers may be more likely to experience cumulative traumatic events (e.g., violence and poverty in the country of origin, piecemeal migration, family separations, and intergenerational trauma; Alcántara et al., 2013; Cerdeña et al., 2021). Recent syntheses document 'chilling effects' of immigration enforcement on Latino/a families' use of health and social services, driven by fear of deportation and institutional mistrust (Vital, 2025; Young et al., 2023). For child protection workers or mental health professionals, Latino families may appear uncooperative due to language barriers, low levels of acculturation, negative perceptions of the legal and social service systems, and fear of deportation (Fontes & Tishelman, 2016; Fontes, 2005; Orozco et al., 2001). Controlling for socioeconomic status, Leslie et al. (2005) found that Latino/a children were half as likely as non-Latino/a children to receive outpatient mental health services following child welfare involvement, regardless of the form of maltreatment experienced. Therefore, it is important to engage the caregivers who bring the children to the therapy spaces.

Regardless of how the caregiver's response is defined or assessed, there is growing consensus that non-offending caregivers of child sexual abuse (CSA) victims require targeted mental health support (Tavkar & Hansen, 2011). Yet, recent research on caregivers' psychological needs remains limited, particularly within the United States (Davies & Bennett, 2022; Fong et al., 2020; Vilvens et al., 2021). Davies and Bennett (2022) found that non-offending caregivers reported significantly higher levels of parenting stress compared with normative

samples. In a qualitative study, Fong et al. (2020) identified four major domains of caregiver distress: (1) concerns regarding their child's safety, well-being, and future; (2) negative beliefs about their own parenting competence and protection; (3) family conflict, blame, and strain following the abuse discovery; and (4) reactivation of caregivers' own histories of maltreatment. Cyr et al. (2018) followed nonoffending parents for 12–18 months after their child's CSA disclosure and found that many continued to report significant psychological distress and health problems, particularly mothers, highlighting the enduring nature of caregiver burden following CSA.

Maternal distress, trauma history, depression, and anxiety following a child's disclosure of sexual abuse can affect maternal response after disclosure (Knott & Fabre, 2014). Although caregiver well-being strongly influences a child's recovery, few programs directly support non-offending Latina mothers in their own healing. This gap is compounded by a national shortage of bilingual and bicultural mental health professionals. For instance, less than 6% of psychologists in the United States identify as Hispanic, and an even smaller proportion provide services in Spanish (APA, 2018). The scarcity of Spanish-speaking clinicians has contributed to persistent disparities in access to trauma-informed care for families navigating child abuse interventions in Spanish; this shortage is likely even more acute for speakers of other languages.

To address this need, a bilingual clinical team in an urban New Jersey child abuse treatment center developed the Bilingual Integrative Trauma Treatment (BITT) Parent Group**,** a 12-week intervention conducted in Spanish for mothers whose children had experienced sexual abuse. The project originated as a feasibility and program evaluation initiative rather than a formal research study, yet it provided valuable insights for practice. At the time, the hospital employed only two Spanish-speaking licensed clinicians—insufficient to meet the community's needs. When one clinician conducted the psychosocial abuse evaluation, ethical guidelines precluded that clinician from serving as the child's therapist, further limiting access to treatment. As many of the children were English-dominant, it was often more feasible to assign them to individual therapy with English-speaking clinicians, while their mothers participated in the Spanish-language parent group. Establishing both the BITT Parent Group and a bilingual externship training track expanded the reach, feasibility, and cultural and linguistic accessibility of services for Spanish-speaking caregivers.

The BITT Parent Group was initially piloted more than a decade ago at a state-designated child abuse treatment center to address the unmet needs of Spanish-speaking Latina mothers whose children had experienced sexual abuse. When Spanish-speaking supervisors left the site, the program was discontinued. However, the promising outcomes listed below and renewed bilingual training opportunities underscore the value of revisiting this model's concepts today. Given ongoing immigration-related stressors and systemic service barriers for Latina caregivers, we call for a replication of this previous program as it is both timely and needed. The authors hope to revitalize this bilingual track for the upcoming externship training period.

The BITT Model

The BITT model emerged within a state-designated child abuse assessment and treatment center. Many Spanish-speaking mothers referred had minimal access to therapy in their native language and carried their own trauma histories. These non-offending caregivers were deemed appropriate for the group if their child (age 4-17) disclosed sexual abuse during a psychosocial evaluation and the child required individual psychotherapy to manage symptoms.

The BITT child program drew inspiration from Briere and Lanktree's (2013) Integrative Treatment for Complex Trauma (ITCT), adapting and expanding it to use with Latina caregivers. The clinical team—bilingual psychologists and advanced externs—created a group space that honored Latino cultural values while addressing trauma and parenting stress.

Supporting Latina Mothers

A specific group was developed for Latina mothers to increase their ability to be supportive of their children and allow mothers to process their feelings, parenting concerns, and reactions to their children's disclosure in a safe space. The co-leaders of the groups received training on Latino/a family values and traditions, research related to sexual abuse, and caregivers' reactions to their child's sexual abuse. The training was provided by the RDTC licensed clinical supervisors in weekly, structured didactic teaching sessions, and was further discussed in group supervision. A bilingual licensed psychologist and a licensed clinical social worker supervised bilingual externs and licensed associate clinicians. The children received individual therapy at approximately the same time that the mothers were in the group session. If the children finished their session earlier than the parent group, or if they started their session any time after the parent group started, then the children waited with the hospital's Child Life Specialists in a child-friendly waiting room.

Each 90-minute BITT session addressed themes common among non-offending Latina mothers coping with child sexual abuse. Early sessions focused on stress and somatic symptoms using relaxation and mindfulness methods, progressing to parenting and coping with vicarious trauma. Psychoeducation regarding common sexual abuse myths was provided from the outset. During the third and fourth sessions, mothers provided more details about their parenting concerns, which were addressed, along with cultural aspects of parenting. For example, the mothers expressed concern about what they believed to be "American" behavior (e.g., perceived disrespect, permissive parenting). The group provided Latino-based positive parenting ideas from the Spanish version of Carmen Inoa Vazquez's (2005) book, *Parenting with Pride: Latino Style*.

Mid-phase discussions explored trust, immigration fears, guilt, and self-blame, emphasizing safety and peer support. Later sessions integrated trauma processing and empowerment, concluding with goal-setting and collective reflection. Representatives from the prosecutor's office and an immigrant-rights group demystified legal and immigration processes, reducing fear and mistrust, which are critical barriers to engagement. A Spanish-speaking prosecutor came into the session to answer questions. A local immigrant rights group came in at the end of another session to discuss basic immigration options. As their children were victims of crime, they discussed whether they were eligible for a U-Visa. The parents were provided with information on immigrant rights in the event that they needed a more thorough consultation. Across sessions, interventions combined relaxation and mindfulness exercises, and psychoeducation anchored in core cultural values. Several of the Christian mothers expressed concern about the relaxation and mindfulness exercises, as they believed that this could conflict with their religious beliefs because it "sounded like yoga." As such, there was an open discussion on how we could adapt the exercises to meet their needs. Some mothers preferred to pray and/or think about God while engaging in simple breathing exercises.

With guidance from the group leaders, the mothers progressively learned to help each other process their feelings and problem-solve their reactions to their children and families. The group members also supported each other during the trauma narrative sessions 8-9. Finally, the group also processed their views of their sexually abused child. Helping parents reframe their child as a survivor, not "damaged goods," was intended to instill hope. Group members discussed disagreements about the value of virginity and culturally based definitions of sexual abuse. Throughout the sessions, the mothers compiled a list of songs that helped them feel more hopeful and less stressed. The last group session was a potluck celebration to process the treatment accomplishments, with music playing in the background.

Cultural Adaptation and Core Values

Cultural responsiveness was central to BITT's design. Our team identified several values that shaped how we conducted the intervention (see Table 1).

Table 1.

Cultural Values Integrated into BITT Parent Group Treatment

Core Cultural Value	Definition / Conceptual Focus	Application in BITT Sessions	Illustrative Interventions
Personalismo	Emphasis on developing genuine, respectful personal connections that prioritize trust over formal authority (Organista & Muñoz, 1996).	Co-leaders began each session with small talk, warmth, and personal engagement to reduce power differentials.	Informal check-ins over coffee; self-disclosure to model authenticity and connection.
Simpatía	Preference for harmony and pleasant social interactions; avoidance of confrontation or emotional tension (Guarnaccia & Martinez, 2003; Paniagua, 1994).	Group tone emphasized respect, gentle transitions, and supportive listening to create emotional safety.	Grounding exercises, collaborative discussion rather than directive questioning, validation of emotions.
Familismo	Prioritization of family unity, loyalty, and mutual support (Fontes, 2005).	Framed 'protecting the family' as protecting children from further harm while preserving cohesion.	Psychoeducation on safety planning and reframing caregiving roles; shared family narratives.
Fatalismo	Faith-based acceptance that life events are predetermined ('this is my cross to bear'; Comas-Díaz, 1995).	Acknowledged spiritual meanings of suffering while introducing active coping and empowerment themes.	Guided reflection integrating faith, prayer, and mindfulness practices.
Collectivism	Value of community and interdependence in coping and healing (Hernández & Villodas, 2019).	Fostered peer encouragement and group cohesion; celebrated progress collectively.	Group rituals (shared meals, music, closing ceremonies); peer mentorship.

Present Study

Participants

Sixteen mothers participated in the two initial pilot groups conducted in Newark, NJ. Group participants emigrated from nine different countries, including Ecuador (43.8%), Mexico (12.5%), and Guatemala (12.5%). Eleven (68.75%) of these mothers reported that their child was abused by a family member, most commonly the uncle (37.5%). Sessions were 90 minutes long and co-led by a licensed psychologist and a doctoral trainee. Meetings began informally over coffee and conversation, reflecting *personalismo*

and helping build trust. Nine of the 16 mothers did not report their own history of maltreatment in childhood in the intake questionnaire, but five of these nine women later disclosed an abuse history during the group intervention. Therefore, a total of 12 mothers (75%) disclosed a history of sexual abuse either on the demographic questionnaire or during the group treatment.

Pre-Screening

All caregivers completed a demographic questionnaire, the Brief Symptom Inventory (BSI; Derogatis, 1993), Parenting Stress Index (PSI; Abidin, 1995), the Trauma Symptom Inventory (TSI; Briere, 1995) and the Perceived Cultural Competency scale (Michalopoulou, 2009). The original evaluation used instruments (e.g., BSI, PSI, TSI) that remain among the most validated cross-cultural tools in trauma and parenting research, with Spanish versions that continue to demonstrate strong psychometric reliability. Their enduring utility supports replication using comparable metrics for consistency and comparability. All the participants chose to complete the measures in Spanish. The Bilingual Integrative Treatment team met together to review the pre-screening symptom profiles and to work conjointly on overall group treatment goals. Issues regarding safety were assessed prior to group participation during the child's psychosocial evaluation. Seventy five percent of the sample had clinical levels of Paranoid Ideation (M = 65.63, SD = 8.04), 75% Parenting Stress (M = 69.69, SD = 29.07), 56% Interpersonal Sensitivity (M = 60.19, SD = 8.90), 56% Parent Child Dysfunctional Interaction (M = 69.63, SD = 26.65), 50% Depression (M = 60.25, SD = 6.91), and 37% Defensive Avoidance (M = 61.50, SD = 10.39). Less than a third of mothers also reported clinical levels of Somatization, Anxiety, Hostility, and Intrusive Experiences.

Clinical Course and Observations

The weekly caregiver group met 14 times: 12 intervention sessions, each 90 minutes long, and two meetings dedicated to completing pre- and post-intervention measures. Over twelve sessions, the groups evolved from tentative sharing to collective problem-solving. Early sessions focused on stress education and myths about sexual abuse. Later sessions addressed guilt, anger, and parenting challenges in bicultural families. Common emotional themes included fear of deportation or child-welfare involvement, anger toward perpetrators or unsupportive relatives, sadness over family division, and self-blame for not preventing the abuse.

Through discussion and guided exercises, mothers reframed these experiences, moving from silence to self-advocacy. The mothers supported each other and discussed ways they could empower one another. They transported each other to sessions. Having practiced relaxation scripts modeled by the group leaders during the first few weeks, the mothers later took turns leading these exercises for the group. As discussed above, several verbally disclosed their own histories of abuse despite their initial denial in prescreening documents. These disclosures came only after trust deepened, underscoring the need for sustained, culturally safe spaces. Mothers often described feeling isolated or judged; the group offered a rare opportunity for connection and shared understanding.

Analysis Results of Preliminary Effectiveness

Two-tailed paired sample t-tests indicated that participants made statistically significant improvements in their overall BSI Global Severity score from pre (M = 60.63, SD = 8.43) to post-treatment (M = 55.25, SD = 7.42); [$t(15)$ = 3.55, p= .003] with a medium effect size (g = .645). None of the participants deteriorated on the global severity index and one did not demonstrate any change. Similarly, TSI Defensive Avoidance declined from $M = 61.50$, $SD = 10.39$ to $M = 56.31$, $SD = 8.88$, $t(12)$ = 2.72, p = .02, g = .65. On the Parenting Stress Index (PSI), mothers reported significant improvement in the Parent–Child Dysfunctional Interaction subscale, with scores decreasing from $M = 69.93$, $SD = 26.65$ to $M = 52.88$, $SD = 32.94$, $t(12)$ = 2.23, p = .04, g = .53. TSI Intrusive Experiences decreased from M = 54.81, SD = 11.74 to M = 51.31, SD = 8.92, $t(12)$ =

2.15, $p = .05$, g = .51.while overall Total Parenting Stress decreased non-significantly from $M = 68.75$, $SD = 29.83$ to $M = 54.27$, $SD = 35.84$, $t(12) = 2.10$, $p = .06$, $g = .51$.

Eight participants reached clinical levels in the Global Severity Index of the BSI and half of these ($n = 4$) no longer had clinical elevations at post-treatment. Notably, 12 of the 16 participants met clinical levels of paranoid ideation in the pre-treatment phase; and only four continued to have a T score > 63. Of the 11 participants who met clinical levels of TSI Defensive Avoidance at pre-treatment, only three continued to meet clinical levels (T > 65); however, symptom reduction with recovery was not as promising for other symptoms.

The Perceived Cultural Competency scale scores suggested that the clients perceived the group treatment providers as having cultural knowledge, awareness, and skills. There were nine items on a Likert scale of 1-7, and each subscale had three items. The group mean of 59 out of the possible 63 indicated that they perceived their clinicians to be culturally competent in the areas of knowledge (M = 19.69), awareness (M = 19.54), and skill (M = 19.77).

Qualitatively, mothers described sleeping better, feeling calmer, and perceiving themselves as stronger parents. One participant shared in Spanish, "*I thought I was alone in this pain, but here I learned I am not the only one—and that gives me strength*."

Lessons Learned

1. Mothers need their own space for healing. Conjoint sessions with children are valuable but insufficient. A separate parent group allows caregivers to process complex emotions that could otherwise impede support for their child. While fathers were also invited to participate in the group, fathers did not end up participating in this group. In the future, we should consider how to include more participation from fathers and whether they would prefer a separate group.
2. Language access is not the same as cultural access. Simply translating materials into Spanish is inadequate. Clinicians must integrate Latino cultural values and community partnerships into treatment design (Fontes, 2005).
3. Group structure fosters empowerment. Collectivist values aligned naturally with group work. Mothers' mutual encouragement became a therapeutic force, reducing shame and isolation (Hernández & Villodas, 2019).
4. Trust opens the door to deeper trauma work. Several participants revealed personal abuse histories only after weeks of rapport-building. Clinicians should expect delayed disclosure and pace interventions accordingly. The group provided space for mothers to process their personal trauma narratives at a tolerable pace, fostering integration and healing. Participants who continued to exhibit clinical levels of symptoms at post-treatment were referred for individual therapy within their community. Mothers who continued meeting clinical levels of symptoms when assessed post-treatment were referred to individual therapy in their catchment area.
5. Collaboration with community partners strengthens outcomes. Bringing in bilingual prosecutors and immigrant-rights advocates transformed fear into knowledge, empowerment, and connected families to real-world resources. The participants knew what to expect regarding potential criminal charges, or lack thereof, as well as what to expect if they went to court. They learned about potential immigration options resulting from their children being crime victims.
6. BITT's group supervision model conducted in Spanish enhanced clinician comfort with dialects, idioms, and culturally sensitive dialogue. New Jersey has a diverse Latino population; our program members were from nine different countries, and as such, cultural and linguistic misunderstandings could arise. Supervision allowed for discussion about these issues, and by having exposure to supervisors and trainees with differing levels of Spanish skills and dialects, we

were able to process these concerns.

7. It would be ideal to have different groups for intrafamilial and extrafamilial abuse cases, as the intrafamilial cases were typically more complicated and the mothers in intrafamilial cases were more symptomatic.
8. While most of the child victims were female, it may be beneficial to address with parents issues related to the gender of the child. Parents may have different views regarding sexual abuse of boys that may warrant further discussion.

Conclusion and Recommendations

The BITT Parent Group illustrates that culturally grounded, bilingual interventions for non-offending Latina mothers are both feasible and clinically meaningful within child abuse treatment settings. By addressing caregiver trauma, cultural context, and systemic barriers, BITT helped participants reduce psychological distress, enhance parent–child relationships, and foster community connection. The group format also expanded service access where bilingual clinicians were limited, demonstrating that collective models can effectively complement individual therapy and optimize scarce clinical resources.

Programs serving child sexual abuse survivors should consider integrating parallel caregiver interventions that honor language, culture, and lived experience. Group leaders fostered safety in the initial sessions by building trust through warmth, consistency, and respect. Reframing *familismo* as a protective rather than constraining value can transform guilt, fear, and silence into empowerment and resilience. Incorporating community partnerships, such as collaboration with legal and immigrant-rights agencies, further reduces mistrust and enhances continuity of care for immigrant families navigating multiple systems. This article calls for clinicians to replicate and further develop this model at its original site and beyond.

Although these pilot groups were conducted over a decade ago, the model remains relevant today, given persistent disparities in access to culturally responsive care. Replicating and updating BITT with contemporary evaluation methods and telehealth adaptations could help address the ongoing shortage of bilingual trauma services. Ultimately, programs that invest in both children and parents simultaneously may help create stronger, safer, and more resilient families.

About the Authors



***Aileen Torres, PhD, ABPP**, is a board-certified clinical psychologist and Associate Professor at William Paterson University. She was the Director of the Bilingual Integrative Trauma Treatment (BITT) Program at Newark Beth Israel Medical Center's Regional Diagnostic and Treatment Center. She authored the textbook Child Abuse and Neglect: Culture, Research, and Theory.*



***Nicole Guevara, MA**, is a fourth-year PsyD student at William Paterson University and a bilingual clinician at Newark Beth Israel Medical Center's Regional Diagnostic and Treatment Center. She earned her MA in Clinical Psychology with a forensic concentration from Montclair State University and provides trauma-focused services to children and families.*



***Karyn C. Smarz, PhD**, is a Supervising Psychologist at Newark Beth Israel Medical Center's Metro Regional Diagnostic & Treatment Center. She directs the RDTC Externship Training Program and the Family Life Education Center, providing parenting, anger management, and domestic violence services for families across New Jersey.*

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