PSYKHE
2001, Vol.10, Nº 2, 167-180

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ISSN 0717-0297

Latin@ Sobrevivientes de Abuso Sexual Infantil en los Estados Unidos: Un Acercamiento Relacional al Diagnóstico e Intervención

Latin@ Child Sexual Abuse Survivors in the United States: Relational Assessment and Intervention

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[As a Latin American], I am an ambiguous being, a two-imaged self: ... This ambiguity is not just funny, it is survival rich. We can also make a funny picture of those who dominate us precisely because we can see the double edges, we can see them doubly constructed, we can see the plurality in us and in them. ... Only when we have traveled to each other's "worlds" are we fully subjects to each other (Lugones, 1990, pp. 398-401).

Utilizando una perspectiva relacional y sistémica, este artículo analiza el caso de los Latinos sobrevivientes de abuso sexual en Estados Unidos. La revisión de la literatura analiza una serie de mitos que aún persisten en las prácticas clínicas y de investigación acerca del problema del abuso sexual. El autor utilizó datos de su investigación con terapeutas que trabajan con familias latinas y sus propias experiencias de evaluación y tratamiento clínico para ejemplificar aspectos importantes del tema. Casos clínicos son empleados para describir un acercamiento clínico que es relacional y focalizado en el contexto cultural de los pacientes. Finalmente, el autor presenta una serie de recomendaciones específicas para el diagnóstico y tratamiento de esta población, recomendaciones que deben leerse dentro del contexto de la amplia gama de información que ya existe acerca del diagnóstico y tratamiento de sobrevivientes de abuso sexual que necesitan ayuda clínica.

This article explores the problem of child sexual abuse among Latinos in the US using a relational systemic lens. A review of the literature debunks some of the myths that persist about Latinos in the US and child sexual abuse. Based on research with therapists working with Latinos in the US and the author's own clinical work, an analysis of key issues is carried out. Clinical vignettes are employed to describe a relational and culturally sound assessment and intervention. Specific recommendations are provided to add to the wealth of knowledge that exists about clinical work with child sexual abuse survivors.

Introduction

Professionals, service providers, survivors, and their families are continuously redefining child sexual abuse as a social problem. This evolving and contextualized knowledge has distinctive features, which have, for the most part, been constructed in the last two decades. What we have come to define as child sexual abuse, however, is based largely on knowledge fostered by dominant professional groups. The paper explores the cultural adequacy of existing accumulated knowledge about child sexual abuse among Latin@[1] survivors and suggests several guidelines in the assessment and intervention with children and families in which child sexual abuse is suspected or has occurred. Child sexual abuse is a complex social and psychological form of violence in a patriarchal society. It is a problem that requires more than just an array of clinical techniques, but also a clinical understanding based on an ethics of care and justice. This paper advances such an ethic, as well as adding new ideas for assessing and intervening in the case of child sexual abuse in Latin@ families.

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[1] Latin@s is a gender-friendly abbreviation (Suarez-Orozco & Sommer, 2000) that embraces more accurately the continuous struggle to define what "Hispanic," "Latino," "Latina," "Americano," "Hispano," etc. mean. It is not an abbreviation for Latinoamerican or Latinoamericano; it refers to Latinos and Latinas in the United States.

Child sexual abuse interrogates accepted notions of the private and the public in families. Furthermore, exploring child sexual abuse among Latin@s requires questioning accepted notions of what "private" and "public" mean, since most Latin@s so-called private lives are often under the close scrutiny and gaze of institutions that attempt to define, intervene into, and control them. Statistical projections suggest that Latin@s will soon become the largest minority group in the U.S. (U.S. Bureau of the Census, 1996). Despite the statistical weight of Latin@s, we continue to be invisible or simplified in most research and clinical approaches in comparison to dominant groups that are assumed as the norm. To understand Latin@s lives, clinicians and researchers need to include the structural, organizational, historical, and social contexts in which groups of Latin@s are found.

Studies about Latin@s this population are muddled by traditional normative ideas about Latin@ families and are based on universalizing myths about ethnic Latin@ identity (Baca Zinn, 1995; Montero-Sieburth & Villaroel, 2000). Approaching Latin@s as a single, homogeneous entity leads to significant misunderstandings, since Latin@ identities are composed of a heterogeneous array of cultures, races, social classes, and immigration histories (García & Marotta, 1997). Issues of identity may lead to further confusion since ethnic labels do not necessarily determine how groups of individuals behave or make meaning of their lives. Giovannoni (1979) suggested that the single ethnic identification in child abuse research studies may lead researchers to further confusion since the relative degree of ethnic identification or acculturation may mediate the relationship between sexual assault and problems in functioning (Arellano, Kuhn, & Chávez, 1997). Even languages spoken may not be a common dimension: Latin@s speak mainstream languages, including Spanish, Portuguese, English, French, Creole, Yiddish, and less well-known indigenous languages. In the case of child abuse, research has shown that minority groups are no less tolerant of child abuse incidents than others but are very concerned about child abuse (Giovannoni & Becerra, 1979). Studies of lay individuals show that Blacks and Hispanics perceive incidents of child abuse and child neglect (Rose & Meezan, 1996) as more serious than do their Caucasian counterparts, and the perception of sexual abuse as a more serious problem is more pronounced in the case of Hispanics than in any other racial/ethnic group (Giovannoni & Becerra, 1979).

There are interesting parallels between the experiences of child sexual abuse and the experiences of Latin@s in the U.S. Like child sexual abuse survivors who request our aid in clinical settings, Latin@s often experience invalidation, paternalism, suspicion, dislocation, blame, rejection, and confusion. The available literature about both child sexual abuse and Latin@s seem to suggest that researchers and clinicians contribute to this insidious invisibility in most areas of research and clinical practice. Making sense of Latin@s' "place in the middle" (Anzaldúa in Lunsford, 1999) or of being caught in cultural borderlands is not always a traumatic process, but it may parallel the description of sexual abuse survivors' internal experiences and identity formation. Discrimination, for example, is frequently a subtle process but its impact is painful and often chronic.

Similarly, the experiences of sexual abuse and posttraumatic stress disorder among ethnic minority children parallel other forms of victimization such as institutional racism (Wyatt, 1990). Child abuse researchers have neglected Latin@ children and their families. A survey of *Child Maltreatment*, for example, the flagship journal of the American Professional Society on the Abuse of Children, from 1996 to February of 2000 reveals not a single article dedicated to Latin@ children. Only one article (Geddie, Dawson, & Weunsch, 1998) in the last four years explicitly deals with socioeconomic and ethnic differences; Latin@s, however, are not included in the sample. This exclusion and lack of systematic attention to children of color does not reflect the numbers of clients of color served by child protective services and by researchers whose work, the editor of *Child Maltreatment* acknowledges, is "substantially comprised of work with children and families of color" (M. Chaffin, personal communication, June 14, 2000).

Incidence, Impact, and Intervention: Ethnicity is Not the Issue

Research literature about Latin@s and child sexual abuse is difficult to compare or analyze. Many studies do not report the ethnic composition of their samples, exclude Latin@s from the study, or include a small percentage of Latin@s without any comparative analysis. Research that does study Latin@s is limited to incidence studies and retrospective survey studies in which specific national or ethnic populations are studied. More

fundamentally, it is a challenging task to review the research literature findings about how child sexual abuse occurs in Latin@ families, since most of the clinical literature about child sexual abuse and trauma tends to generalize its findings to all clients, despite class, cultural, and race differences. Commenting on Judith Herman's respected book "Trauma and Recovery" (Herman, 1992), Daniel (1994) stated that most of writings about trauma in the U.S. exclude traumas related to racism, colonization, and social class, thereby promoting a "lack of integrity" in the practice of psychology. This is not only true for research that altogether excludes Latin@s and other minorities from their studies, but also for studies that approach Latin@s as a monolithic group without deconstructing the intersecting roles of race, class, national origin, religion, and gender in the incidence, maintenance, and impact of child sexual abuse in Latin@ communities. Moreover, these markers are also accompanied by the intersecting role of political and family violence in various Latin American countries (Bacigalupe, 2000b).

There is little consensus about the prevalence and circumstances of sexual abuse among Latin@s, some researchers report lower rates for Latinas, others report no differences. Romero (1999) examined the prevalence and circumstances of child sexual abuse in a community sample of Latinas aged 18-50, found that one third reported an incident of child sexual abuse and more than a third had reportedly experienced revictimization. Most of the perpetrators were young males and known by the victim and had occurred during early childhood. In the same study, it was found that four of the women had been forced to marry the perpetrators. In a study of college women, like other community-based surveys, Arroyo (1997) reported no significant ethnic differences in the prevalence of child sexual abuse and incest. White non-Hispanic females, however, were twice as likely to report sexual assault when it did occur as were Mexican American adolescent females (Arellano et al., 1997). Based on a sample of 3000 adult community residents, Hispanics and men reported significantly lower rates of assault than non-Hispanic Whites and women. Rates of rapes reported to police echo rates of violent crimes, which as affecting persons who live in the inner city, are of a lower socioeconomic status, and are members of ethnic minority groups at a higher rate. However, rates of rape are lower for Latinos in comparison to other ethnic groups (U.S. Department of Justice, 1988).

Consistent with national crime statistics showing lower rates of rapes among Hispanic individuals, the lifetime prevalence of sexual assault among non-Hispanic Whites was 2.5 times that of Hispanics. Hispanics were less likely than non-Hispanics Whites, and men were less likely than women, to use any health services regardless of sexual assault experience, age, need, and insurance status. Cultural factors may serve to reduce the risk of sexual assault among Hispanics (Sorenson & Siegel, 1992).

A study of school health clinical records (95% Hispanic) shows an 11% reported rate of child abuse, of which 64% was sexual abuse (McGurk, Cárdenas, & Adelman, 1993). In-depth interviews with these subjects show the following results: the average age at time of the onset of abuse was 9 years old; it was chronic, usually lasting for a period of several months to a year. Only 10% of the victims had reported the abuse when it was still ongoing. In all other cases, an average of six years passed before anyone was told about the abuse and more than 75% of the perpetrators were close relatives or family friends. The perpetrators were strangers in 5% of the cases. The survivors described a "high degree of self-blame for the abuse" and at the same time, "all felt that they should have told someone earlier or made a greater effort to stop the abuse while it was ongoing" (McGurk et al., 1993, p. 198). Her findings suggest that abused students are ready to acknowledge the abuse when "asked a direct question on a self-report" (McGurk et al., 1993, p. 200).

A survey (Roosa, Reinholtz, & Angelini, 1999) of 2003 women between 18 and 22 years of age investigated the relationship between child sexual abuse and depression and whether this relationship differed by ethnicity (African Americans, Mexican Americans, Native Americans, and non-Hispanic whites). Rates of child sexual abuse were similar across ethnic groups; approximately one-third of each group reported some form of sexual abuse and about one-fifth of each ethnic group reported experiencing rape. The severity of child sexual abuse was significantly related to depressive symptoms only for non-Hispanic whites and Mexican Americans. A retrospective study of adult women survivors by Russell (1986) concluded that Latinas had the highest percentage reporting considerable trauma from their abuse, they are followed by African Americans, Asians, and Whites (Russell, 1986). Arellano (1997) concluded that ethnicity "does not play a major contributory role in the

relationship between sexual victimization and poor functioning" (Arellano 1997, p. 456). Other studies also fail to find consistent support for a different rate of victimization among the Latin@ population.

Mennen (1994) found that the "experience of sexual abuse for Latinas is very similar to that of White and African American girls both in characteristics of the abuse and symptom level" (Mennen 1994, p. 481). I agree with Mennen's observations, which suggest that if differences are found "they may relate more to the experience of being an oppressed minority in a majority culture than to differential responses to childhood sexual abuse" (Mennen, 1994, p. 481). This differential may also be linked to a lack of adequate services for Latinas (Bacigalupe, 2000c). A naturalistic study of therapy experiences for a sample of sexually abused girls indicated that the treatment utilization was associated with ethnic minority status. Only ethnicity contributed to the prediction of total sessions of therapy. Indeed, minorities received fewer total sessions of therapy than non-minorities (Horowitz, Putnam, & Noll, 1997).

Latin@s, Trauma, and Myths

Race, class, and colonization have a synergistic effect on the lives of those who suffer child sexual abuse in their families. These dimensions, which are crucial, intersect differently for various ethnic and racial groups. This distinction is necessary, since most of research that alludes to the realities of people of color defines them by opposition, subsuming all those who are not White into one category. When socioeconomic variables are included, a still more complex picture is obtained, a task that still needs to be addressed in the child sexual abuse research. Research in other areas show, for example, that children in poverty report more intense and more frequent fears than children from the upper and middle class, and Latin@s do not differ from Anglos in this regard (Owen, 1998).

Authors often assume that the census categories actually represent the complex realities of each of these groups, including their intra-group differences related to the intersecting roles of race and class in each ethnic and/or immigrant group. Latin@s are a heterogeneous set of groups and communities. We differ primarily due to immigration and political history, socioeconomic status, religion, skin color, documented and undocumented status, language and fluency abilities, education, and access to the country of origin (for those who immigrated to the U.S.). The recurrent precaution in recent literature about Latin@s to remember these differences is commonly understated and forgotten when researchers investigate a specific social problem within an ethnic community that is identified as non-dominant. Child sexual abuse occurs in a localized cultural context that includes among others ethnic, racial, and religious dimensions (Fontes, 1995). Most Latin@s do, however, share some "real" and symbolic dimensions (Augenbraum, 1993; Baca Zinn, 1995; Bernal, 1994; Colorado, 1998; Espin, 1997; Falicov, 1998; Falicov, 1999; García, 1997; González, 1996; Hayes-Bautista, 1987; Heyck, 1994; Massey, 1995). In this paper, I explore some of these similarities as they pertain child sexual abuse. Although similarities allow for generalizations, they need to be contextualized by those domains that forge diverse experiences and identities for various groups of Latin@s.

For researchers and clinicians, the challenge is dual. We need to balance the information and contexts that emphasize those similarities among various groups of Latin@s which differentiate them from the larger dominant culture; with these differences -even within one nuclear family- that intersect specifically with the social, cultural, historical, and racial history of each individual and/or family.

Cultural stories constitute, and actively shape our lives by defining our identities and location in the larger social context (Bacigalupe, 1996; Coll, 1998; Comas-Diaz, 1994; Roberts, 1994; Rosen, 1996; Rosenwald, 1992). Culture influences the coping mechanisms and the way severe stress in the form of trauma becomes a narrative, which in turns becomes a symptom. "Various cultures may pattern narratives of trauma differently (*and the*) meanings conveyed in such narratives may appear through expressive forms that vary widely across cultures" (Waitzkin & Magana, 1997, p. 817).

The prevalent professional narrative that connects the self and trauma in the psychological literature is a regressive one. The dominant perspectives about trauma may miss the complexities attached to the work of therapists working sensitively with Latin@s. The dominant clinical narrative, which often is related to the notion of posttraumatic stress disorder, is insufficient to capture the lives of Latin@s seeking counseling. The posttraumatic stress diagnosis emphasizes a life that is disrupted by an event. A single event may only be

relevant to those who are not aware of the complex stories and ways in which Latin@s may make sense of violent situations or persistent harsh social conditions. Often, practitioners make these conditions invisible by paying attention only to one violent event, rather than to the larger (violent) social and cultural contexts in which survivors were raised or lived. For example, the experience of immigration is shared by most of Latin@s. Most Latin@s are first and second generation immigrants; even those whose ancestors were here before Europeans arrived in the U.S., have been inscribed with the immigration experiences of their peers and communities. In this context, family values are not only construed within the family's transgenerational context but also in terms of perceived changes in societal values. In sum, a trauma-specific model is insufficient to understand the experiences of clients who not only have suffered child sexual abuse but also are embedded within a context that can be very traumatic in and of itself.

Although "notions of a just world and a safe home are not automatic, readily available, or equally distributed" (Gilfus, 1999, p. 1251), psychological trauma has been conceptualized as the set of biopsychosocial manifestations suffered in the aftermath of an event like battering, rape, a natural or human provoked disaster, death of a significant other, or political terrorism, among others. This event is seen as disrupting the "normal" [sic] state of affairs and thus one's belief system is put at risk (Janoff-Bulman, 1992). A major underlying assumption in mainstream psychiatric literature involves an autonomous self bound in a lineal and stable or progressive narrative. The person's life is disrupted by an event that provokes short-term normal stressful consequences or long-term consequences labeled as post-traumatic stress disorder. Such a definition however, may not be inclusive of large groups of Latin@s and other groups who are immersed in contexts that define human nature and worldviews in substantially diverse ways (Sue & Sue, 1999). This critique of the prevalent trauma diagnosis is consonant with conceptualizing child sexual abuse as often involving a prolonged and a chronic experience rather than a single event. In the case of Latin@s, the abuse is compounded by an array of dimensions that make child sexual abuse particularly complex for clinicians to deal with. Trauma models are insufficient to understand the consequences of child sexual abuse among Latin@s as these models are biased away from the experiences of those in marginalized communities, where "normal" life and trauma are interwoven and, considering their history and life circumstances, a single traumatic event does not radically alter a world view that was already premised on life being difficult.

Clinicians often emphasize the concept of male dominance as being specific to Latin@ families when assessing a child sexual abuse case. Despite changes in the expectations about gender among Latin@ males and females, *marianismo* and *machismo* are gender ideologies that continue to play important roles since they support an imbalance in power in traditional Latin@ families (Perilla, Bakeman & Fran H, 1994). More than a religious practice deriving from reverence towards the Virgin Mary, *marianismo* and *machismo* work together to determine an "ideal assigned" gender system. "As stereotype (spirituality, purity, abnegation, sacrifice, virginity, maternity, etc.), *marianismo* may or may not become reality in daily life" (Montecino, 1991, p. 27). More fundamentally, however, these intersecting ideologies provide a sense of strong identity and historical continuity for the experiences of Latin@s as the children of Spanish male conquerors and American[2] indigenous women. This legacy also includes the conquest of the southwest of the U.S. by the Spaniards (Gutierrez, 1991). In this intersecting set of ideologies, machismo is not only an aspect of a universal feature that organizes patriarchal societies. Machismo is a form of recuperating the foundational father (the Spanish conqueror), which involves defining the relationship with the feminine as a struggle, as a violation, and, in sum, as striving to conquer (Montecino, 1991). In affirmative terms, it is also an identity that makes males accountable to their families as providers and protectors, limiting often, however, the autonomy of women. Machismo is nonetheless a patriarchal ideology that is not the property of men of color alone (Bacigalupe, 2000a; Pérez, 1993).

Child sexual abuse authors agree that child sexual abuse is based on the existence of patriarchal systems of domination (Barrett, Sykes & Symes, 1986; Flores-Ortiz, 1997; Fontes, 1995; Fraenkel, 1996; Freer, 1997; Gilgun, 1995; James & MacKinnon, 1990; Russell, 1986; Weingarten, 1995), the same applies in the case of domestic violence (Bograd, 1999; Gordon, 1988; L. Walker,

[2] In this paper, the word American defines the inhabitants of the continent as a whole rather than referring to inhabitants of the United States of America.

1999; L. E. Walker, 1999). It is not clear whether traditional cultural ideologies influence wife assaults in Hispanic-American families, or if culture is confounded with poverty, unemployment, and immigration status stresses. Clinicians' cultural assumptions about latino families as more patriarchal and thus more likely to be abusive have been debunked by comparative studies. Kantor, Jasinski, and Aldarondo's (1994) study of a national sample of 1970 families, for example, show that Hispanic American families, as a whole, did not differ significantly from Anglo Americans in their odds of wife assaults when norms regarding violence approval, age, and economic stressors are held constant. At the same time, considerable heterogeneity was apparent among ethnic subgroups on a number of measures. They also found that being born in the United States increases the risk of wife assaults by Mexican-and Puerto Rican-American husbands. "However, the presence of norms sanctioning wife assaults within any group, regardless of socioeconomic status, is a risk factor for wife abuse" (Kantor et al., 1994, p. 207). Thus, there is very little empirical evidence that aspects of the Hispanic ideology support wife abuse. On the contrary, it seems that cultural dimensions are buffers for domestic violence, but no evidence that there is cultural transmission of abuse. I believe then that these studies about domestic violence may be relevant in the case of child sexual abuse if we consider the contention that cultural values are at stake in the case of child sexual abuse.

Two Stories of Child Sexual Abuse

In the following clinical stories, I limit my interpretative comments in an effort at keeping the complexity inherent to cases of Latin@ child sexual abuse survivors alive. The first case is of a Puerto Rican teenager whose family members travel back and forth between the island and the continent. The second case relates to a South American adult male survivor of sexual abuse who immigrated to the U.S. more than a decade ago. The cases highlight some of the differential dimensions explored earlier in this paper, some shared characteristics with survivors from other racial and ethnic groups, and emphasize the heterogeneity that groups of Latin Americans "share" as a major characteristic.

Teresa[3], a twelve year old Puerto Rican girl who had recently arrived on the continent, was referred by Child Protective Services for a sexual abuse evaluation. After the initial referral, Teresa was not available for interviews, since she had been running away from both her foster home and biological mother's home. She had lived with her family in Puerto Rico until 1996, when her mother and stepfather came to the continent with her. Teresa and her mother returned to Puerto Rico a year later, while her stepfather stayed in the U.S. At that time, Teresa started to abuse alcohol and marijuana, to skip school, and to have sex with a young adult male. A year before the evaluation, Teresa and her mother returned to the U.S. Teresa was said to have begun presenting severe behavioral difficulties soon after.

According to the child protective services, Teresa had not been listening to her mother and was "hanging out" with 16-19 year-old boys until early in the morning. Teresa reportedly disclosed that she was "having sex" with a friend who then told Teresa's mother. Teresa was subsequently placed in two foster placements. She disobeyed the rules set by foster parents and ran away from both placements. Later on, she stayed with a friend of her mother's, but soon this "foster parent" reported Teresa to child protective services because Teresa was being threatening, physically abusive, and was found stealing at home and in a store. Teresa's therapist had also raised some concerns about her safety and conduct. The child was placed in a residential facility where she attended therapy that needed a translator and where the therapist's diagnosis was of major depressive disorder with symptoms of post-traumatic stress disorder. The psychological report noted that Teresa appeared to be "an immature, psychologically impoverished, socially unskilled girl, who has limited coping resources available to deal with stress or environmental complexity shows inconsistent, poorly planned, and inappropriate behavior." Personality test results suggested reduced self-esteem "which is, in turn, often a source of depressive episodes." Her school performance was found at a "very low level due to the language barrier between Teresa and her teacher."

Her therapist reported that at times Teresa became a lively but superficial conversant in

[3] Names are fictitious and identifying data have been changed to protect the identities of clients, and family and community members.

counseling. She often refused to speak about her behavioral problems, blamed staff for her own difficulties, associated with people on the streets with whom she was found abusing drugs, stealing, and truant from school. She was described as sexually promiscuous as well. Teresa described herself as *"brava* (someone to be afraid of) like my mother," and she reported being proud of fights with peers. She also stated that at times she felt like she is "nothing." Her clothing (a short and tight fitting dress) made her look older and seductive, but she only stated that it was "the weather."

Teresa had been placed in various residential treatment facilities and foster care placements, none of which has resulted in Teresa's developing adaptive behaviors. Each placement became the source of new difficulties and non-adaptive behaviors. She missed school, ran away with increased frequency, shoplifted in malls where she also seemed to be engaged in sexual behavior with older teenage boys, and her looks increasingly called the attention of law enforcement agents. In one of her residential placements, Teresa engaged in sexual physical contact with one of the workers and some fellow residents. Attempts at having her evaluated to assess her clinical needs were curtailed by a cycle of institutional mishaps on the part of those called to intervene and her increased acting-out behaviors.

Lack of coordination is particularly acute in cases like this one, although interprofessional collaboration is crucial (Hallett & Stevenson, 1980). Although providers "seemed to know" the needs of Teresa and teams have diagnosed her accurately as in need of trauma treatment, little was done, since coordinated services in Spanish or with a culturally sensitive team of practitioners are, for the most part, lacking. Thus, by the time a culturally competent clinician was called to assess Teresa, the number of factors that inhibit treatment after disclosure was enormous and the probability of failing on the part of the clinician who is called to assess and intervene was great. As in Benitez' (1998) analysis of sexual abuse versus consensual sex in the treatment of Latina adolescents who have been kidnapped or "robbed," Teresa's case exemplifies the intersecting role of immigration, gender, race, family values, and the well-intentioned but clumsy institutional intervention of child protective and psychiatric services.

Manuel, a thirty-year-old graduate student from a South American country, disclosed in therapy that he was sexually molested when he was seventeen years old by a foster father who hosted Manuel in his house in New Mexico as part of an international educational exchange. Manuel had not disclosed these experiences to anyone in his biological family and/or his friends, nor had he confronted the molester about the sexual abuse. In therapy, fifteen years later, Manuel described how during the six month period of his stay, the foster parent started to touch him and approach him sexually when there were no other individuals close by (in hotels, vacation apartments, and saunas). Manuel revealed that he found himself trapped in a situation in which disclosing the event would have brought shame, invalidation, and discredit to his biological family in South America. Besides, he thought that he would have lost some of the economic and social privileges he obtained while he was an exchange student.

Manuel was an activist in his country of origin, a good student, and a well-adjusted person who had pursued the international experience as a way of learning in a freer context, since he had lived most of his teenage life under a military dictatorship. Coming back to the U.S. more than ten years later to pursue graduate studies posed a new set of challenges to him as he recognized that the abusive past was not out of his life as he may have thought. He was still unable, however, to conceptualize this abuse as traumatic and having lasting effects almost two decades later; and he was unable to construe the sexual abuse as a dramatic and painful experience that distorted his sense of identity. Manuel was, in the public eye a successful, self-driven professional, who was respected by his professional peers. However, his relationship with his wife and child was in crisis and he became neglectful and harsh with them. He, nonetheless, worked hard in therapy to keep himself accountable about his behavior. He performed well at his workplace, where he obtained steady positive feedback from his employees. His therapy also dealt with his experiences in his own country of origin, where he had also frequently been censored and restrained from pursuing his goals. In therapy, he acknowledged how being under siege was not only a psychological state, but also a real one that needed processing and resolution. His first trip to the U.S. was a way out of siege, but he found himself in another form of siege that also enforced silence.

Manuel, raised in a middle-class family by two professional parents, represents well the kind of middle and upper middle class white Latin@s who come to the U.S. and, successfully pursue business

or educational opportunities, although their lives as they start in the U.S. are filled with rejection, misunderstanding, poorly paying jobs, and discrimination. Their sense of identity seems very different from the kind of identity forged by clients who fill outpatient clinics and child protective caseloads in the U.S. The latter, like Teresa, are frequently darker skinned, poorer, less educated, and have a history of oppressive contexts. Still, Manuel's story is distinctively marked by the influences of class, race, gender inequity, and postcolonial dimensions that, without doubt, mark cases in which larger institutions like social protective services are involved.

Having a clinical practice in a wealthy suburb and practicing as a consultant and clinician with child protective services in an urban setting continuously provides me with contrasting and shared features that are embedded in these two cases. These vignettes emphasize the importance of social class as framing the Latin@ experience and, therefore, the experiences of abuse and trauma for *Latin@s*.

Latin@s are the poorest minority group in U.S. urban settings and thus Latin@ cultural experiences are often conflated with the experience of being poor (Massey, Zambrana & Bell, 1995). Clinicians need to be aware of the intersecting role of class and race before making any generalization about their Latin@ clients, nonetheless, social class is a marker of family life (Facundo, 1990). The cases described above provide a contrasting perspective about the diversity of Latin@ experiences in the U.S. Despite these differences, shared familiarities are also present since the majority of Latin@s in the U.S. are younger than the general population, have larger families, stayed married longer, and are the poorest. Latin@ families that are served constitute the wealth of the clinical load for therapists. A smaller group of Latin@ clients are seen in private practice and little is known of their experiences.

Latin@ Families

The Latin@ family is difficult to identify as a homogeneous ethnic and racial group because of its variations of social class, race, and immigration histories. Latin@s nonetheless often identify themselves as part of family networks that include friends and non-biological members. This fact is particularly salient in the immigration process, in which webs of families participate (Harter, 1997; Suro, 1998). Important decisions often involve the question of how immigration will affect the nuclear and extended family. Several authors have written about the involvement of the extended family and how Latin@s visit each other and rely more often than non-Hispanics on the extended family for childcare and other family care functions.

The importance of the extended family, with its biological and non-biological members, may account for evidence that extended family members appear to be child sexual abuse perpetrators in Latin@ families more often than in non-Hispanic-White or Blacks (Huston, Parra, Prihoda, & Foulds, 1995; Moisan, Sanders-Phillips, & Moisan, 1997; Sanders-Phillips, Moisan, Wadlington, Morgan & English, 1995). Hispanics have reported proportionally more abuse by extended family members than did non-White-Hispanics (Arellano et al., 1997). In a study of abused males, Moisan and collaborators (1997) found that "Latino males were more likely to have been sexually abused by an extended family member, experienced more genital fondling, and were exposed to more sexually abusive behaviors" (Moisan; Moisan & Sanders-Phillips, 1997, p. 473) than by others. The same study concluded that sexually abused latino boys are more often abused by extended family members, more of them in the house, and with more force and coercion, and that for those who disclose there is very little support after the disclosure. The impact of these added attributes to the sexual abuse may compound the burden that Latino boys confront; thus they may delay disclosure and/or working through the abuse. If Latin@ children are less prone to disclose, they will be less protected, since the more people know, the more protected the child will be (Finkelhor & Browne, 1998). This research may also imply that clinicians need to consider the potential contribution of extended family members or those the family consider "family" like godparents, friends, or distant relatives to protect children, confront perpetrators, and foster healing.

Obliviousness to extended families as potential resources is compounded by a pure focus on risks and little attention to strengths and protective forces within the family. Risk assessment in child protective case management and investigation rarely focuses on the strengths present in the family and the community. When strengths are presented, they are only used as part of a balance in relationship to risks but not as decision-making elements that stand alone (Pecora & English, 1993). Extended family

members may be overlooked as protective resources since dominant ideas about family only regard the nuclear, close, and biological members as significant. Research about help-seeking behavior also corroborates the importance of a family orientation for Latina teenagers who appear more likely to seek help from parents, family members or friends when they have a problem (Rew, Resnick & Blum, 1997).

A larger ecological family perspective (Falicov, 1998, 1999) is necessary in attending to Latin@ survivors, considering a strong family, rather than individualistic, orientation (Marín & Marín, 1991). There are serious social consequences when the predominant approach to child abuse is strictly based on child protective legal mandates, in particular when child protective services workers evaluate if a child needs to be removed from their home (Lang & McAdam, 1997). The same can be said for an assessment that misses to evaluate the ecological impact and potential healing factors in the ecology of relations that sustain the survivor. This observation may not only apply to the case of Latin@s, but it is certainly central in the Latin@ experience. The extended as well as the immediate family may be located close by or in another country, constituting transnational family formations that individuals internalize as still emotionally very close. The intimate involvement of geographically distant family members runs counter to mainstream notions of acculturation and social support.

Sound clinical judgment about the impact of child sexual abuse emerges from a contextualized account of trauma as it relates to dimensions like immigration, subtle and overt forms of discrimination, resilience, the meaning of talking about trauma with helpers, and the institutional responses that may actually trap families into experiencing further trauma and re-traumatization. Figure 1 outlines these lenses and intersecting dimensions and contexts to consider in assessing and treating a person who has been traumatized as the result of child sexual abuse.

Using historical, contextual, developmental, and interactional lenses, a clinician can assess the intersecting role of these various traumatic and/or healing dimensions. These contexts represent not only a psychosocial understanding of the survivor, but also involve a social, cultural, and political analysis. A focused recollection of the facts or history of trauma is framed within these past and present contexts. These intersecting dimensions affect each other and have the potential to transform each other. For example, a supportive, egalitarian parent-child relationship may empower and counter a sexist cultural context that forces a teenage girl to doubt her judgment when she refuses the sexual advances of a male. As a micro-interaction, this egalitarian

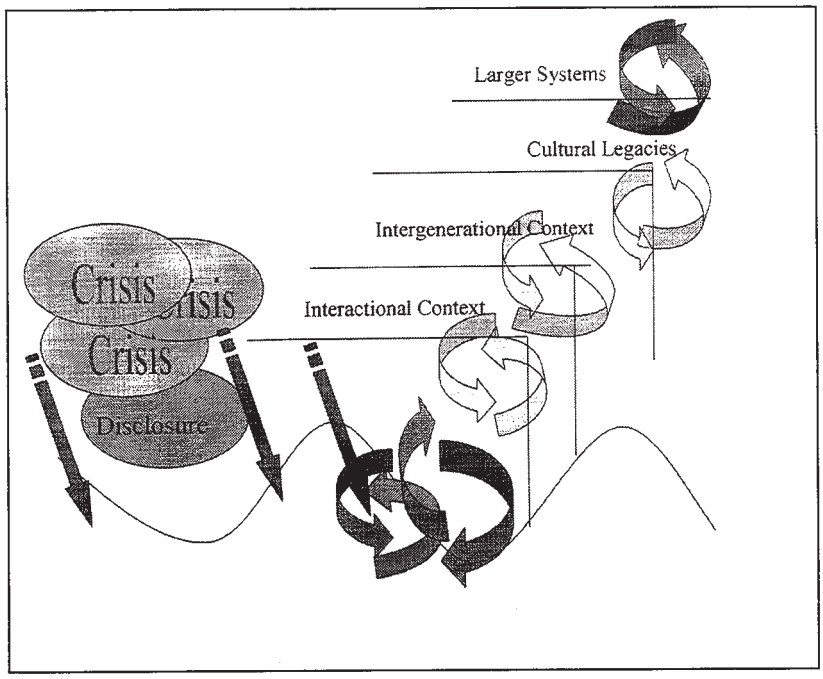

Figure 1

Trauma Assessment & Intervention Model

parent-child relationship may run counter to stereotypes about how parents and teenagers should relate in Western societies, but be very effective at responding to a cultural context that send contradictory messages about sexuality, assertiveness, and empowerment to boys and girls. Messages that are still more complex when these children have to negotiate various national, country of origin, and ethnic discourses.

Disclosure and Institutional Responses

Clinicians who work with survivors of child sexual abuse know the impact of disclosure -its timing and circumstances- as an important piece in the work with survivors. Survivors and their families often experience disclosure as a tremendously shameful process. In this regard, in the therapeutic room, the telling of the story may be more significant that the story being told. When Child Protective Services are involved, an intervention may bring forth not only the potential for healing and safety, but also all forms of discrimination and institutionalized racism (MacKinnon, 1998). These interventions resemble the benign attempts of experts and professionals to colonize others to save them from their weaknesses, a particularly dangerous process when the others are from a different cultural background. In colonial relations, participants are directed, mandated, and/or seduced into compliance with a specific knowledge, a practice, or a way of defining the dominant dimensions of a particular culture, i.e., psychotherapeutic or child protective discourses (Bacigalupe, 1998).

Institutional and structural barriers for access and quality of services for Latin@s in health services have been amply documented (Bacigalupe, Upshur & Cortés, 2000). These barriers have a humiliating effect for child sexual abuse survivors, considering their multiple biopsychosocial needs and precarious family support at the time of disclosure. Arellano (1997), for example, found that non-Hispanic-Whites were significantly more likely than were their Hispanic counterparts to have been in psychotherapy. Hispanics were also more likely than Non-Hispanic-Whites to indicate that nothing happened as a result of their disclosure of child sexual abuse. Barriers to appropriate services include lack of adequate insurance, transportation, scheduling flexibility, and understanding about therapeutic institutions, as well as services that simply are not friendly because they require technological literacy or exist within the constraints of institutional forms of racism. Children and their families may experience non-medical interventions with fear and resentment. Latin@s may construe non-medical personnel (mental health and social services, outreach efforts) as dangerous, and family members may therefore disguise the truth to protect their sense of identity. Moreover, being in the care of strangers (the experience of families in which children are removed or may be removed) is experienced with shame and fear. It is also construed as yet another form of cultural disrespect that support beliefs about discrimination, often involves further abuse, and a generalized punishment (not safety) from which families feel the need to escape (Bacigalupe, 2000c).

When child sexual abuse is disclosed and child protective institutions intervene, a conflict of priorities between survivors' advocacy and family-oriented agents makes an objective analysis extremely difficult since little relevant research is available. "As a result of the intense feelings generated by the problem of child abuse by caretakers and of the scarcity of objective information to guide decisions, polarized opinions can emerge among professionals involved in the treatment of abusive families" (Roizner-Hayes, 1996, pp. 176-177).

This conflict of interest and social ambivalence toward helping families in poverty (Halpern, 1999) compounds the negative effects on Latin@ families. "Individuals who have limited access to resources and limited control over their environments are especially vulnerable to exploitation and victimization" (Levy, 1988, p. 389). This observation applies to not only adults who abuse but also to those who are referred as helpers. As with other groups, strengthening resilience in the survivor and removing the source of the abuse makes a substantial difference in preventing further abuse. For Latin@ children, the approach may need to be culturally tailored specifically to the needs and values of their families. Clinical decision cannot be based on rules, but rather on a collaborative decision making process between service providers and family members.

Institutional barriers magnify the difficulties posed by language barriers. Language, however, is not a barrier in itself when the interlocutor is able to employ the inherent possibilities of bilingual expertise or lack of bilingual capabilities. Language maintains continuity and is a source of change; code-

switching exemplifies that balance (Espin, 1997). In a review of the Hispanic mental health literature and the use of language, Altarriba (1994) concluded that when the client's dominant language is employed, the client can use a broader vocabulary, speech production is facilitated, and language-specific information can be easily communicated. But, doing so might inhibit clients from discussing painful events. When the non-dominant language is used, clients are allowed to discuss painful events, but the vocabulary is limited, speech production is impaired, and depth of pragmatic/nuances is lacking in the second language. When a bilingual modality is employed, the advantages of both situations are compounded and language mixing is possible.

The assessment of factors like language proficiency, level of acculturation, and the degree to which cultural expressions do represent symptomatology should be considered in the development of an effective treatment plan. For instance, survivors may be paying more "attention to pronouncing words and phrases correctly rather than focusing on meaningful content (which may result in an) inconsistency between what is said and how it is being communicated can often result in misinterpretation of client responses leading to an inaccurate diagnosis" (Altarriba & Santiago-Rivera, 1994, p. 389). Despite the power of language, sociolinguists have concluded that social factors supersede linguistic ones (Zentella, 1997). That is, when families are of a higher social and economic status, the quality of their bilingual capacities is not a barrier to seek services. In sum, language difficulties exacerbate institutional and socioeconomic barriers (Bacigalupe et al., 2000) but can also be a source of forensic, assessment, and therapeutic possibilities.

Specific Recommendations

Waitzkin and Magaña (1997) ask if we can have a culturally sanctioned space in which the terrible narrative finally could be returned to consciousness, expressed explicitly and coherently, and worked through in a supportive social context.

To achieve this task, I propose that the following steps need to be incorporated within a sound child sexual abuse assessment and intervention.

1. Maintain an ecological framework, which incorporates multiple layers and intersecting dimensions in the assessment of child sexual abuse. Applying schematic and simplistic ideas about survivors only serves to continue their oppression. Applying a both/and rather than an either/or perspective allows professionals and families to navigate the ambiguous and muddled terrain that sexual abuse introduces into the lives of survivors, families, and institutions.
2. Learn about culturally sensitive ways of approaching survivors and their families with trained professionals who may share or know about your clients' context and histories. Abandon hypothesis that are based on a very few details. Embrace an assessment of the situation that incorporates a wealth of information and respectfully explore new sources of information. Be a cultural witness by maintaining a dual vision (continuity and change), as immigrant families do
3. Keep in mind that Latin@s may construe non-medical personnel (mental health, social services, outreach visits) as dangerous and that family members may disguise the truth to protect family's sense of identity and not necessarily to condone child abuse. Accept clients' fear of institutions as part of their reality rather than as resistance to obtaining services. Contact as many providers and family members as the survivor seems comfortable dealing with. Analyze with survivors the feasibility of helping them establishing relationships with family members and professionals who may assess them or their loved ones in a negative light.
4. Stay attentive to the ways in which language inhibit access to services and the healing process and evaluate constantly the quality of the case management, legal, and clinical work that is offered to Latin@ survivors. Bring services to clients and help them to access them rather than just providing them with a list of phone numbers. Involve and accept extended family's participation (as defined by the person who seeks help) to counteract the lack of access and quality of services available to these families.
5. Becoming a cultural broker and a bridge between institutions ensures more trust and effectiveness. As much as we need to help families to enter the system, we also need to help them leave it. Throughout the process, envision your clients as future members of the board of directors of your agency or institution.
6. Psychotherapy is a useful approach to human systems problems. Supportive environments, however, may be much more meaningful to

create the psychological and physical space that is needed to heal. Reconstructing the memories of the abuse becomes possible as the surrounding context becomes safe and welcoming. Pure historical reconstruction without changes in the social context in which the survivor lives will fail in productively addressing the needs of Latin@ child sexual survivors. In the assessment and clinical intervention besides work around the traumatic history, venture often into the following dimensions: the immigration story, subtle and overt discrimination, forms of resilience, trauma event and disclosure, talking about trauma, institutional responses, and reminding yourself that despite the best intentions and practices, we may introduce a new series of problems and challenges for families, thereby reducing the possibilities for change.

7. Be attentive to conditions in which power relations are recreated and formalized to truly develop *epistemological curiosity* (Freire & Macedo, 1995). Acknowledge clients and "collaterals" as a collaborative body. Conversations in team meetings, for example, are not rhetorical exercise but opportunities for truly emancipatory experiences in which professionals and families create knowledge that can be useful and serve them and others.
8. These guidelines are coherent with the clinical practices developed by trauma professionals in multicultural contexts. These recommendations, I believe, are applicable to child sexual survivors of any race or ethnicity who have immigrated and live in contexts far from their "homes." When dislocation, language difficulties, immigration, and experiences of colonial disempowerment are present, the experiences of Latin@s in the US may resemble those of other groups. Those who construct the Latin@ experience as bound by a few ethnic and cultural characteristics will fail to relate effectively and respectfully with Latin@s who are in pain.

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