ABSTRACT

A SUPPORT AND PSYCHO-EDUCATIONAL GROUP FOR ADULT SURVIVORS OF CHILDHOOD MALTREATMENT: A GRANT PROPOSAL

By

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The purpose of this project was to write a grant proposal to create, implement, and test the effectiveness of an innovative support and psycho-educational group program for adult survivors of childhood maltreatment. This pilot program is geared to alleviate trauma related symptoms that impair their ability to be successful members of society. Adult survivors of childhood abuse and neglect are often times undetected and not considered as obvious targets for prevention and intervention programs. For this reason, this pilot program was named Interventional Strategies for Imperceptible Survivors of Childhood Maltreatment (ISISMA) to recap their increased need for mental health services and the need to strategize concurrent and comprehensive prevention and treatment approaches.

To address the gap in services and budgetary limitations, this pilot program was delineated to provide services in a group-community setting. It is tailored to mitigate their unique needs and challenges of this marginalized population living in Anaheim and

surrounding areas. This pilot program is expected to be an innovative platform for planning, expansion, and implementation of other replicated support and psycho-educational group programs.

SUPPORT AND PSYCHO-EDUCATIONAL GROUP FOR ADULT SURVIVORS OF CHILDHOOD MALTREATMENT: A GRANT PROPOSAL

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TABLE OF CONTENTS

CHAPTER Page

Page

CHAPTER 1

INTRODUCTION

Statement of Problem

During periods of economic downturn, there is a general concern that child maltreatment rates increase (Millett, Lanier, & Drake, 2011). The way families react to an economic crisis poses a risk to the overall well-being of children, primarily, children may be at a greater risk of becoming victims of negligence and physical abuse (Fraad, 2012; Millett et al., 2011). Conditions such as poverty, mental health instability, and lack of support and resources have been shown to increase the levels of stress at home making parents more likely to abuse their children (Fraad, 2012). Among all of the developed countries, the United States has the highest poverty rate in the world and 21% of its children are impoverished (Fraad, 2012).

In a study conducted in several states, including Arizona, California, Massachusetts, Missouri, North Carolina, Oregon, and Wisconsin, findings suggested that child neglect is connected to the rates of unemployment (Millett et al., 2011). From an ecological perspective however, child maltreatment rates have been linked to poverty, lack of socioeconomic supports, and population mobility. This creates tension in the family and housing instability (Freisthler, Merritt, & LaScala, 2006).

Population at-Risk Needing Mental Health Services

The population in Orange County, California grew from 3,010,232 inhabitants in April 1, 2010 to an estimated number of 3,090,132 in July 1, 2012, which represents 2.7% increase in population size (U.S. Census Bureau, 2013). Also, trends in geographical mobility from 2007 to 2011 reflect a rise in the Orange County population density with 55,167 new residents (U.S. Census Bureau, 2013). Furthermore, during this time, 10.9% of the population was living below the Federal Poverty Line (FPL). In California, the percentage of those living under the FPL was 14.4%, and nationally the percentage of the population living under the FPL was 14.3% (U.S. Census Bureau, 2013).

As the national economy began its path to recovery in June 2009 (Gnuschke, Wallace, & Smith, 2010), child abuse rates in Orange County started to show an inverse correlation (O.C. Social Services Agency, n.d.). According to reports from Orange County Social Services Agency, the rates of substantiated child abuse incidents during the years of 2009, 2010, and 2011 slowly declined. These incident rates, as compared to the overall population of children in Orange County, were 73%, 69% and 67% for these consecutive years (O.C. Social Services Agency, n.d.). These trends, although positive, do not represent considerable gains towards reducing or eliminating child abuse in the near future.

The need for mental health services continues being high for people living under the FPL. In several studies, economic constraints and poverty have been linked to the tendency of deprived families and communities to abuse and neglect their children (Gilbert et al., 2009). In a longitudinal study of younger adults from different

socioeconomic backgrounds and ethnicities (Whites, Blacks and Hispanics), Schilling, Aseltine, and Gore (2007) found that young adults from low socioeconomic strata were highly exposed to negative childhood events. Schilling et al. (2007) pointed that negative and traumatic childhood experiences impact the mental health status of people. This study maintained that the recurrence of negative childhood experiences contribute to the development of mental health problems such as depression, drug use, and antisocial behavior. According to these researchers, the results from this study validated earlier findings that suggested that aggregated childhood negative experiences had a reciprocal effect on the severity of symptoms formation.

In this study, the researchers noted that gender influenced the expression of symptoms. For instance, young men reported using more drugs and more anti-social behaviors than young women. Nonetheless, levels of depression were similarly found for both groups (Schilling et al., 2007). These researchers expect that findings from this study help concentrate attention on extending prevention and treatment efforts for these communities. Agencies at the local, state, and federal levels continue supporting such efforts and further developing programs for all victims of child maltreatment.

Orange County is considered a highly dense community. It is the third largest county in California and the sixth nationwide (Ruane, 2012). In July 2011, the population of Orange County consisted of 43,043,964 inhabitants. There was a slight increase in population size during the years of 2010 and 2011 (Ruane, 2012). The number of new residents added to the county during this period was 21,356 and this growth is expected to continue at the same pace in the following years (Ruane, 2012). Consistently with this report, the UCI Medical Center in Orange County reported that the

percentage of population growth projected for the years of 2010 to 2015 is expected to be of 4.8% (UCI Irvine Medical Center, 2013). Similarly, the population growth between the years of 2000 and 2010 was 8.6% (UCI Irvine Medical Center, 2013).

Purpose of Project

Interventional Strategies for Imperceptible Survivors of Childhood Maltreatment (ISISMA) is a support and psycho-educational group program in Orange County aimed at providing treatment to improve the quality of life of adult survivors of child abuse, and preventing future abuse. The purpose of this pilot program was to write a grant proposal to fund a support and psycho-educational group program for adults with histories of childhood abuse and neglect. The purpose of this grant project is to secure funding to implement this program to serve those in need, who are English and/or Spanish speaking adult survivors of child abuse and neglect from culturally and racially/ethnically diverse backgrounds in need of services in Orange County.

Definition of Terms

Child abuse: Adult behaviors, which pose a threat or compromise a child's general well-being. (National Council on Child Abuse and Family Violence, 2013). (Child abuse and neglect, and child maltreatment are used interchangeably for the purpose of this project).

Physical neglect: Is defined as the failure to meet a child's basic needs for food, clothing and shelter, and the neglect of his or her medical and/or physical need (Stoltenborgh, Bakermans-Kranenburg, & Van Ijzendoorn, 2013).

Emotional neglect: Was harder to conceptualize due to the variation in interpretations and subjectivity in measurements; however, overall, it was defined as the

failure to meet the emotional and developmental needs of a child as well as the failure to provide developmental stimulation, warmth, protection, guidance, limits, and structure (Juntunen, 2013; Stoltenborgh et al., 2013; U.S. Department of Health and Human Services [USDHHS], 2013b).

Child maltreatment: Refers to any intentional or unintentional acts of commission or omission that can hurt or has the potential to hurt in any way a child, including witnessing domestic violence (Gilbert et al., 2009).

Psychological maltreatment: Is defined by Kairys and Johnson (2002) as a persistent negative pattern of interactions between an adult and a child. These include intimidating, threatening, belittling, humiliating in public, terrorizing, exploiting, ignoring, rejecting, and/or exposing them to witnessing domestic violence. These authors included in this definition the negligence of basic needs, as well as intentional disregard of a child well-being with the purpose of making him or her feel unappreciated, unlovable, and undesirable.

Emotional abuse: Is defined by Slep et al. (2011) as acts that might endanger the psychological and developmental well-being of a child resulting in developmental delays, psychiatric problems or somatization caused by stress, for instance, indifference and dismissal, terrorizing, scapegoating, humiliating, confusing, and confining.

Physical abuse: Is defined by the Centers of Disease Control and Prevention (CDC; 2008) as the intentional infliction of harm with the use of force to a child's body which may or may not result in physical injury such as "hitting, kicking, punching, beating, stabbing, biting, pushing, shoving, throwing, pulling, dragging, dropping, shaking, strangling/choking, smothering, burning, scalding, and poisoning" (p. 14).

Child sexual abuse (CSA): Is defined by the (CDC, 2008) as coming in contact with the private parts of a child by the use of hands, fingers, penis, or objects. An adult does these acts to a child by coercing him or her to commit acts against others such as exposing a child to pornography, videotaping, prostituting, and exhibitionism.

Substantiated cases: Refers to allegations of child abuse that have been validated under state law and state policy (Child Welfare Information Gateway, 2013).

Multicultural Relevance

This group, although designed predominantly to meet the needs of low-income individuals, is inclusive of various socioeconomic and demographic factors. It is expected to serve adult survivors of childhood maltreatment from different walks of life regardless of age, nationality, gender, race, creed, culture, religious, political affiliation, or sexual orientation. It will be culturally sensitive to the consumers assisted and relevant within the community. A prior assessment of the population who is more at-risk in the community of Anaheim has guided the demarcation of the parameters of this program. This program is culturally relevant to those that come in looking for mental health services at the Anaheim/Harbor Family Resource Center (FRC).

Social Work Relevance

This support and psycho-educational group is based on the core values of the social work profession as prescribed by the National Association of Social Workers (NASW; 2008). This program will expand the social work professional efforts, particularly, for the advancement of service to others, social justice, and promoting individual and collective change through interpersonal relationships. This innovative

program will serve those from disadvantaged communities of adults dealing with mental health challenges as a result of their own maltreatment during their childhood.

Some adults with a history of childhood maltreatment are identified by social service programs as needing services when they have abused their own children, or have been reported to be perpetrators or victims of domestic violence. Justice cannot be delivered to them effectively when they are not identified as needing anticipated supportive services. According to the NASW (2008), the primary function of social workers is to improve the quality of life of the least fortunate ones through service and advocacy.

There are existing parenting skills programs in this community whose missions are to assist parents with preventing abuse; however, there are not any social group treatment programs that embrace distinctively those adults dealing with the aftermath of their own childhood maltreatment. Many survivors of childhood abuse do not disclose their abuse to others and commonly live in isolation. According to Shi (2013), these patterns of behaviors are mostly seen in victims with histories of emotional abuse, who develop low self-esteem and mistrust. It is through interpersonal engagement that they may come out of the shadows and have their voices heard by a community of care. This support and psycho-educational group program will place human relationships as a fundamental piece of treatment and recovery.

State of California, National, and Global Mental Health Statistics

The Mental Health Services Oversight and Accountability Commission (MHSOAC; 2012) recognizes shortage of mental health services. According to the Commission, a half million to 1.7 million people in California did not receive mental

health services before the passage of Proposition 63. This gap in mental health services poses a risk for individuals and families to become productive members of society.

According to data reported in the Mental Health Services Act (MHSA) in 2012, a range between 5% and 7% of adults suffer a mental health condition in California. These percentages also correlated with those found in children, which were estimated to range between 5% and 9% (MHSA, 2012).

Although there is not a system in place to track anxiety, the CDC (2011b) considered it to be as prevalent as depression in the general population. Both depression and anxiety were, therefore, linked to stress. The CDC, through a surveillance system, monitored risk factors for the development of diseases. In California, it was estimated that 8% to 9% of adults ages 18 and over suffer from depression, 4% to 5% suffer psychological distress, and 3.7% and up reported not feeling well within the last 30 days due to stress, depression, or emotional issues (data drawn by state quartile in 2006, 2007, and 2009 respectively; CDC, 2011a). From accumulated data since 2006 to 2010, people in California between the ages of 18 to 24, and 45 to 54 reported generally not feeling well mentally and physically in the last 30 days. The majority of these reports also came from females (CDC, 2012).

The most common type of mental disabling problem found was depression affecting 26% of adults in the nation, and is projected to be the second leading cause of disability worldwide by 2020. According to the CDC (2011b) about 25% of the U.S. population suffers from a mental health condition, and about 50% of the national population is predicted to develop a mental health issue across their life span.

CHAPTER 2

LITERATURE REVIEW

This chapter will cover issues related to the impact of child maltreatment in adults and children. It will review literature on the magnitude of the problem, including costs, prevalence and incidence, short-term and long-term consequences, and vulnerable populations. Studies were reviewed regarding symptomatology, coping mechanisms, ineffective and effective adjustment. Therefore, this chapter covers barriers to treatment, treatment recommendations and therapeutic interventions; support and psycho-educational groups, and program recommendations for adults impacted by childhood maltreatment.

National Costs of Child Maltreatment

Based on 579,000 documented cases of child abuse in 2008, it was estimated by Fang, Brown, Florence, and Mercy (2012) that the costs of child maltreatment were $124 billion dollars to the U.S. healthcare system. These calculations were based on short-term and long-term physical and mental health costs, productivity loss, child welfare system costs, and criminal and special education costs (Fang et al., 2012). These researchers used a prevalence-based approach to calculate the lifetime costs of child maltreatment for surviving (579,000 new substantiated cases per year) and non-surviving (1,740) victims in 2008. The costs were calculated using a median age of 6 for younger victims, and the median age of 41 for older victims (Fang et al., 2012). They indicated

that the individual average cost per surviving victim was projected to be $210,012 (based on living costs in 2010) and for non-surviving victims this cost was $1,272,900. Costs included health care, productivity loss, social service payments (Medicaid usage and welfare assistance), criminal justice costs (for juvenile and adult potential detentions), and special education costs (Fang et al., 2012). One notable finding from this study was the calculation of annual productivity loss for adult victims of childhood abuse. According to these researchers, participants in this study had an annual projected income loss of $5,890 compared to the control group, which consisted of adults with no histories of maltreatment.

Prevalence and Incidence

In a meta-analysis consisting of worldwide studies from first world countries between 1980 and 2008, researchers estimated that the occurrence of child physical neglect was 16.3% for every 1,000 children and the occurrence of child emotional abuse was 18.4% for every 1,000 children (Stoltenborgh et al., 2013). The genders of the child victims were not found to be statistically significant. Research data reviewed from 55 studies indicated that, unlike rates for physical neglect (which were found to be similar for both genders), women were 2 to 3 times more likely than men to be sexually abused during their childhood (Barth, Bermetz, Heim, Trelle, & Tonia, 2013).

In a national subsample drawn from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), out of 34,000 participants over the age of 18, the prevalence of CSA in respondents was 10.14%: women representing 75.2% and men representing 24.8% (Pérez-Fuentes et al., 2013. The proportion of female and male victims of CSA in this study was similar to those found worldwide in the previous study

(Pérez-Fuentes et al., 2013). The number of men and women with a history of CSA reported more frequent incidents of physical abuse and neglect compared to those reported by their counterparts (without a history of CSA). Similarly, this group had higher incidences of being diagnosed with mental health disorders; primarily Post-Traumatic Stress Disorder (PTSD), mood disorders, Attention Deficit Hyperactivity Disorder (ADHD), addiction (not including alcohol use or compulsive gambling), and suicide ideation. More often than not, they reported to have had a parent with a substance use disorder, being raised in a single parent home, witnessing domestic violence, and feeling less socially supported (Pérez-Fuentes et al., 2013).

There is an indication that CSA prevalence in males may be higher than estimates suggest (Sigurdardottir, Halldorsdottir, & Bender, 2012). However, due to the generalized misconception in society that denies that boys may in fact be sexually abused and due to stigma in society, many remain silent about their abuse. These researchers explained that society assumes that once a boy becomes a victim of sexual abuse, he is destined to become a sexual perpetrator himself (Sigurdardottir et al., 2012). In this qualitative study of male victims of CSA, participants reported having a difficult time disclosing their abuse to others and reaching out for professional help. Their reasoning was that nobody would believe them about the abuse. During the interviews, most of the participants admitted to coming forward with the abuse in their adulthood when they were at the verge of losing everything or about to commit suicide (Sigurdartottir et al., 2012).

Maniglio (2010) discussed that history of CSA in adult survivors may not be accurately estimated due to memory lapses and illnesses of those reporting. On the other

hand, Maniglio (2010) posited the questionable validity of the instruments used, and the lack of formal conceptualization systems for the detection of abuse, anxiety, and depression. Despite shortcomings of self-reports from adult victims of CSA and variation on instruments used, Maniglio (2010) found that child abuse might be a general but not a specific promoter for depressive symptoms or depression.

According to the National Child Abuse and Neglect Data System (NCANDS), endorsed by the USDHHS (2009), the rate of unique count of maltreated victims was 10.3 for every 1,000 children in the children population across the country in 2008**,** and in 2011 the rate of maltreated children was 9.9 unique victims for every 1,000 child population nationwide (USDHHS, 2012.). Child Protective Services (CPS) reports from 51 states, including the District of Columbia and the Commonwealth of Puerto Rico, identified 681,000 children as victims of child maltreatment (child abuse and neglect) in 2008 (USDHHS, 2009) and 772,000 victims in 2011 (USDHHS, 2012.). Similarly, reports have indicated an increase in the victimization of neglect and physical abuse during the 2008-2011 periods. In 2008, of all child maltreatment reported, 71.1% were reports of victims of neglect and in 2011 the percentage rose to 78.5%; victims of physical abuse were 16.1% and 17.6% respectively during these time frames. Victims of sexual abuse were 9.1% and remained unchanged for both periods (USDHHS, 2009, 2012).

These reports also acknowledge the fact that there were cases of abuse that went undetected or overlooked either because no one made a report or because, during the screening process, social workers thought there was not enough evidence to merit an investigation (USDHHS 2009; 2012). According to the NCANDS, the rate of

investigated child maltreatment cases rose from 3.5 million in 2007 to 3.7 million in 2008 (USDHHS 2009; 2012). In 2009, 700,000 out of 3.3 million children were confirmed to be victims of child abuse by child protective agencies (Widom, Czaja, Bentley, & Johnson, 2012).

Types of substantiated child abuse cases in Orange County were consistent with national figures in 2008 in regards to ranking categories (type of abuse), with neglect and physical abuse persistently at the top of the list. In 2008, Orange County reported 15,328 (57.9%) cases for general neglect, 6,159 (23.3%) for physical abuse, and 4,974 (18.8%) for sexual abuse (O.C. Social Services Agency, n.d.). In 2008, parents of the victims were reported to be the main perpetrators accounting for 80.1% of all reported cases, and in 2011 accounting for 81.2% of the cases investigated, including in duplicate counts (children who were reported as victims more than once (USDHHS 2009; 2012).

Estimates about the incidence and prevalence of child maltreatment come from two sources: (1) Child Protective Services agencies (CPS) and (2) law enforcement agencies. The USDHHS (2012) only collects reports from CPS. However, the Office of the Attorney General created a centralized system called Child Abuse Central Index (CACI). This system compiles and integrates reports from county welfare agencies and probation departments (U.S. Department of Justice, 2014). The access to this centralized system is restricted from the public and is only accessible to law enforcement and child welfare agencies for investigative purposes. Because of this and the barriers discussed earlier, it is presumed that the rates of child maltreatment might be higher across the United States.

Short-Term Consequences

In a longitudinal study of victims of child abuse, Buckingham and Daniolos (2013) noted that some child abuse appears as Shaken Baby Syndrome or other non-accidental injuries. They explained that when a child is brought in for medical treatment, the caregiver reports the incident as being caused by misfortune or accidental injury. These researchers pointed out that the results of child maltreatment may be manifested in a victimized child as physical symptoms, for instance, sleeping irregularities, loss of appetite, constant and severe nightmares, and irritability. Further, they explained that it can appear as behavioral regression, PTSD, and depression followed by Reactive Attachment Disorder (RAD). This disorder is said to be a source of interpersonal conflicts throughout the lifespan of the victim (Buckingham & Daniolos, 2013).

Long-Term Consequences

Nelson, Baldwin, and Taylor (2012) reviewed several quantitative and qualitative studies on CSA from 1990 to 2009. They found that CSA was connected to inexplicable medical or organic health conditions. Patients sexually abused as children often reported chronic fatigue, irritable bowel syndrome, pelvic pain, respiratory problems, fibromyalgia, and headaches not associated to mental disorders. The neurological pathway responsible for the regulation of stress response was found to be altered in CSA patients. Somatization was often detected in combination with anxiety, depression, and dissociative disorders. Moreover, CSA was determined to "add age" to the person due to psychosomatic illness, pain, and decrease in daily routines.

Similarly, in a 30-year cohort prospective study of maltreated children from birth to 11 years old, child abuse was correlated with higher risk of health related issues.

Abused and non-abused participants in a control group were matched based on socio-demographic factors. Adults abused as children declared having problems with poor nutrition, lung disease, reduced vision, diabetes, poor oral health and obesity compared to the non-abused control group (Widom et al., 2012).

Buckingham and Daniolos (2013) reaffirmed that child abuse contributes to the development of chronic physical complaints or mental health disorders such as substance use, anxiety, and depression, and causes victim survivors to be on higher alert mode. These researchers determined that hypervigilance may lead to interpersonal conflicts which they point back as an indicator of the development of a RAD. They explained that RAD can be developed at any age as a result of maltreatment; however, they found that RAD has a detrimental effect when maltreatment takes place during infancy or early childhood. Other physical complaints found in this study were those of chronic fatigue syndrome, asthma, heart disease, and diabetes.

According to Bowes and Jaffee (2013), higher levels of stress cause physical and mental illnesses as well as behavioral and social impairments in victims of child abuse. These researchers maintained that persistent levels of stress cause disruptions in cortisol response level and in the stress regulatory--hypothalamic pituitary-adrenal (HPA)--system though the mechanisms are unknown (Bowes & Jaffee, 2013). Similarly, in a review of psycho-neurological studies, Hart and Rubia (2012) found that brain scanning of maltreated adults and children exhibited some malformations of brain structures and alterations in serotonin, HPA, and the sympathetic nervous system (SNS). These systems are said to be in charge of the stress response, arousal, and emotional control (Hart & Rubia, 2012). Because of these biological changes in the regular functioning of the brain,

victims of childhood maltreatment usually find it hard to regulate their emotions. Heart and Rubia concluded from their review that there is a strong association between childhood maltreatment and cognitive, behavioral, and emotional deficiencies.

Gilbert et al. (2009) noted that childhood abuse consequences could reappear later in life as physical and mental health issues. These researchers stated that some of the long-term effects of child maltreatment may include internalizing (i.e., chronic pain, obesity, anxiety, and depression) and externalizing (i.e., aggression, delinquent behavior, substance use) symptoms. Gilbert et al. found other developmental shortfalls such as low academic achievement. In a prospective longitudinal study of young adults in a low socioeconomic community of Chicago, Mersky and Topitzes (2010) observed that maltreated participants were less likely to obtain a high school diploma, less optimistic about the future, had more history of unemployment and law violations leading to arrests.

Vulnerable Populations

In a sample of 139 CSA adolescent girls receiving medical care at an acute care facility, Anderson and Robboy (2011) found that teenagers with mothers who had histories of childhood abuse, mainly CSA, experienced other forms of childhood maltreatment compared to teenagers being abused but whose mothers had no history of child abuse. The mothers in this study were involved in the justice system due to allegations of abusing their own children and were previously screened by child protective agencies. One of the purposes of this study was to analyze if CSA trauma in one generation could produce multiple victimization in the next generation as a result of maternal trauma (Anderson & Robboy, 2011). These researchers were able to confirm their hypothesis; however, they could not pinpoint the mechanisms by which trauma can

be translated into multiple victimizations of second generation victims of CSA. They suspected that one of the mechanisms might be related to mother-child attachment disruption. In addition, Anderson and Robboy pointed out that these second generation of victims (teenagers) presented higher maladjusted coping compared to their mothers. For instance, the teenagers resorted to self-injurious behaviors such as cutting, burning and hitting themselves, and consuming alcohol and illegal substances in order to deal with their overwhelming feelings (Anderson & Robboy, 2011).

In a longitudinal study of 499 mothers with a child or children up to 26 months old, Appleyard, Berlin, Rosanbalm, and Dodge (2011) linked participants' history of child physical and sexual abuse, but not neglect, to their use of alcohol and drugs, and later maltreatment of their own children. Appleyard et al. detected a strong linear correlation between mothers' own history of child physical and sexual abuse, to substance use and reports of abuse perpetrated by them onto their own children. Eight percent of the mothers were later found to be abusive parents according to county records. Mothers were recruited initially while receiving pre-natal care at a community clinic and were followed until their children were 26 months old (Appleyard et al., 2011). They indicated that substance use mediated the path to child victimization, which was found to be significant in mothers with history of child physical or sexual abuse. Out of the 499 mothers who participated in this study, 9.4% (*n = 40*) reported having history of childhood physical abuse, 25% (*n = 125*) of sexual abuse, and 10% (*n = 53*) of neglect. Therefore, 2% (*n = 11*) participants reported histories of all three types of childhood maltreatment. This study corroborated findings from previous study about the transmission of child victimization (Anderson & Robboy, 2011).

In a study on domestic violence (DV) police reports, in a U.S. metropolitan city, Babcock and Deprince (2013) noted that 47% of 236 participants who were abused by their partners had been severely traumatized as children. Participants disclosed being abused and/or witnessing DV while growing up. Women agreed to participate in this study soon after the DV incident and agreed to have a follow-up interview 6 months later. Babcock and Deprince found at second time of the interview that DV victims, who were financially dependent on their partners and were unemployed, experienced more severe physical and sexual abuse by their partners than those who were employed. Babcock and Deprince revealed that the vestiges of child abuse along with their unemployment status made these victims of DV more vulnerable to added abuse by their partners. The victims were representative of different ethnic groups, mainly Whites, African-Americans, Hispanics, and American Indian or Alaskan Natives. Further, the researchers determined that women with higher PTSD and low depression levels were more likely to leave their abusive partners a year later than those reporting higher depression and low PTSD levels.

Similarly, Stevens et al. (2013) found in a community sample of 139 urban women living in a low socioeconomic status (SES) that 44.6% reported at least one type of childhood abuse while 83.8% also reported being verbally or physically assaulted by their partners recently.

Easton, Renner, and O'Leary (2013) surveyed 487 sexually abused men from three national organizations dedicated to empowering men against CSA. In their study, an increase in suicide attempts in men was observed to be linearly correlated with intensity and frequency of the CSA. Suicidal attempts were paralleled with mental health status and men's perceptions of masculinity (Easton et al., 2013). These researchers

found that sexually abused men who displayed mental health issues and who scored higher in conformity to male societal rules of power and control were found to be more vulnerable to suicide attempts in the last year.

In a quantitative comparative probability-based sample of Lesbian, Gay, and Bisexual (LGB) and heterosexual people taken from the Maine, Washington, and Wisconsin Behavioral Risk Factor Surveillance Systems (BRFSS), Andersen and Blosnich (2013) recognized that the occurrence of child abuse of any sort and familial dysfunction was greater in the sexual minority groups. Findings revealed that the gay/lesbian group reported having more adverse childhood experiences, followed by bisexuals and in contrast to heterosexuals (Andersen & Blosnich, 2013). Both minority groups were at least twice more likely to report sexual, emotional, and physical abuse (Andersen & Blosnich, 2013). These findings suggest a need for added support for this population that endures abuse outside their homes as a result of their sexual orientation (Andersen & Blosnich, 2013).

In a national sample population of Lesbian, Gay, Bisexual, and Transgender (LGBT) individuals, mostly Latino and Asian Americans reported incidents of physical abuse in these communities. Lesbian, Gay, Bisexual, and Transgender Latinos and African Americans particularly reported higher incidents of sexual abuse when compared to their White counterparts. Unlike, physical and sexual abuse, emotional abuse was fairly distributed among these three (Latinos, Asian Americans, and African Americans) ethnic minorities and was statistically significant in the prediction of anxiety, depression, and perceived stress in these three groups (Balsam, Lehavot, Beadnell, & Circo, 2010).

Risk Factors

According to Hearn (2011), several risk factors contribute to child maltreatment; however, poverty was singled out as the most prominent risk factor, which generates other unfavorable conditions linked to child maltreatment. Lack of financial resources makes it difficult for parents to meet their children's basic needs. This researcher stated that: "Parents living in poverty operate within circumstances that are likely to make it very difficult for them to be able to best provide for their children's needs, financially and socially" (p.716). Hearn further explained that under such conditions, parents might fail to provide proper medical care, childcare, and education, and supervision.

Other risk factors noted by Buckingham and Daniolos (2013) were related to caregivers' mental health conditions and substance use histories. Stevens et al. (2013) found that lack of emotional regulation or perceived social support as well as exposure to interpersonal violence (IPV) in adulthood increases the risk of Post-Traumatic Stress (PTS) symptoms caused by child abuse trauma.

Symptomatology

In a large cross-sectional study from a National Epidemiological Survey on Alcohol and Related conditions carried out in 2000-2001 and 2004-2005, Sugaya et al. (2012) observed that CSA increased the risk for suicidal attempts and the manifestation of psychiatric disorders in participants including, ADHD, PTSD, bipolar disorder, panic disorder, substance use, anxiety disorder, and major depression disorder. These researchers found that 8% of the participants experienced CSA. Moreover, they found that 79% of those with CSA histories also endured other types of childhood abuse, neglect, and parental psychopathology (Sugaya et al.).

In a large study of undergraduate students with and without histories of child abuse, Hetzel-Riggin and Meads (2011) revealed that the susceptibility for re-victimization in adulthood by an intimate partner is directly proportional to the intensity of the abuse experienced during childhood. Hetzel-Riggin and Meads explained that adults who were severely abused as children are more likely to be abused by a partner because they are less equipped to recognize when they are in an abusive relationship. Therefore, these researchers suggested that people without childhood abuse history but with phobic anxiety are less likely to be in an abusive relationship than others with childhood abuse history and phobic anxiety. According to Hetzel-Riggin and Meads, the latter group of participants stays in abusive relationships because their fear of the unknown.

In a qualitative study of male survivors of CSA, the propensity to commit suicide was more so triggered by prolonged bottled up feelings of deep sadness, anguish and low self-worth leading them to stress, depression, insecurity, self-blame, anxiety, and ire (Sigurdardottir et al., 2012). The victims in this study developed complex PTSD (Sigurdardottir et al., 2012). All participants disclosed dissociating and being emotionally disconnected, and having difficulties building or maintaining relationships with their partners or others outside the family. One participant stated:

> I remember when I stepped out of the car how everything was different. This was not the same world and then I think I detached myself somewhat from my emotion . . . so I had distanced myself from myself . . . but it was wonderful to stop hurting. (Sigurdardottir et al., 2012, p. 692)

Maniglio (2013) conducted a meta-analysis to test the influence of CSA in the development of anxiety disorders. Maniglio (2013) found that a growing body of literature has produced conflicting results. In his analytical qualitative review, he found that some studies linked directly CSA to anxiety while other studies found other factors influencing the relationship between CSA and anxiety disorders. Maniglio (2013) stated that some studies identified intercepting factors in the relationship between CSA and anxiety such as the intensity of the abuse, gender of the victim, or family structure. Even though Maniglio (2013) did not observe a direct cause-effect between CSA and anxiety he maintained that CSA is a general cause for the development of anxiety disorders, particularly of Post-Traumatic Stress disorder (PTSD). In addition, his study showed that gender does not play a decisive role in the manifestation of anxiety. He also acknowledged that anxiety level was higher for those victims of CSA where there was more use of violence, and where there were more perpetrators involved (Maniglio, 2013).

Orbke and Smith (2013), using a developmental framework, demonstrated that adult survivors of childhood abuse, as a result of trauma, have a distorted image of the world around them and their selves. The researchers found that these distortions prevent them for increasing resiliency needed to cope and overcome adversity and impair their capacity to respond more accordingly under stressful circumstances. Moreover, they explained that shame and guilt along with low self-esteem and low self-concept lead to self-destructive behaviors, for instance, alcohol, drug use, and destructive relationships.

Powers, Ressler, and Bradley (2009) in their study of 378 participants consisting of 46% males and 54% females, receiving medical care at different clinics showed that the level of depression in adults was higher in those participants who were emotionally

neglected or emotionally abused than in those who experienced other types of childhood maltreatment.

Milner et al. (2010) conducted two simultaneous studies of 5,394 U.S. Navy recruits in a military center in Illinois and 716 students enrolled at a Midwestern University. In the U.S. Navy sample, 36% had history of CPA, 20% had history of CSA, and 25% were exposed to (IPV). Similarly, in the college sample, 36% of participants had history of CPA, 20% had history of CSA, and 25% had witnessed IPV. Results from these studies showed that CPA produced higher symptoms and predicted higher propensity for CPA risk when compared to the other types of childhood abuse (Milner et al.). Therefore, this study revealed that adults with CPA histories were at higher risk for adult CPA only if they rated high in *Defensive Avoidance* than those with CPA who scored low in this coping pattern. Other symptoms associated with adult CPA risk in both studies were found to be diminished sense of self and of self-control (Milner et al.). The researchers observed that 90% of trauma symptoms served as a bridge between history of CSA and adult CPA risk for the intergenerational transmission of IPV (Milner et al.).

Coping Mechanisms

From a psychoanalytic standpoint, Massie and Szajnberg (2006) suggested that everybody displays defense mechanisms, which are auto-regulatory processes to cope with difficulties and inner conflicts triggered by abuse. These researchers pointed out that these defenses help reduce symptoms, or prevent the appearance of psychiatric disorders. They also noted that the most common defenses are denial, apathy, acting out, passive-aggression, and identification with the aggressor. By contrast, sublimation,

humor, and self-reflection are more sophisticated defenses that might be an antidote against devastating feelings of shame, guilt, deception, confusion, anguish, anger, and sadness (Massie & Szajnberg, 2006). They might be "functional", but yet, they discussed that these defenses do not create barriers against depression, anxiety, substance use, or against negative alterations in personality, cognitions, or emotions.

Cramer and Kelly (2010) expanded on these ego-defenses saying that a child who cannot respond to the abuse due to his/her fragility or immaturity may use denial to overcome pain, anger, and the sense of being betrayed by someone they relied on. This becomes a way for him or her to handle stress (Cramer & Kelly. Shi (2013) noted that defensive mechanisms serve the purpose of lessening the psychological suffering stemming from the trauma. These researchers warned that the use of these defense mechanisms may transcend into adulthood, impacting some of them in their role as parents. According Cramer and Kelly, these parents are less likely to have a clear perspective of their own abusive behaviors towards their children. Although Buckingham and Daniolos (2013) clarified that most adults with histories of child abuse do not turn into abusers, they recognized that victims of childhood abuse tend to be on higher alert mode. Cramer and Kelly found that through projection, parents attribute their own flaws onto their child(en) justifying the use of physical discipline. Further, through identification, they self-identify with the person who harmed them by adopting a similar style. These researchers considered identification in childhood as a vehicle for emotional connection.

In regards to attachment style, Cramer and Kelly (2010) found that people with fearful attachment score higher in denial and lower in identification with their

perpetrators whereas those with more preoccupied attachment score lower in denial and higher in identification with their aggressors. By contrast, the researchers explained that those who had a dismissive style scored lower in use of denial, but higher in use of projection whereas, the preoccupied (anxious) group used more identification to stay connected with their abuser.

Ineffective Adjustment

Cukor and McGinn (2006) examined the link between child abuse history and adult depression as well as the function of cognitive schemas, as defined by these researchers as styles of thinking and feeling about oneself and the world, in the severity of depression**.** In their study, they compared a group of young patients with childhood abuse histories receiving treatment at an outpatient clinic to a controlled group with no childhood abuse history. They classified schemas into five main categories: disconnection and rejection, impaired autonomy, other directedness, over vigilance, and impaired limits. These researchers found that the younger participants with childhood abuse histories scored higher in the use of maladjusted schemas clustered in the disconnection and rejection category. Level of depression and use of maladjusted schema was higher for patients with history of abuse than for those who reported some abuse or not abuse at all in childhood (control group; Cukor & McGinn, 2006). The schemas represented in these categories acted as intermediaries in the relationship between childhood abuse and depression **(**Cukor & McGinn). In this study, it was found that schemas activated the path to depression in participants who had an inaccurate view of themselves and others. These participants often reported feelings of incompetence,

emotional deficit, shame, loneliness, abandonment, and having trusting issues (Cukor & McGinn).

It is in the midst of difficult relationships that unresolved issues from childhood trauma find expression and relief. According to Gostecnik, Repic, Cvetek, M., and Cvetek, R. (2010), many survivors undoubtedly feel more compelled to replay the emotions attached to the early trauma despite the pain it might provoke in them because they hope someday they will be able to understand and process those experiences. This might explain why the cycle of violence is a so-called "vicious cycle" and why couples remain in unhealthy relationships as if there is no other option. These researchers explained that addictions are hypothetical relationships for survivors that serve as outlets to release psychic pressure and to maintain a relationship that otherwise could not be attained in the realm of healthy human relationships (Gostecnik et al.). These researchers interpreted addictions as a strong desire for human connection. (Gostecnik et al.).

Effective Adjustment

Powers et al. (2009) found that friendship particularly in women functions as a protective barrier against depression. Likewise, Folger and Wright (2013) found that perceived family support was a protective factor only in less severe cases of abuse for both men and women. When measuring aggregated trauma in relation to depression-anxiety and aggression, perceived social support ameliorated PTSD symptoms in women, and anxiety and depression in men (Folger & Wright, 2013).

Religion and spirituality emerged in some studies as positive coping strategies. Ellor and McGregor, (2011) defined religion in terms of the religious life experience of people involved in religious practices at churches, synagogues, temples or mosques while

spirituality was defined as the connection to a divine being or to the universe. The researchers explained however that both religion and spirituality were conducive to questioning personal purpose in life.

Spirituality and religion have been recognized in different fields as pathways to physical and mental health recovery of patients regardless of their religious affiliation (Bowland, Biswas, Kyriakakis, & Edmond, 2011). In a qualitative study of 43 women, 55 and older, with childhood histories and interfamilial violence, Bowland et al. (2011) observed that women in support groups with higher level of spirituality reported a higher sense of well-being and recovery compared with those experiencing more spiritual suffering. Out of the 43 women, at least 36 reported problems forgiving themselves and others.

In a national qualitative purposive study of 90 men and women with histories of child abuse, Skogrand et al. (2007) suggested several core elements in the personal recovery of participants. According to these researchers, all participants declared transcending the material world and recovering when they realized the abuse was not their fault. According to participants, the capacity to transcend was crucial in their recovery (Skogrand et al.). Resilience was explained by them as the capacity to take control of their lives, being able to reframe their experience, and being able to make changes to move above and beyond physically and psychologically Skogrand et al).

Acceptance was seen by the researchers as the ability to come to terms with the abuse, the abuser, and oneself, changing the interpretation of the event and improving self-image (Skogrand et al.). Forgiveness and letting go were described as acts of good faith towards oneself and the abuser. There were essential elements in participants'

recovery (Skogrand et al.). Therefore, care and compassion for oneself and others was depicted as an act of kindness towards oneself and others. Some participants reported finding comfort in a divine being or a greater good, and finding a purpose of life during and after the traumatic event (Skogrand et al.). Many participants saw God as sailors and saviors who help them get through the hard times (Skogrand et al.).

Barriers to Treatment

Wolf and Nochajski (2013) commented that there are three types of sexually abused survivors, those who have recalls of their traumatic experience, those who partially remember it, and those who do not remember at all what happened to them. These researchers pointed out that the latest group suffers from dissociative amnesia. Wolf and Nochajski (2013) commented that, unfortunately, there is no treatment for patients with dissociative amnesia. Mental challenges constitute a barrier to treatment mainly for those who have no memories of the event. Nevertheless, these researchers explained that all survivors regardless of their mental health condition can find relief of symptomology in a therapeutic environment.

Skogrand et al. (2007) noted that traumatic experience affects self-esteem negatively, refraining the person from doing what he or she wishes to the internal dialogues (scripts) coming from being psychologically and emotionally disturbed. (Ng et al., 2011) warned that adults with long-standing victimization could be less likely to perceive good social or family support due to negative schemas formed in childhood and feelings of mistrust and insecurity. Schimmenti (2012) pointed out that due to feelings of shame derived from trauma, many survivors isolate themselves because they are afraid of once again being rejected by others, as they were when they were younger. Often times,

they try to escape through compulsive ruminations about their insecurities (Schimmenti). This researcher explained that this keeps them from being positively connected to others.

This finding was validated in Futa, Nash, Hansen, and Garbin's (2003) comparative study of two groups of women with and without childhood abuse histories. The results showed that victims of only one type of childhood abuse, be it physical or sexual, tended to distance themselves from others as a coping strategy to deal with the traumatic memories and psychological distress Futa et al. (2003). Similarly, in a cross-sectional study of mild-life adults, Ford, Clark, and Stansfeld (2011) confirmed that parental physical abuse and sexual abuse were connected to more limited social networks and higher conflicts in close relationships.

"A psycho historical account of child abuse trauma indicated that: People who grow up on the grenade range of parental rage, or the exploding danger of a violent, crime-ridden environment, shut down. They may physically survive, but they lose their sense of self." (Fraad, 2012, p.1). Reoccurrences of emotional abuse are usually unnoticeable to the victim and to others as the victims often live silently in fear, shame, and isolation (Fraad). They might not reach out for help as they believe their abuse is less severe than that of others (Shi, 2013). As seen in previous studies covered here, often, victims do not view treatment as necessary due to being unaware of symptom formation as a result of the abuse, lack of recognition of the problem, or stigma in society.

Treatment Recommendations and Therapeutic Interventions

Snodgrass (2009) stated that the aging population in the United States is increasing and therefore they are in greater need of services that include spirituality as

part of a comprehensive treatment plan. Skogrand et al. (2007) examined the role of spirituality in traumatized adults in a group setting. According to the researchers the participants in their study reflected on their painful experiences as turning points which enabled them to be more sensitive and kind to others. Furthermore, these researchers suggested the necessity of mental health professionals to be cognizant of the ageless malleability of the brain and how Cognitive Behavioral Therapy (CBT) can be beneficial in the treatment of depression and anxiety. Snodgrass noted that CBT is an evidence-based approach that has been demonstrated to be effective in helping adults change unhelpful cognitions, behaviors, and helping them manage stress levels. Along with CBT, Snodgrass stressed the importance of including a spiritual component during treatment to help consumers re-evaluate important religious beliefs and values. "Spiritual resources, support systems, and communities represent three sources for providing holistic care." (Snodgrass, p. 227).

To work with adults with a history of childhood maltreatment, Orbkey and Smith (2013) suggested designing a CBT and psychodynamic model of intervention. These researchers emphasized the need for a holistic approach**.** For example, "working to rebuild a client's foundation, conceptually, that addresses earlier developmental needs, may prove to be more fruitful, rather than attempting to develop skills and coping mechanisms on top of an ineffective internal working model." (p. 52). These researchers believe that in order to help victims reintegrate their sense of self and their memories, which were fragmented after the event, it is necessary to reconstruct their inner perspectives and their view of the world. These researchers explained how difficult it is

for a survivor of childhood abuse to enhance resiliency when there is a distorted frame of reference of the self and the world around him or her (Orbkey & Smith).

Similarly, Wöller, Leichsenring, Leweke, and Kruse (2012) noted that traumatized adults are overwhelmed with mixed emotional states and have a hard time distinguishing and separating feelings evoking past victimization from feelings related to a current triggering situation. *Imaginative psychodynamic technique* was suggested to resolve these inner conflicts and *Resource-activating technique* to regulate emotions and to uncover capacities, dreams, and hopes. Anderson and Robboy (2011) stressed the need to offer intergenerational treatment given that when abused parents have not dealt with their own trauma they cannot be supportive to their own children.

Support and Psycho-Educational Groups

Support and psycho-educational groups are socio-therapeutic environments that may promote connectedness among participants (Fritch & Lynch, 2008). According to these researchers, these group environments may create opportunities for self-exploration as participants hear others reflect on their own experiences, failures, and successes (Fritch & Lynch). Fritch and Lynch (2008) stated that support group intervention has proven to be effective in the treatment of different mental health disorders as well as for personal growth and development of social skills. Fritch and Lynch considered that psycho-education is gaining recognition as it helps people to understand the source of their complaint through education.

On the other hand, Donker, Griffiths, Cuijpers, and Christensen (2009) pointed out that psycho-education group treatment is less costly as more people can be treated concurrently. Watzke, Rueddel, Koch, Rudolph, and Schulz (2008) brought attention to

the issues of treatment fidelity of therapeutic techniques employed which they said may vary from one experiential group to another due to flexibility in their format. Fritch and Linch (2008) pointed out that some have a more relaxed design whereas others are more clinically oriented.

Fritch and Lynch (2008) in their meta-analysis of group work interventions, maintained while reviewing validity of approaches, that most studies had restrictions in the selection of participants, not much inclusion of comparative groups, and small sample sizes making it hard to generalize results. They also found that studies were often conducted solely on females. Despite these shortcomings, Fritch and Lynch), in their meta-analysis, concluded that some of the most effective therapeutic interventions to work with trauma survivors in groups were:

Seeking Safety, (a CBT treatment modality), reduced PTSD symptoms and substance use in participants with histories of CPA and CSA. Likewise, these researchers found that trauma related and present-focused CBT reduced depression, thoughts of substance use, and increased self-esteem in participants with chronic and severe symptomatology. Therefore, participants reported substantial progress in family and social functioning.

Cognitive Processing Therapy reduced PTSD and depression in child abuse survivors. Interactive Psycho-educational Group Therapy (IPGT) also reduced symptoms of PTSD in survivors of CSA. IPGT is a CBT trauma-focused sort of intervention that help participants replace unhealthy coping with healthier coping strategies. IPGT consists of three phases. In the first phase, group participants focus on self-exploration of issues related to shame, trust and identity. In the middle phase, participants increase self-

awareness of how trauma causes them to have problems in areas of trust, intimacy, and sexuality with others. In the last phase, participants search for a high level of connection with the world and for meaning in their lives.

Long-term (46 sessions) and short-term (20 sessions) psychodynamic techniques demonstrated to reduce dramatically symptoms of distress in survivors of at post-treatment point and 12 month follow-up for the first group, and at 12-month point for the second group. This included two stages of present-focused and trauma-focused orientation for both groups. These groups were compared to a controlled group of participants waiting to receive treatment.

Victims to survivors group of CSA (20 closed sessions) reduced inner conflicts, for instance, anxiety, depression, discomfort, and PTSD. This treatment modality combined CBT and psychodynamic techniques. These researchers stated that it follows the four stages of recovery. In the first stage, participants work on creating a safe place for exploration in the group. In the second stage, they share their story with their peers. In the third stage, they process their traumatic experience through practical exercises and develop personal goals. In the fourth stage, they review their accomplishments, plan for the future, and works towards termination.

In Analytic group for males, acknowledgement of thoughts, feelings, behaviors, and past and present relationship greatly reduced symptoms of depression and anxiety at post-test, but not at 6-month follow-up.

Long-term dynamics (28 months) decreased level of anxiety and depression in males with histories of IPV. The group adhered to group-analytic principles to challenge cognitions, behaviors, and feelings. Pre and post-treatment evaluations indicated a

reduction of anxiety and depression in participants; however, anxiety reductions were not sustained beyond treatment, at 6 month follow-up.

According to the National Registry and Evidence-based Programs and Practices (SAMHSA; 2013), Seeking Safety and Trauma Affect Regulation Guide for Education and Therapy (TARGET) are validated approaches to work with adult survivors of childhood abuse that may fit well for groups in community settings. The TARGET program instructs survivors how to manage their negative emotions and problematic thoughts while enhancing self-sufficiency (SAMHSA; 2013). These modalities of treatment seem to have a combination of CBT and psychodynamics (PD).

In a meta-analytic investigation**,** Donker, Griffiths, Cuijpers, and Christensen (2009) validated the effectiveness of brief *passive psycho-education*. These researchers explained that brief passive psycho-education is less direct because this type of intervention does not require participants to be present. It relies heavily on written communications mailed out to them such as flyers, pamphlets, and newsletters. This brief passive psycho-educational modality did not offer advice to participants*;* however, it has demonstrated that it reduces symptoms of psychological distress in participants. Contrary to the passive approach, *active psycho-education* is more direct and didactic requiring participants to complete activities in classroom and at home Donker et al. (2009).

In a large study of 171 patients assigned to 19 groups with co-occurring disorders, Watzke et al. (2008) found that a short-term CBT approach in groups was as effective as (PD; *focal analytic approach to* group in *action, style, and content).* Watzke et al.

supported both approaches due to the possibility of balancing powers between intra-psychic and interpersonal dynamics of the group.

Watzke et al. (2008) categorized CBT and PD groups with short-term based format on content in the following fashion: CBT psycho-educational group went over the etiology of disorders and provided information whereas PD groups dig into group conflicts and positioned the client within the group.

Practice and Policy Recommendations

Besides addressing intrapersonal and/or interpersonal factors affecting victims of child maltreatment, there is a call for interventions that aim at modifying, whenever possible, environmental risks and protective factors. Mersky and Topitzes (2010) identified the need for interventions that enhance the quality of life of maltreated adults and children, reducing as much as possible risk factors such as socioeconomic disparities in disadvantaged communities. Also, these researchers suggested revision of polices related to child welfare, and recommended increase mental health services provisions to prevent abuse and to promote mental health in adult victims with childhood abuse histories. Likewise, Perez-Fuentes et al. (2013) emphasized the importance of practitioners to assess more carefully for risk of suicidality in clients with history of CSA. Maniglio (2010, 2013) extended the importance of addressing anxiety and depression besides other sequels of abuse. In these two latter studies, Maniglio recommended that during treatment sessions, other interwoven risk factors such as family (which may accentuate the onset of symptoms) be addressed. To boost protective factors in adult survivors of childhood abuse, Sigurdardottir et al. (2012) strongly suggested journaling and talking about experiences.

Buckingham and Daniolos (2013) pointed out that the goal of therapy be a combination of psychotherapies and medication to deal with symptomology stemming from child abuse. To extend the benefits of short-term positive outcomes at program completion and for program sustainability in the long run, Lawson et al. (2012) further recommended before termination to link participants with extended supportive services to mitigate their needs. A participant receiving mental health treatment declared that he did not know what do with the emotions that arose unexpectedly in the post-treatment phase as he was left with no sustained support **(**Harper, Stalker, Palmer, & Gadbois, 2008).

Slep et al. (2011) recommended that an insertion of multifaceted child abuse prevention and intervention programs be used, looking at the person in relation to his/ her environment inside the family and in their specific socioeconomic contexts (Slep et al.). Lawson et al. (2012) stressed the importance of developing more multi-layered programs to enhance the quality of life of fragile populations who have experienced child abuse, domestic violence, and drug use. It was suggested that programs have mental health improvement and social developmental components to be effective. Lawson et al. recommended family resource centers as the focal point for provision of services. Lawson et al. explained that this is with the purpose of reducing risk factors of isolation and distress in impoverished areas.

CHAPTER 3

METHODS

Strategies for Identification and Selection of Potential Funder

The search to identify potential funders was conducted through a variety of means. They were conducted using the internet and telecommunication systems. Contacts were made over the telephone and e-mail at the local, state, and federal levels. Private donors, corporations, institutions, and community organizations were taken into consideration. This extensive search generated the following results:

Private foundations such as the Endowment Center in Los Angeles and the Orange County Community Foundation in Woodland Hill are interested in preventing illnesses and improving the health of California residents. The California Endowment Center was contacted and visited. The California Endowment Center's mission is to strengthen communities providing an array of supportive services to improve health in their communities to the broadest extent.

The California Endowment Center endorsed the mission of this pilot program as two out of ten outcomes met their criteria for funding: their criteria Number 3--Health care prevention and human services for families and Number 5--Children and families violence prevention (The California Endowment Center, 2009). The California Endowment Center has selective criteria for funding. They welcome innovative initiatives though they do not typically fund unrequested grant proposals. This

foundation could be an opportunity for future funding, but was not chosen.

The Orange County Community Foundation was also contacted via telephone. Program Officer, Patricia Benevenia from the Orange County Community Foundation stated that there were no funds available at this time, however, their mission of improving the health and well-being of residents in Orange County was in alignment with this pilot program (P. Benevenia, personal communication, September 5, 2013).

This writer visited One O.C. Center-Accelerating Nonprofit Success--located in Santa Ana, California. This resource center offers comprehensive assistance to organizations and individuals to prepare, plan, and launch projects focused on improving the life of residents in Orange County by providing volunteer, consultation, trainings, and corporate services. The One O.C. Center assists organizations in resource management, accountability, leadership, and fundraising. Therefore, this Center helps individuals in writing effective grants and matching projects with funders. This Center has a comprehensive foundation directory database at the disposal of grant-seekers; however, this writer found that their database could only be used on-site and had limited accessibility.

This writer browsed the One O.C. Center database to identify possible private funders, corporations, or charitable institutions interested in child maltreatment prevention and intervention projects for adults in Orange County. This search provided hints to some funding opportunities; however, grant-writing requirements by funding source could not be obtained as it requires grant-seekers to have a special Tax Identification Number (TIN) for access. The Center was visited twice and although they

said that they had a volunteer onsite to assist with searches, that person was unable to provide assistance.

Another method used to identify potential funding sources was The Grantsmanship Center's list of the most influential foundations in California. These foundations, although rooted in humanitarian, health, and environmental causes, did not directly support child maltreatment prevention and intervention efforts focusing on adults (The Grantsmanship Center, 2013**).**

The CDC shared this project's view regarding child abuse being a public health issue. The CDC is interested in promoting good health to people of all ages through preventive measures. An email was sent to the CDC presenting a brief proposal of this project. They suggested visiting the grant.gov site where they post all available grant opportunities, and recommended enrolling to receive e-mail alerts of new grant opportunities. Even though this writer followed the CDC's instructions, it was found that most of their funding is directed towards research projects related to drugs and alcohol, diabetes, and obesity (CDC; 2013.).

Grants.gov was ruled out after communication received via e-mail and over the telephone informing lack of funding available to support group developments with adults with histories of child maltreatment. Therefore, the government had particular criteria for funding and none of the grants available at that time were geared to provide funding and support for this type of project (Grants.gov, n.d.).

The USDHSS which upholds the mission of this pilot project was contacted. The USDHHS shared and supported the project's mission and showed enthusiasm about this pilot program. They explained that states manage federal funding for child abuse

prevention and intervention programs. Following their recommendations, this writer contacted The Department of Social Services, Children and Family Services Division. The Children and Family Services Division referred this writer to the Child Welfare and Policy Development Bureau. Upon contact, Latifu Munirah, Associate Government Analyst, informed the writer that no funds were available at this time, and suggested visiting their website for future funding at www.childsworld.ca.gov. (personal communication, September 6, 2013).

Upon visiting their website, it was found that the State Children Trust Fund might provide funds for child maltreatment promising projects under the Welfare and Institutions Code Section 18969. The office of Child Abuse Prevention monitors programs and the effective use of federal funds such as the State Children Trust Fund. Nonetheless, at this time, their investments are focused on research of effective and creative programs, professional training, and publications of instructive material on a large scale. Funding is provided to organizations with a strong long-standing reputation in the community, thus there is no current funding for small pilot projects. Because of this, the State Children Trust Fund had to be discarded as it did not match the size of this pilot program.

The National Resource Center for Community-based Child Abuse Prevention under the administration of the Children's Bureau, under the USDHHS was contacted via telephone. Sarah Rock who is the state contact for the Office of Child Abuse Prevention program commented that funds were solely being allocated for training and technical support of inter-partnership agencies in California (S. Rocks, personal communication,

September 4, 2013). Nonetheless, their interest in promoting health and preventing abuse in families and children was related to this pilot program (Benefits.gov, n.d.).

After a preliminary review of possible funders, the California Department of Mental Health, now merged and managed by the Office of Statewide Health Planning and Development (OSHPD) and affiliated with the Health and Human Services Agency, was determined to be the funding source for this pilot project.

Potential Funder

Matching Criteria for Selection

During the process of writing this grant, the California Department of Mental Health merged to be managed by the California Department of Health Care Services under the OSHDP (California Department of Health Care Services, 2013). The California Department of Mental Health's vision and priorities was found to be in alignment with this pilot program's vision and mission. Two out of five components of the California Mental Health Services Act (Proposition 63) passed by the legislature in 2004 match this pilot program's mission. Those are component numbers four and five. Both components are related to the provision of direct mental health services to adult clients.

Component four assigns the use of discretionary funds for the early detection, prevention, and treatment of mental health illnesses. Along with the direct provision of mental health services to clients, funds should be used to ameliorate delays in service delivery and to address social issues. That is, funds should be used to reduce the length of time clients wait to be assessed, served, and referred. Funds should also be used to reduce stigma in society around mental health illness and utilized accordingly to address

discrimination against those suffering with a mental illness. Component five entails the use of funds to evaluate effectiveness of programs in reaching out to those most in need of mental health services. Funds should enhance and stimulate community and organizational ties through inter-partnership alliances (MHSOAC; 2012).

Funder's Goals

The OSHPD seeks to fund programs that are unique, resourceful, culturally sensitive to the population they serve, cost-effective, and inclusive. It looks to fund promising mental health programs in impoverished communities. The programs' design should have the potential to become evidence-based approaches to mental health problems. Thus, the OSHPD, through the use of Proposition 63 funds, provides support to promising programs offering a different approach to mental health service delivery **(**Mental Health Services Act, 2012).

Since this pilot program meets the eligibility criteria for funding through the OSHPD, this writer contacted Ms. Bonnie Birnbaum, Orange County coordinator for mental health services for the County of Orange Health Care Agency. After presenting a brief description and purpose of this pilot program, (B. Birnbaum, personal communication, September 23, 2013) agreed that this pilot program fit two out of the five required components of Proposition 63 for funding.

Ms. Birnbaum expressed that funding for component five has already been allocated for this fiscal year; however, she explained that in order to learn about grant application process, this writer needed to attend a steering committee. She invited this writer to attend the steering committee meeting to learn about coordination, planning, and process for future funding. Therefore, she encouraged this writer to join the

subcommittee for direct adult community mental health services as this subcommittee's discussions are pertinent to this pilot program's goals and mission.

Planning and Process

This writer attended the steering committee meeting. This writer enlisted to receive e-mail communication about future meetings, updates regarding current mental health program outcomes, and evaluations, and discussions of other local and state mental health issues. It was informed that the process for funding is lengthy. It involves different stakeholders in the decision-making process, including the general public. The guidelines for the new funding and application process were to be discussed later. It was also noted that it is up to the County of Orange Board of Supervisors to approve new directions and new mental health projects. During this steering meeting, MHSA coordinator for Orange County, Ms. Birnbaum informed the audience that the OSHDP acknowledged the gap in mental health services in marginalized populations. The services that this pilot program offers will assist narrowing the existing gap in mental health services for adult survivors of childhood maltreatment.

Target Population

ISISMA is a pilot program aimed at serving underprivileged populations in Anaheim with a mental health problem stemming from childhood maltreatment. It will provide mental health services to at least 24 adult survivors with histories of child maltreatment, who are English and Spanish speaking, ages18 and older. Most of the clientele to be assisted will be Latinos and Whites since these races/ethnicities are the most representative in the region. However, this pilot program will also embrace other ethnic groups in need of mental health services, but whose primary or secondary

language is English. Statistical reports from the Southern California Association of Governments (SCAG; 2013) indicated that there were 343,793 people living in Anaheim in 2012. The population was broken down in groups, Hispanics representing 54.0%, Whites 25.6%, Asians 15.4%, African-Americans 2.4%, Native Americans 0.2%, and other ethnicities 2.4% (SCAG; 2013).

Host Agency Description

Services Provided

The host agency for this pilot program will be the Anaheim Harbor Family Resource Center (FRC). This Center serves mostly Spanish and English speaking clients. Similar to the vision of OSHPD and the Anaheim Harbor FRC, this pilot program will serve the community while empowering and strengthening ties between individuals, families, and other interlocked ecosystems.

The Anaheim Harbor FRC is one of 12 Families and Communities Together (FaCT) family resource centers intentionally situated in the highest risk community in Anaheim. It offers wraparound services to individuals and families in need through interagency collaboration to help them succeed in their communities. Individuals and families often come to be assisted with basic needs such as food, adequate housing, and proper medical care. The Center provides assistance with Medi-Cal, Cal-Fresh, and Cal-Works, parenting education, and counseling.

It is estimated that about 60% of people come to the Center looking for mental health services. The Center offers individual counseling; however, the Center does not have enough funds to extend mental health services to reach all those in need. It offers case management, advocacy, and classes to increase individual and family self-

sufficiency. It also offers others supportive services to adoptive and foster care families, and to relatives who are caregivers.

Statistics of People Served

According to a report provided through the Vista Share database, in 2012 this Center served 767 individual clients. The predominant race/ethnic groups who sought support were Latino/Hispanic (701) and Caucasian/White (44). Comparing demographic distribution in the region as depicted earlier for Whites and Hispanics to the number of people served at this Center, Hispanics were exceedingly more in need of services. Regarding gender distribution, there was not a marked difference, serving 323 males and 435 females. The average household income ranged from $0.00 to $19,999. Most of those served were walk-ins who were mainly referred by social workers and counselors. Demographic information Data was provided by the Anaheim Harbor FRC through the Vista Share Database.

This Family Resource Center receives public funding and support from county, state, and federal agencies such as the Orange County Social Services Agency, the Office of Child Abuse Prevention, and the USDHHS to name a few. It also utilizes volunteer services and accepts in-kind contributions. However, these contributions are not enough to mitigate the needs of this highest risk population.

CHAPTER 4

GRANT PROPOSAL

Geographic Area

The City of Anaheim is divided into four districts, west, east, central, and south. Each district within the city is composed of neighborhoods that are grouped together given their proximity and location to one and other. Geographic boundaries are defined for administrative purposes and to determine neighborhood costs. The center of the city is located in the central neighborhood district, near the Anaheim Police Department. According to a city report on neighborhoods published in 2013, Anaheim Central District was the most overpopulated of all the four districts in the region. Population reached 38.1%, having 126,627 inhabitants in 2012 (City of Anaheim, Finance Department, 2013).

Coordination of Services with Anaheim Harbor Family Resource Center

ISISMA will operate out of the Anaheim Harbor Family Resource Center. The aim of this pilot program is to extend mental health services to adults who were neglected or abused as children. Services will be available to low-income adults who cannot otherwise be served by the Family Resource Center. Mental Health treatment modalities for support and psycho-educational groups will be complementary and not in conflict with other mental health services offered at the Family Resource Center in order to avoid duplication of services from occurring. These treatment modalities are not currently

offered to this unique population of adult survivors of childhood neglect and abuse, throughout Orange County.

Support and Psycho-Educational Phases

Adult survivor of childhood maltreatment will attend a closed support membership group during Phase I followed by a closed psycho-educational membership group during phase II. Members' commitment to attend both phases of the program is required in order to create a safe atmosphere and to enhance the therapeutic effects of interventions. The initial cycle corresponds to the Phase I of support and Phase II of psycho-education. This will begin and end when a first wave of clients graduate from the program. The subsequent cycle of support and psycho-education repeats itself.

Successful culmination and graduation from the program implies that members of the group have attended 80% of all sessions in Phase I and Phase II. That is, members of the group should have attended at least 8 out of 10 sessions contained in Phase I and Phase II. Each cycle will begin and end in approximately 5 months when new members joining the group graduate from the program. It has been calculated that 4 groups will participate on this pilot program during the fiscal year of 2015 and 2016.

These groups will be facilitated by two licensed clinicians during Phase I and Phase II of the program. In order to maximize therapeutic benefits, there will be no more than 8 participants in each English and Spanish speaking group. Both groups will participate simultaneously in both phases of support and psycho-education. Participants should have previously authorized the program to conduct follow-up interviews at 6 months and 12 months after completing each phase. This is with the purpose of tracking down sustained benefits over time.

In working with marginalized populations, it is anticipated some program drop outs. Common challenges and barriers affecting group members' attendance are often related but not limited to illnesses, relocation, change in work schedules, personal and family crisis situations, lack of childcare, and lack of transportation.

Phase I

Phase I will consist of 10 closed support group sessions, taking place once a week for 10 weeks. The group will meet at the Anaheim Harbor Family Resource Center once per week for 90 minutes for 10 consecutive weeks. During the first phase, 12 adult survivors of childhood abuse and neglect will participate in a support group. The group format will not allow new members to join the group. This is with the purpose of enhancing therapeutic alliances and the building of trust among participants. The purpose of the support group will be to create a therapeutic environment for exploration and growth. It will be a safe place for group members to share similar experiences as they relate to childhood abuse and neglect. They will discover, through others, how those experiences have shaped them into being who they are, and how they have been affected. From a spiritual standpoint, the support group will create the environmental conditions for participants to learn that they are not alone in their journeys. They will discover inner strength and positive coping techniques they have used unintentionally and will learn additional ones from others. The goal is that this will give them a sense of hope and vitality needed to overcome their challenges.

They will also share about their problems, thoughts, feelings, and behaviors. This will help them normalize their experiences, as they will feel connected with others who are on the same path to recovery. They will gain insight into their own symptomatology

(i.e., depression, anxiety, anger, and stress) as they hear the stories of others). Themes to be discussed in sessions will be selected by the program based on responses of participants' to questions during enrollment. The themes will be connected back to the goal and objectives. For instance, participants may discuss how feeling inadequate affects their self-esteem and how feelings of mistrust induce them to be isolative.

Phase II

During Phase II, group members from the Phase I will transition into the second phase of psycho-educational support. This phase will consist of 10-closed psycho-educational support sessions. Similar to the first phase, the group will meet at the Anaheim Harbor Family Resource Center once a week for 90 minutes for 10 consecutive weeks. At this point, members of the group should feel more connected and more amenable to interact with others. This will allow them to be more open to embrace the psycho-educational material to be covered within each session.

The purpose of the psycho-educational group is to introduce topics related to childhood abuse and neglect through a variety of didactic material and curricular activities. They will learn basic concepts of brain functioning as it relates to child maltreatment. Group members will also learn about the vestiges of child abuse and neglect. They will become cognizant of developmental symptomatology such as stress, depression, anxiety, anger, low self-esteem, and social impairments. They will acquire new skills to cope better with their symptoms. They will develop adequate interpersonal skills leading to more effective and fulfilling social interactions, preventing isolation and mistrust. Therefore, they will learn to identify healthy and unhealthy adjustments to

childhood trauma. With this information, group members are expected to replace maladaptive cognitions, feelings, and behaviors with more adaptive ones.

Program Therapeutic Approaches

This program will use CBT, PD, Neuroscience, ecosystems, and spiritual frameworks that will in turn encompass all program endeavors. ISISMA believes that the healing path to recover from childhood trauma may begin when participants start their inner work to care for the wounded child inside themselves and begin to transcend the adversity through spirituality in Phase I. This may provide them with the tools to understand themselves and others, and challenge themselves to make the change in Phase II.

Program Goals and Objectives

This pilot program has two simultaneous goals aimed at improving the quality of life of adult survivors of childhood maltreatment. The first one is an interventional goal geared at reducing the negative consequences caused by child abuse trauma in adult survivors. The second one is a preventive goal aimed at decreasing survivors' vulnerability for interpersonal and intergenerational abuse. These goals will be intertwined in Phase I and Phase II of the program. The objectives listed below have been noted to be the cornerstone of treatment based on research and empirical studies done in the fields of psychology, psychiatry, criminology, social work, and neuroscience (Boisvert & Wright, 2009, Herrenkohl, T., Klika, Herrenkohl, R., Russo, & Dee, 2012 , Mueller-Pfeiffer et al., 2013, Teicher, Samson, Polcari, & Mc.Greenery, 2006, Thornberry & Henry, 2013, van der Kolk, 2013).

Objective #1

Participants will reduce their level of stress, anxiety, and depressive symptoms at the end of the program implementation. Certain levels of stress have been proven to be essential in order to mobilize a person to action, or the expected response to fear, threats, and/or uncertainty in the general population. However, high levels of stress have been associated with illnesses and somatic disorders. Both persistent stress levels and anxiety levels have been linked to health related problems. Depression has been related to genetic makeup and to neurobiological changes of the brain functioning and structure. To be sure, depression and subsequent changes in the brain as mentioned earlier have often been correlated with trauma exposure. The focus of attention for this pilot program will be geared towards providing participants with the tools needed to regulate their mood. Level of stress, anxiety, and depression will be reduced in each domain. This will be reflected through the administration of the Self-perceived Stress Scale, the Hamilton Anxiety Scale, and the Beck Depression Inventory respectively, or through the administration of a three-dimensional tool, The Depression, Anxiety and Stress scales. Observations of participants' progress in these three dimensions will be derived from these self-reported instruments administered at baseline and after group treatment delivery.

Activities. Participants will acquire knowledge and recognition of physical, psychological, emotional, and behavioral distress. They will learn how to cope with stress, anxiety, and depression through the use of interactive activities in the classroom. Participants will learn and practice relaxation and breathing techniques through role-playing.

Objective #2

Participants will decrease their tendency towards aggression and hostility. They will improve their view of themselves and others, and will be more understanding of some of their externalizing symptomatology such as oppositional, disruptive, or criminal behaviors. Participants will identify triggering factors and signs of physiological arousal while learning management of impulses and motivations. Focus of attention will be directed towards increasing conflict resolution techniques and awareness of the effects of interpersonal conflicts, violence, and victimization. Tendency towards aggression and hostility will be reduced. This will be assessed using the Propensity of Aggression Questionnaire. Scores obtained during the pre- phase will be differentiated from the post phase, with the goal of showing significant improvement in the latter stage.

Activities. Participants will learn about the Cycle of Anger through visual aides and Power Point presentations**.** They will complete in-home worksheets tracking their daily mood levels. They will bring those worksheets completed to the class to share and receive feedback from others. Likewise, they will provide accounts to others in the group about real life situations of earned self-controlled.

Objective #3

Participants will improve their self-esteem/ self-worth. They will recognize and utilize more adaptive coping strategies or defenses while acknowledging and decreasing the use of maladaptive ones. They will become more conscious of some of their internalizing symptomatology such as self-directed anger, self-destructive or risky behaviors. They will improve their self-concept learning to identify and appreciate their inner resources, strengths, and potential despite failures and limitations.

Self-esteem/ Self-worth, and recognition and utilization of more adaptive coping and less maladaptive strategies will be identified by the provision of the Coopersmith Self-esteem Inventory, and a program-designed Coping Scale, respectively. This latter scale will measure recognition and utilization of healthy coping skills, and decrease the use of unhealthy coping mechanisms. They will increase their self-esteem, self-worth and adaptive coping skills, and will decrease their use of maladaptive coping. These measurement instruments will be collected from participants during the pre-phase and again during the post-phase.

Activities. A panel of experts who were victimized as children will be invited to speak to the groups. They will provide members of the group with insight about how they overcame feelings of worthlessness, guilt, and shame. Moreover, they will share with the group what they have done to boost their self-image, which in turn has influenced their image of others.

Objective #4

Participants will improve their social skills and interactions with family members, neighbors, friends, and the community at large. The focus will be implicit (non-verbal) and explicit (verbal) language and communication, and congruency in messages received and delivered. They will expand their social networks and increase the quality of interactions with family members, neighbors, friends, and their community.

Participants will be expected to report improvement in a close relationship, make at least one new friend, and attend or be part of a social event or gathering. This may include attending community programs at the family resource centers, schools, churches, fairs, sport activities, or museums. They will become familiar with at least three local

resources at exit point. Participants' success in connecting with others and their communities will be evaluated based on self-report.

Activities. They will learn to develop healthy ways of connecting with others through peer-to-peer interactions in the group. They will recognize sources of interpersonal conflict through role-plays.

Program Philosophy

The philosophy behind ISISMA acknowledges that behind any human condition and suffering, there is potential for growth and transformation. Participants in this group program will learn to reorient their mindsets towards more positive and productive endeavors, reshaping their existence and so living more fulfilled and joyful lives. They will come to the realization of how their new worldview, attitudes, and behaviors will influence them and those around them positively. Thus, they will be more prepared to stop the cycle of abuse once perpetrated onto them.

Program Participation

During the intake process, participants should be familiarized with program goals/ objectives, group format and expectations. They should have provided consent to participate on program protocols and pre and post evaluations. Likewise, they should know about the limits of confidentiality and Tarasoff laws. Participants will be provided with copies of intake documentation, meeting agenda, times, and location.

In working with marginalized populations, it is anticipated some program drop outs. Common challenges and barriers affecting group members' attendance are often related but not limited to illnesses, relocation, change in work schedules, personal and family crisis situations, lack of childcare, and lack of transportation.

Program Performance and Evaluation

Group participants completing the program will demonstrate considerable gains in the aforementioned four objectives compared to untreated and wait-listed sample populations. They will increase their knowledge, understanding, and recognition of sources of psychological and physiological distress. They will also increase their coping skills to manage their symptoms. Treatment benefits from participation in the ISISMA program will be assessed short-term at exit point and long-term at 6 and 12 month follow-ups after program culmination of each phase.

Sign-in sheets will be passed around to attendees during each session during Phase I (support group sessions), and during Phase II (psycho-educational group sessions). Absenteeism will be documented. These entries will include a description of the circumstances provided by the absentee in advance or upon their return. These records will help inform staff about personal and program level challenges.

Members of the group will complete a pre-test with closed-ended and two open ended questions about areas of impairment in individual and/or social functioning and what they expect to get out of treatment. The post-test will also have closed-ended questions and two open-ended questions for them to provide feedback about their achievements and suggestions to enhance quality of services. Input from these pre-and post-tests will guide best practices and empower participants who will feel connected to a system of care. Therefore, group facilitators will provide members of the group with feedback regarding their performance and accomplishments inside the group and how those accomplishments can impact their lives outside the group in families and communities.

The effectiveness in the development and execution of this pilot program will be qualified and quantified by an outside program evaluator and researcher for transparency and accountability. This professional will be contracted to examine the impact of the program on clients' well-being. Data will be collected from participants' assessment tools, questionnaires, surveys, attendance logs, incident reports (if any). He or she will also analyze program administrative reports. Therefore, this program evaluator will examine periodic follow-up evaluations of clients' sustained benefits after leaving the program. A decrease in debilitating symptoms, linked to childhood neglect and abuse, will be re-evaluated prospectively at 6 and 12 months at the end of each phase. As mentioned earlier, phase I corresponds to the10-sessions of support group and phase II corresponds to the10-sessions of the psycho-education. Post-evaluations will only be conducted on those participants who have completed the program during the two phases. The data gathered from all sources will serve to measure the program's outcomes for future research purposes, and for support for additional funding.

Budget Narrative

This prevention and intervention pilot program requires an annual budget of $100,918 dollars. This includes personnel salaries and employee related expenses at 21% for four employees, a Program Director, two Clinicians and a Human Services or Social Work assistant. This budget also provides justification for direct and indirect costs. It includes costs for direct and indirect operating expenses. Please see Appendix for a line-item budget.

Personnel

Program Director: This professional will also be a LCSW, and should have a background in administration of non-profit programs, and at least 10 years of experience working with at-risk populations. This is a part-time, 4 hours per week, position. The annual salary is $7,280, which is equivalent to working 208 hours per fiscal year at a $35.00 hourly rate, not including employee benefits. The Program Director will be responsible for shaping and overseeing the program. He or she will be responsible for analyzing data for accountability**.** Additionally, this professional should enforce policies, procedures, and ethical principles. This is to ensure participant's rights are not curtailed by those involved in the coordination and provision of services. He or she will provide three hours of weekly program supervision to the clinicians using the same frameworks and approaches as defined in this pilot program to evaluate their job performance. Supervision time will also be used to go over participants'' cases and progress, as well as to discuss program challenges, successes, and directions. This professional should have excellent communication and social skills to maintain collaborative alliances with the host agency and other community organizations. He or she will work closely with the Anaheim Harbor FRC (host agency), and will also coordinate fundraising effort needed to sustain this program.

Clinicians- Group Facilitators: These two professionals will hold a clinical licensure and should have at least five years of experience working with adults, children, and families with mental health challenges. This is a part-time, 20 hours per week, hourly position. Their annual salaries are $56,160, which corresponds to working 1,040 hours during the fiscal year at $27 per hour, not including employee benefits. These

clinicians will develop a psycho-educational curriculum with CBT/PD activities to be covered in each group session during the Phase II of the project. Both clinicians will prepare and run support and psycho-educational groups, and submit reports. They should have received training regarding brain functioning of mistreated victims from a Neurobiological perspective. The purpose of this is to educate clients about the effects of child abuse and neglect trauma in brain functioning.

These clinicians should be cognizant of the role spirituality plays for the healing process for some participants. The purpose of this is to incorporate culturally diverse views, and interpretations of spirituality in healthy coping strategies. Thus, they will integrate concepts and principles of CBT, PD, Neuroscience, and spirituality in the curricular material. These clinicians will use a strength-based approach (promoting competency, self-determination, and physical and mental health of participants) from an ecological perspective. These clinicians will be culturally sensitive to the population served and uphold the standards and the ethical values of the social work profession. These professionals will carry out program goals and objectives, participant activities, and administrative duties under the direction of the Program Director.

Program Assistant: This professional will hold an undergraduate degree in human services or social work, and should have experience working with adults, families, and children. This is a part-time, 20 hours per week, position. The annual salary is $15,600, which is related to working 1,040 hours per fiscal year at a $15 hourly rate, not including employee benefits. The responsibilities of this position are to enroll participants into the program, provide case management, and administer questionnaires and other evaluation tools to participants. The duties of this position also include

completing participants' progress notes, preparing statistical reports, and assembling materials to be used during group sessions.

Employee-related expenses: This amount was calculated adding the four salaries for the Program Director, the Clinicians, and the Program Assistant, which totals $79,040, and then calculating 21% of the total salaries (amount rounded off to the nearest tenth).

Training and professional development: Staff will receive on-going training to keep abreast of policies and best practices in the field as required by their profession. The annual amount will be $1,440 for the salaried employees.

Direct Operating Expenses

Cellular telephones: These will be provided the Clinicians and the Social Work Assistant in order to support fast communication, ensure safety of clients and staff, and to protect confidentiality. Three cell phone lines will be paid at a cost of $36.00 per month for a total of $1,800 per year.

Office equipment: In order to execute functions related to the job, it will be required to allocate $8,000 for the purchase of two computers, a printer, furniture, a projector, and other related equipment.

Educational materials: The amount allocated for educational material will be $5,000, which will cover curriculum costs, visual aids, and therapeutic supplies such as blocks for communication exercises or relief products for stress and anxiety.

Printing, copying, posting, and office supplies: Participants will receive a packet with instructional and program materials. This designated amount will be $5,500 annually. This amount will also cover postage to mail communication to participants,

and office supplies such as paper, pens, three ring binders, and note pads. Participants will receive detailed written information of the purpose of the program, as well as the frameworks for both phases of support and psycho-education. The packet will also contain information about group composition, size, format, and timelines for both phases. Participants will receive a program outline; consent forms, and other enrollment documentation. During the psycho-educational phase, participants will receive handouts for in-session and take-home activities.

Travel expenses: This fund will only be used to provide occasional in-home crisis interventions, support, and case management to participants as deemed appropriate for services. The amount allocated will be of $1,200 per year.

Emergency assistance: Participants who might be experiencing financial hardships might receive bus vouchers to attend group meetings, gift cards or in-kind donations such as childcare provision. The expected allocation of funds will be in the amount of $1,200 per year. Participants will only qualify for assistance twice per year, given they meet qualifications.

Refreshments: Refreshments and snacks will be provided to participants during sessions. The funds allocated are $1,000 per year.

Miscellaneous: This fund will cover unforeseen expenses or costs not itemized elsewhere in this budget. The amount allocated will be of $2,000 per year.

Indirect Operating Expenses

Evaluation expenses: This pilot program is an innovative approach to mental health services. Because of this, an outside program evaluator will be hired at the rate of 10% of the total budget cost or an estimated $8,796 (amount rounded off to the nearest

tenth). His or her input will provide an objective glance into program performance, and will influence the decision-making process for this pilot program and will save time and money in the long-run as this project expects to be expanded and to become a model for the region.

In-Kind Donations

Administrative support: A volunteer is expected to donate his or her time to provide administrative support to the program, preferably to donate eight hours per week. This could be someone recruited through the Anaheim Harbor FRC or a student from a local Regional Occupational Program (ROP). This person should have computer skills and intermediate knowledge of basic operating systems such as Microsoft Windows, Excel, and PowerPoint.

Rental and utilities assistance: The Anaheim Harbor FRC will put $8,800 in-kind donation towards rent payment and utilities to launch this program for the fiscal year of 2015 and 2016. The designated areas to run the support and psycho-educational groups as well as the administrative activities will be arranged as convenient.

CHAPTER 5

LESSONS LEARNED

Grant Writing Process

The first step in the grant writing process is the selection of the host agency. The agency must be thoroughly researched based on the goals, objectives, existing programs, funding support, target population, and geographic location. It is helpful to have a clear understanding of the services provided by the selected agency as the grant writer begins researching funding sources. These considerations can make the process of writing a grant a smoother and more efficient process.

Once the host agency is selected, the next step is to determine what type of grant the grant writer is seeking. This requires the grant writer to conduct extensive research and review the target population to have a good understanding of the needs of the population. An assessment of needs for this population of survivors was a key component in the literature review. The purpose of incorporating assessment needs of this population was to identify and create a program that would address their particular mental health needs. To accomplish this, this grant writer review extensive literature on adult victims of childhood maltreatment, the magnitude of the problem, the ripple effect of untreated childhood trauma in the life of survivors, their families and communities.

One of the most cumbersome tasks when writing this grant was searching for statistical data that could shed light into the scope of the problem at all levels,

countywide, statewide, or nationwide. This writer had to go beyond the national boundaries to overcome some of these limitations searching for worldwide reports for adults with childhood abuse histories.

Conducting an extensive literature review requires finding numerous reliable sources of information such as peer reviewed articles, statistical information, current data and current grants that describe the target population. This writer found that there is not centralized data collection system to identify percentage of adults with histories of childhood maltreatment in the U.S. Another problem was searching nationwide for possible existing group programs working with adult survivors of childhood abuse and neglect. This writer could only locate a support group for adult survivors of childhood maltreatment located in San Francisco, California; however, this support group does not use evidence-based or empirically tested methods of intervention. The lack of statistical data of the prevalence and incidence of adults with histories of childhood maltreatment was a case in point as there was the gap in literature regarding the existence of mental health programs designed to address the specific mental health needs of these victims.

The next step in grant writing is the identification of potential sources of funding. This grant writer conducted an extensive search of federal, state, and foundation grants. The Google Advance Search Engine is a helpful tool to identify possible funders. For example, it was used to access grant databases such as the Grantmanship Center, the USDHHS for government grants, and The California Endowment Center, and the One O.C. Center -Accelerating Nonprofit Success-. It was also important to narrow down the potential sources of funding by identifying the specific guidelines and eligibility requirements that each funder requires.

The final step is completing the grant application. Due to the competition for funding, it is extremely important to follow the guidelines that are set forth by the funding source, and to be cognizant of the funder's priorities when writing the grant. As a frame of reference, it is convenient to look at other programs the funder has supported in the past. In addition, it is essential during the grant writing process to establish the need for the proposed program by researching the extent of the problem in the community and creating and aligning program goals with those of the funder. Likewise, it was necessary to delineate effective evidence-based practice through research to demonstrate the likelihood of the proposed program to address the shortage of mental health services in untreated communities.

Challenges

The grant writer learned that writing a grant proposal was a challenging experience, as the grant writer had to transition from an academic writing style to a grant writing style. In order to readjust, the grant writer used the funder guidelines, the challenges of the target population, the needs of the hosting agency, and extensive research to justify the need for support and psycho-educational groups for adult survivors of childhood maltreatment. The grant writer also learned throughout the grant writing process that applying for grants can be competitive process partly due to the requirements of the funding source, reduction of funds, and the current economy. Attending relevant workshops was also helpful, as well as viewing YouTube workshops to learn more about grant writing. The grant writer also found out that writing for a grant must be detailed, clear, and evidence-based in order to differentiate his or her grant proposal from others to maximize the likelihood of funding. A strong program evaluation plan and being able to

appropriately measure success is an essential piece of writing a grant, as this will help encourage the expansion of the proposed program and the continued funding by the funding source. This grant writer gained invaluable knowledge on how to write a grant, and how to research and access information in regards to potential funding sources.

Implications in Social Work Practice

Throughout the process of writing this grant, this writer learned about the different and vital roles social workers can have in becoming effective agents of change. Social workers should be expected to be well rounded and knowledgeable in the areas of research, grant writing, micro and macro practice. Grant writing is a valuable skill in the social work profession, especially during financial hardships due to cuts in funding. Creating a comprehensive program that includes multiple systems in the community can be an effective way of working with adults who were victims of childhood abuse and neglect. In addition, obtaining funding for a program and showing effective results increases the probabilities of receiving more funding. Due to the competition for funding, it is critical for social workers to show program effectiveness through evidence-based practice. The ability to develop and implement a program that addresses specific issues affecting adult survivors of childhood maltreatment has the potential to significantly impact the mental and physical well-being of the adult survivors, and the relationships within their families and outside in their communities.

APPENDIX: LINE-ITEM BUDGET

INTERVENTIONAL STRATEGIES FOR IMPERCEPTIBLE SURVIVORS OF CHILDHOOD MALTREATMENT PILOT PROJECT LINE-ITEM BUDGET

Appendix: Line-Item Budget

Budget Request –Fiscal Year July 2014 – June 2015

Interventional Strategies for Imperceptible Survivors of Childhood Maltreatment

Pilot Project

EXPENDITURES	FTE	AMOUNT	IN-KIND SUPPORT
PERSONEL SALARIES AND EMPLOYEE EXPENSES			
Program Director - PTE = 10%		$7,280	
Clinician Group Facilitators (2) – PTE = 50%		$56,160	
Program assistant (BA/BS) PTE = 50%		$15,600	
Employee-related expenses (EREs @ 21%)		$16,598	
Administrative Support			$4,160
Training and Professional Development		$1,440	
Total Salaries and Employee-Related Expenses		$97,078	$4,160
DIRECT OPERATING EXPENSES			
Rent			$8,800
Cellular telephones (3) @ $36 monthly service		$1,320	
Office Equipment (Computers, furniture, projector)		$8,000	
Educational Materials (Curriculum)		$5,000	
Printing, Copying, Postage and Office Supplies		$5,500	
Travel Expenses (Mileage Reimbursement)		$1,200	
Emergency assistance (bus passes, gift cards)		$1,200	
Refreshments		$1,000	
Miscellaneous		$2,000	
Total Direct Expenses		$25,220	$8,800
INDIRECT OPERATING EXPENSES			
Evaluation Expenses		$8,796	
Total Indirect Expenses		$8,796	
SUBTOTAL PROJECT EXPENSES		$131,094	$12,960
TOTAL BUDGET REQUEST		$144,054	

REFERENCES

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