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Understanding the Relationship between Child Internalizing Problems and Familial Cohesion following Child Sexual Abuse: The Moderating Role of Caregiver Abuse History

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Abstract

Due to the heterogeneous nature of symptoms in survivors of child sexual abuse (CSA), extensive research is needed to understand the complexity and further improve intervention practices. This study examined the relationship between risk and outcome factors, specifically caregiver history of emotional abuse and youths' internalizing problems, and their influence on familial cohesion following CSA. Using a moderation model, it was hypothesized increased child internalizing problems would be related to decreased family cohesion when caregivers have an extensive history of emotional abuse. Participants were 215 non-offending caregivers of sexually abused children attending Project SAFE (Sexual Abuse Family Education), a 12-week cognitive-behavioral treatment program held at a Child Advocacy Center. Caregivers were 23 to 72 years old (M = 37.66, SD = 7.99), 86.9% female, and 85.6% European American. There was a significant interaction between caregiver history of emotional abuse and child internalizing problems as predictors of family cohesion and a regions-of-significance analysis revealed that less family cohesion was only significantly associated with increased child internalizing problems when scores of caregiver emotional abuse history were 9.4 or higher. This suggests that caregiver history of emotional abuse may function as a mechanism that influences how CSA victims' internalizing problems impact familial cohesion. Given the importance of familial cohesion to the recovery process, this study has meaningful clinical implications such as providing support for interventions that deliver concurrent services to victims as well as their underserved caregivers.

Understanding the Relationship between Child Internalizing Factors and Familial Cohesion following Child Sexual Abuse: The Moderating Role of Caregiver Abuse History

Child sexual abuse (CSA), defined as any range of contact to non-contact sexual activity involving a child (Dominguez et al., 2001) is a prominent public health issue in the United States due to its impact on survivors' cognitive, social, emotional, and behavioral functioning (Toffey, 2019). CSA can lead to a plethora of negative symptomology including depression, anxiety, Post-Traumatic Stress Disorder (PTSD), substance abuse, and sleep problems (Cantón-Cortéz et al., 2015; Hardner et al., 2018; Kearney et al., 2010; Lindert et al., 2014). These outcomes not only occur short-term but can also have lasting long-term effects that impact other realms of the survivor's ecological systems including educational attainment, career advancements, and future relationships (Blanco, 2017; Hardner et al., 2018). Though much research has found that survivors present higher degrees of internalizing and externalizing problems compared to non-abused peers (Quas et al., 2003), other CSA youth present little to no clinical symptomology (Kendall-Tackett et al., 1993). The heterogeneity of symptoms and symptom presentation pose a major challenge for both clinicians and researchers. Thus, further exploration into both risk and protective factors is warranted.

There has been extensive research on factors related to CSA in order to better understand its multifarious nature. One theory by Yancey and Hansen (2010) separates factors related to CSA outcomes into three categories: personal factors, familial factors, and abuse-related factors. Personal factors are those related to the individual including their age, gender, attributions to the abuse, and treatment. Familial factors relate to the family: parental history of abuse, familial support or stress, and caregiver mental health. Lastly, abuse-related factors are those that connect to the abuse including severity, length, number of perpetrators, and the perpetrator-child

relationship (Yancey & Hansen, 2010). For this study, our focus is primarily on familial factors, including caregiver history of trauma and familial cohesion, and their relationship with the child's internalizing behaviors following CSA.

Internalizing Problems

There are two broad-band categories that are used to describe behavioral, emotional, and social problems: internalizing and externalizing. Internalizing factors are those that manifest and are directed towards the self and are represented by *"disorders with prominent anxiety, depressive, and somatic symptoms;"* whereas externalizing factors are directed outward and encapsulate *"disorders with prominent impulsive, disruptive conduct, and substance use symptoms"* (*Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. [*DSM-5*]; Achenbach et al., 2016). Internalizing factors refer to the person's emotional and psychological state and can include anxiety and depressed mood (Liu et al., 2011; Oh et al., 2020). The prevalence rate of depression is between 5% and 8% in adolescents in the general population, and the rate for anxiety is between 12% and 20% for adolescents in the United States, with higher pervasiveness in at-risk populations (Liu et al., 2011; Oh et al., 2020).

The links between child maltreatment and internalizing behaviors are widely documented. In particular, exposure to maltreatment, including emotional, physical, or sexual abuse, or neglect, is positively associated with depression, anxiety, and loneliness (Brown et al., 2016). So, having experienced maltreatment during childhood is correlated with increased internalizing problems. Furthermore, child sexual abuse may be a uniquely salient risk factor for significant internalizing behaviors when compared to other forms of child maltreatment (Noll, 2008). A study by Lewis and associates (2015) examined internalizing problems between sexually abused, maltreated but not sexually (defined as any child protective service (CPS) report

that does not include sexual abuse), and non-abused populations. Their results found that those who have experienced sexual abuse displayed significantly higher internalizing problems when compared to their peers. Additionally, these results were consistent over time (i.e. sexually abused youth displayed significantly higher internalizing scores as they aged; Lewis et al., 2015).

Child sexual abuse is also related to a particular subset of psychological injury in comparison to other forms of maltreatment (Lewis et al., 2015). These encompass feelings of shame, betrayal, stigmatization, and powerlessness in addition to traumatic sexualization (Feiring et al., 1996; Finkelhor & Browne, 1985) which can in turn significantly impact internalizing problems (Ferguson et al., 2000). In summation, child maltreatment and sexual abuse play a significant role in a child's development and severity of internalizing behaviors.

Caregiver History of Trauma

As previously stated, childhood trauma can have lasting adverse effects that continue into adulthood and beyond. It can impact psychological processes like reward, emotion- and self-regulation, cognitive and social development, and mental health (i.e. depression; Larsen et al., 2019; Roesler & McKenzie, 1994; Shaaf, 2014). Though all are correlated with negative outcomes, the type of trauma experienced can influence which outcomes are most prominent (Allen et al., 2017). For example, those who have experienced physical abuse are at a higher risk to develop malnutrition and vision problems (Widom et al., 2012), whereas those who experience CSA are at a greater risk for suicidal ideations, suicide attempts, and feelings of worthlessness and guilt (Allen et al., 2017). A history of emotional abuse is associated with a host of negative outcomes. Studies have shown that individuals who have suffered emotional abuse in childhood are more likely to experience low self-esteem and depressive symptoms,

particularly when facing current life stressors, and have difficulties in their adult relationships (Allen et al., 2017; Briere & Runtz, 1990; Riggs, 2010; Shapero et al., 2014).

One relationship that may be impacted is the parent-child relationship as a caregiver's history of abuse can also negatively affect their offspring (Bailey et al., 2012). A study conducted by Young (2019) examined the relationship between parents with a history of childhood trauma and their children's psychopathology. The results found parent childhood abuse and neglect overall predicted multiple forms of child offspring psychopathology including depression and anxiety (i.e. internalizing problems). One possible explanation for this relationship is that early emotional abuse can hinder emotional regulation (Riggs, 2010).

The development of emotional regulation, an important process that includes adaptive ways of responding to emotions to develop behavioral control (Gratz & Roemer, 2004), is a vital skill that can be disrupted by experiencing childhood emotional abuse. The impact of early abuse is particularly detrimental as the plasticity for emotional regulation is heightened in childhood and adolescence when cognitive and emotional capacities are rapidly developing (John & Gross, 2004). Emotional dysregulation, or maladaptive ways of responding to emotions, is linked to poor social support and attachment difficulties in adults (Brenning et al., 2012; Riggs, 2010). A study by Oshri and associates (2015) found that a history of childhood emotional abuse is associated with five factors emotional regulation: lack of clarity, limited access to emotional regulation strategies, impulsiveness, difficulties engaging in goals, and nonacceptance (the sixth factor, awareness, was not correlated). Significant associations between the six factors of emotional regulation and attachment difficulties were also observed (Oshri et al., 2015). Additionally, parents that are unable to regulate their own emotions may have difficulties

providing their children with emotional regulation skills leaving them vulnerable to negative psychosocial outcomes (Young, 2019).

Therefore, a caregiver's history of emotional trauma is a variable of interest due to its negative association with offspring internalizing behaviors and its correlation with relational difficulties including hinderances with both the parent-child relationship and the family unit as a whole.

Familial Cohesion

The family system has a robust impact on a child's beliefs, attitudes, functioning, and development. A positive family environment can foster growth in a developing child, but a negative environment, like the presence of violence, can have detrimental effects on the child's behavioral, emotional, and social development (Rudo et al., 1998). For children who have experienced sexual abuse, research has shown a significant link between the familial environment and child outcomes (Ferguson, 2009) in that positive traits like family support can buffer long-term child psychopathology (Kendall-Tackett et al., 1993) and negative traits like family dysfunction are associated with higher levels of psychological distress (Bhandari et al., 2011).

Familial cohesion, defined as the emotional bonding family members have towards one another (Olsen et al., 1982), can function as a predictor for depression, self-esteem, and social and psychological adjustment (Fromuth, 1986; Ray & Jackson,1997). Additionally, a study by Meyerson and associates (2002) examined the relationship between the familial environment (i.e. conflict and cohesion), child sexual abuse, and psychological adjustment. Their results found that females who have experienced sexual abuse reported less familial cohesion than their non-sexually abused counterparts. However, this pattern was not seen for sexually abused males,

suggesting possible gender differences in the relationship between familial cohesion and CSA. Furthermore, familial cohesion in addition to sexual abuse, predicted internalizing behaviors like depression and distress (Meyerson et al., 2002).

Mental Health Treatment

Because child sexual abuse is a significant societal problem that can lead to many negative outcomes related to victimization (Walsh & Bruce, 2014), it is critical that mental health treatment is readily accessible. There are various intervention and treatment programs available to alleviate symptomology that are empirically supported. Gillies and colleagues (2012) reviewed the effectiveness of psychological therapies for PTSD in children who have experienced trauma. Of the six therapies examined, (1) cognitive-behavioral therapy (CBT), (2) exposure-based therapy, (3) psychodynamic therapy, (4) narrative therapy, (5) supportive counseling, and (6) eye-movement desensitization and reprocessing (EMDR), CBT was found to have the greatest improvement of PTSD, depression, and anxiety for up to a year following treatment (Gillies et al., 2012; Murray et al., 2014).

With growing literature demonstrating the importance of familial support and trauma specific treatment, other therapeutic methods have become more prominent trauma-focused cognitive behavioral therapy (TF-CBT). TF-CBT is a multimodal treatment method incorporating concepts from primarily cognitive-behavioral principles, but additionally, cites factors from attachment, humanistic and family systems theories (Runyon et al., 2019).TF-CBT follow the acronym PRACTICE: (P) Psycho-education and parenting, (R) Relaxation, (A) Affect regulation, (C) Cognitive coping, (T) Trauma narration and processing, (I) In vivo mastery, (C) Conjoint sessions, and (E) Enhancing safety and future development (Runyon et al., 2019). This intervention, by utilizing a safe parental figure, focuses on educational components related to

symptoms and trauma through emotional regulation training, providing skills for stress management, and understanding the relationship between the experience, their emotions, and their behaviors (Pleines, 2019; Sinanan, 2015).

Project SAFE (Sexual Abuse Family Education) is a cognitive-behavioral treatment program developed by the Child Maltreatment Research Laboratory and Psychological Consultation Center at the University of Nebraska-Lincoln. This intervention program is based on a three-factor model that describes the major areas of functioning that are impacted by CSA: the individual (self-esteem, guilt, fears), their relationships (with family, peers, or others), and sex (sex or sexual abuse knowledge; Hansen et al., 1998). Therefore, Project SAFE treatment includes psychoeducation on CSA, sex education, skill building, and prevention of future abuse. It has consistently delivered beneficial treatment for sexually abused youths and their non-offending caregivers through significant improvements in function and reduction in symptomology (Hubel et al., 2014; see procedure for further information on Project SAFE).

Study Aims and Hypotheses

A myriad of research has investigated the effects of familial support on child sexual abuse (CSA) victims and their psychological outcomes; specifically, familial cohesion in conjunction with CSA can predict internalizing problems (e.g., depression; Meyerson et al., 2002). In addition, individuals with a history of childhood abuse often have problems securing positive social support (Allbaugh et al., 2018), which can negatively affect familial cohesion (Zhao et al., 2011). The purpose of this study was to further expound the complexity of the interaction and examine how a caregiver's history of trauma influences the relationship between familial support and the child's symptomology before seeking treatment for CSA. It was hypothesized that both child internalizing problems and caregiver abuse history are positively

correlated with each other and negatively associated with familial cohesion. It was also hypothesized that there is a negative association between internalizing problems and family cohesion when caregiver history of emotional abuse is high.

Methods

Participants

Participants included 215 non-offending caregivers of sexually abused youth from Lincoln, NE, and surrounding areas who attended a mental health treatment program. Most caregivers were referred to this treatment program from the local Child Advocacy Center and were compensated monetarily for their participation in research. Caregiver demographics are summarized in Table 1. Of the 215 caregivers, 187 (86.9%) were females, while 28 (13.1%) were male. Caregiver age ranged between 23 to 72 years old (M = 37.80, SD = 8.09). The majority of caregivers identified as European American (87.9%) and were the child's biological mother (78.3%) or the biological father (9.7%). The remaining 12.0% of parentage span adoptive parents, stepparents, grandparents, foster parents, and aunts/uncles. There was much variability in household income: 29.1% had an annual income of $15,000 or less, 11.2% reported income as $15,000-$25,000, 21.4% reported income between $25,000 and $40,000, 15.8% reported annual income between $40,000 and $60,000, 14.8% reported between $60,000 and $100,000, and lastly, 7.1% of participants reported annual income over $100,000. Caregiver marital status also varied: 49.8% of participants were married, 30.5% were divorced, 11.3% were separated, 4.9% never married, but were cohabitating, and 3.0% never married and were not living with someone.

Youth demographics and abuse characteristics are summarized in Table 2. Youth ages ranged from 4 to 19 years old (M = 11.31, SD = 3.31). They were 80.1% female and 79.6% identified as European American. The total number of perpetrators varied between one to three,

with the majority (88.1%) having reported one perpetrator, compared to 9.0% reported two and 2.5% reported three. Of these perpetrators, over half (57.0%) were related to the child and 43.0% were non-family member individuals. The perpetrators were between 4 and 80 years old (M = 27.18, SD = 14.01) and 99.0% male.

Measures

Participants completed various demographic and self-report measures at multiple time points throughout the treatment program (pre-treatment, mid-treatment, post-treatment, and 3-month post-treatment follow-up). The following three pre-treatment measures were closely examined for this study.

Child Behavior Checklist. The Child Behavior Checklist (CBCL) is a 118-item standardized measure for caregivers to assess their child's (ages 6-18) behavioral and emotional problems and competencies (Achenbach, 2000). Eight scales in this instrument are separated into two broad scores: internalizing problems and externalizing problems. The internalizing problems score utilized in this study measures negativity focused towards the self and includes the Anxious/depressed, Withdrawn-depressed, and Somatic Complaints scales. Participants ranked each statement as (0) *Not true of me*, (1) *Somewhat or sometimes true of me*, or (3) *Very true or often true of me*. Sample internalizing statements included in this measure are "refuses to talk (Withdrawn scale)," "physical problems without known medical cause: nausea, feels sick (Somatic Complaints scale)," and "feels or complains that no one loves him/her (Anxious/depressed scale)." High scores on internalizing statements indicate greater internalizing problems. This questionnaire has been tested for reliability and validity (Achenbach, 2000) and Cronbach's alpha in this sample was $\alpha = 0.926$ demonstrating excellent internal validity.

Childhood Trauma Questionnaire. The Childhood Trauma Questionnaire is a brief 28-item survey to screen for an individual's history of abuse (Bernstein & Fink, 1998). The questionnaire assesses five categories of childhood trauma: emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect. The emotional abuse scale was used. Statements in the measure were rated 1 through 5 (1 = *Never True* and 5 = *Always True*) with higher scores representing more frequent trauma exposure. Sample emotional abuse statements include "people in my family said hurtful or insulting things to me," "I felt that someone in my family hated me," and "people in my family called me things like 'stupid,' 'lazy,' or 'ugly.'" This measure has demonstrated acceptable internal reliability ($\alpha = 0.84$ to 0.89; Bernstein & Fink, 1998).

Family Adaptability and Cohesion Evaluation Scale. The Family Adaptability and Cohesion Evaluation Scale (FACES-III) is a 40-item survey that evaluates family cohesion and adaptability (Olsen, 1986). Statements are divided and assessed in two categories: current cohesion/adaptability and ideal cohesion/adaptability. This study utilized the Cohesion Now scale that evaluated how the family functioned at the present moment. This subscale includes 10 items with statements like "family members like to spend free time together," "family members as each other for help," and "family togetherness is very important." Participants rated each statement on a scale of (1) *Almost never,* (2) *Once in a while,* (3) *Sometimes,* (4) *Frequently,* and (5) *Almost Always.* FACES-III has demonstrated fair internal reliability with Cronbach's alpha = 0.62 to 0.77 (Olsen, 1986).

Procedure

Participants attended Project SAFE (Sexual Abuse Family Education), a 12-week cognitive-behavioral treatment program for child sexual abuse survivors and their non-offending

family members held at a Child Advocacy Center (CAC). The CAC is an organization that utilizes a multidisciplinary team to provide focused, coordinated, and investigative efforts to CSA victims (Hays, 2020).The local CAC has an ongoing collaboration with the University of Nebraska-Lincoln's (UNL) Clinical Program to deliver parallel group treatment for children (ages 7-12), adolescents (ages 13-17), and their non-offending caregivers. The caregiver, child, and adolescent treatment groups meet independently, yet concurrently once a week for 90 minutes. Each session is led by a head therapist, a trained master's level therapist, and a co-therapist, a pre-master's level therapist in the UNL Clinical Training Program. Sessions follow a training manual with goals to educate on CSA, understand emotions and feelings, and assist in positive management. Specifically, the goals of treatment for the youth groups are to "improve outcomes for children's sense of stigmatization and isolation associated with the abuse, assist them in exploring and coping with their feelings about the abuse, and empower them in preventing future victimization" (Hubel et al., 2014). For the parent group, goals of treatment are to "[assist] parents in understanding and dealing with their children's behaviors and feelings" to promote consistency and stability across the children's environments to ensure therapeutic gains (Hubel et al., 2014).

Prior to the beginning of treatment, assessment packets are administered by doctoral students at UNL to both youth and parents. The assessment batteries for the caregivers include the aforementioned measures (see Measures) as well as questionnaires that evaluate dyadic adjustment, stress, and problem-solving attitudes and behaviors. In Addition, the caregivers fill out demographic and history forms related to the child's abuse. The assessment batteries for the children and adolescents examine depressive symptoms, anxiety, loneliness, fears related to victimization, self-esteem, and the child's expectations following sexual abuse. These

assessment measures are administered at three additional time points: mid-way (week 7) through treatment, after the completion of treatment, and during a three-month follow-up. Measures are then coded, reviewed, and entered by UNL undergraduate research assistants.

Additionally, Project SAFE offers brief family interventions (BFIs), a shorter 3-6 session individual treatment intervention for families who are not participating in group treatment. There is also a 6-week treatment program for non-offending siblings of the CSA youth attending group. The sibling group occurs during the last six weeks of the 12-week youth and caregiver group. Lastly, Project SAFE offers a one-time crisis session called Parent Support and Education Services (PSES) to provide immediate coping strategies and assist with emotional processing related to disclosure. However, these efforts are not explored in this study.

Results

Data were analyzed in two parts: preliminary analyses and descriptive statistics, and structural modeling to examine the moderating effect of caregiver abuse history on the relationship between child internalizing problems and familial cohesion. The conceptual model is depicted in Figure 1.

Correlations and descriptive statistics are summarized in Table 3. Caregiver abuse history is positively associated with child internalizing problems ($r(215) = 0.159$, $p = 0.020$) and negatively associated with familial cohesion ($r(215) = -0.271$, $p < 0.001$) suggesting that greater emotional abuse experienced in a caregiver's childhood is related to higher internalizing problems in their children and less family cohesion following CSA. There was also a significant negative correlation between child internalizing problems and familial cohesion ($r(215) = -0.233$, $p = 0.001$) where higher internalizing problems are associated with less familial cohesion.

Data were analyzed with PROCESS, a computation tool for SPSS (Hayes, 2013). Results of the model including unstandardized coefficients and standard errors are depicted in Figure 2. showed neither child internalizing problems nor caregiver history of emotional abuse was significantly related to family cohesion when controlling for the other variables in the model. However, there was a significant interaction between caregiver history of emotional abuse and child internalizing problems as predictors of family cohesion (unstandardized coefficient = -0.014, SE = 0.006, p = .019). A regions-of-significance analysis was conducted, which determines whether there are points along the continuum of the moderator (parent-reported history of emotional abuse) at which the conditional effects of child internalizing problems on family cohesion transition between statistically significant and not significant (Hayes, 2013). Results revealed that less family cohesion was only significantly associated with increased child internalizing problems when scores of caregiver emotional abuse history were 9.4 or higher; the conditional effect at that point was -0.075 (unstandardized), 95% CI [-0.1494, -0.0006]. The final model explained 13.3% of the variance in family cohesion.

Discussion

Providing support for previous research, significant associations were found between caregiver history of emotional abuse and child internalizing problems such that greater emotional abuse history is related to more significant internalizing problems. Additionally, caregiver history of emotional abuse is associated with less familial cohesion. Lastly, child internalizing problems were also significantly linked to less familial cohesion. This highlights the importance that the familial environment, including caregiver abuse history, can have on CSA youth outcomes.

It was hypothesized that child internalizing problems were only related to familial cohesion when caregiver abuse history was moderate or high; however, results from the analyses suggest that this relationship is significant at moderately low (CTQ = 9.4) levels of caregiver childhood emotional abuse as well. This suggests that caregiver emotional abuse history has a greater impact on the relationship between child internalizing problems and familial cohesion than initially predicted. Given that the average score on the childhood trauma questionnaire (CTQ) in our population was a 12.05 (categorized as moderate in the CTQ), this relationship is significant for the majority of our clinical sample.

Though child internalizing problems were significantly correlated with familial cohesion, when controlling for other variables in the model, this relationship is not found. However, this path became significant at moderately low, moderate, and high levels of caregiver emotional abuse history. Therefore, this suggests that caregiver history of emotional abuse may function as a mechanism that influences how CSA victims' internalizing problems impact familial cohesion.

This study has significant clinical implications and provides support for concurrent treatment to children and their caregivers. Research has shown that childhood abuse can have lasting effects that impact other realms of a person's life including attachment, functioning, and emotional regulation, which as previously mentioned can be exacerbated through life stressors. Thus, caregivers with an abuse history may not be equipped to support their sexually abused children and are in need of coping, emotional regulation, and trauma processing skills as well. These results also provide additional topics to address in intervention practices. Treatment programs should include both youth and caregivers and address parental histories of trauma, child internalizing problems, and include advice on how to promote positive familial environments.

Parent-child interaction therapy, trauma-focused cognitive behavioral therapy, and Project SAFE all acknowledge and incorporate the need for concurrent treatment for youth and their underserved caregivers. They represent exemplary models utilizing education, coping and management techniques, and promoting safe familial environments. The results of this study give support for intervention program applying those techniques.

Limitations and Future Research

Limitations of this study include the inability to causally interpret results due to the non-experimental nature of the data collection (i.e. no random assignment or manipulation of variables). All variables in this study were measured at the same time-point, so it would be beneficial to analyze this relationship longitudinally. The study was also limited in gender and ethnicity. Replication with a larger sample size and more diverse populations, as well as more males would lead to greater generalizability.

This study used pre-treatment data; follow-up projects could examine this population's post-treatment data in order to effectively evaluate Project SAFE treatment. This study also focused exclusively on caregiver emotional abuse history, but further exploration into the relationship between other caregiver abuse history and their offspring's CSA would be beneficial. Additionally, there is high co-occurrence between internalizing problems and externalizing problems, so replication exploring both would offer additional insight.

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Table 1

Summary of Caregiver Demographics.

Variable		Descriptive Statistics
Gender	Female	187 (86.9%)
	Male	28 (13.1%)
Ethnic Affiliation	European American	182 (87.9%)
	Hispanic American	12 (5.8%)
	African American	4 (1.9%)
	Bi-Racial	4 (1.9%)
	Other Ethnicity	6 (2.5%)
Parentage	Biological Mother	162 (78.3%)
	Biological Father	20 (9.7%)
	Other	50 (12.0%)
Household Income	$15,000 or less	57 (29.1%)
	$15,000-$25,000	22 (11.2%)
	$25,000-$40,000	42 (21.4%)
	$40,000-$60,000	31 (15.8%)
	$60,000-$100,000	29 (14.8%)
	$100,000 or more	14 (7.1%)
Marital Status	Married	101 (49.8%)
	Divorced	62 (30.5%)
	Separated	23 (11.3%)
	Never married, cohabitating	10 (4.9%)
	Never married, not cohabitating	6 (3.0%)
Age	Range: 23-72 years	M = 37.80 SD = 8.09

Table 2

Summary of Youth Demographics and Abuse Characteristics.

Variable		Descriptive Statistics
Gender	Female	173 (80.1%)
	Male	43 (19.9%)
Race/Ethnicity	European American	156 (79.6%)
	Hispanic American	9 (4.6%)
	African American	10 (5.1%)
	Bi-Racial	11 (5.6%)
	Other Ethnicity	10 (5.1%)
Age of Youth	Range: 4-19 years	*M* = 11.31 *SD* = 3.31
Number of Perpetrators	1	177 (88.1%)
	2	18 (9.0%)
	3	5 (2.5%)
Relationship to Perpetrator	Intrafamilial	113 (57.0%)
	Extrafamilial	85 (43.0%)
Gender of Perpetrator	Female	2 (1.0%)
	Male	199 (99.0%)
Age of Perpetrator	Range: 4-80 years	*M* = 27.18 *SD* = 14.01

Table 3

Descriptive Statistics and Correlations.

	Child Internalizing Problems	Caregiver Abuse History	Family Cohesion
Child Internalizing Problems	-		
Caregiver Abuse History	0.159*	-	
Family Cohesion	-0.233***	-0.271***	-
M	60.11	12.09	37.22
SD	11.48	5.96	6.25
N	215	215	215

*$p < 0.05$ **$p < 0.01$ ***$p < 0.001$

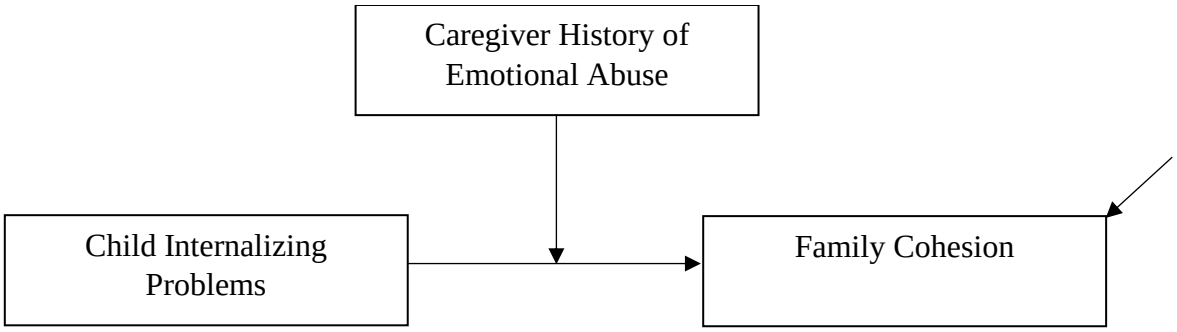
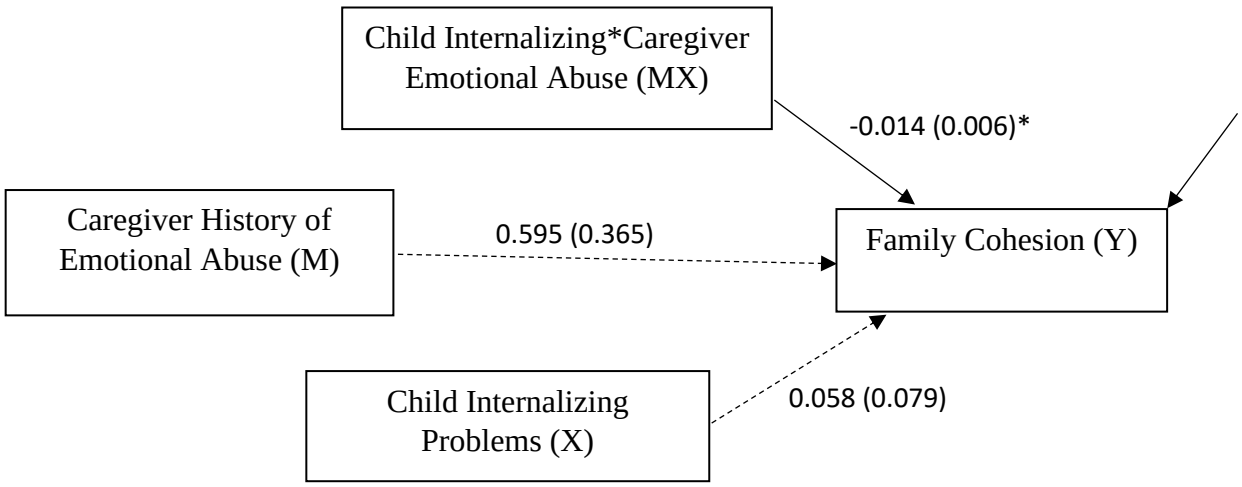


Figure 1

Conceptual Model: Caregiver Emotional Abuse History Moderates the Relationship Between Child Internalizing Problems and Family Cohesion.



*$p < 0.05$ **$p < 0.01$ ***$p < 0.001$

Figure 2

Conceptual model with unstandardized coefficients (SEs). Caregiver emotional abuse history moderates the relationship between child internalizing problems and family cohesion. Child internalizing problems was negatively associated with family cohesion when caregiver emotional abuse history scores were 9.4 or higher; the conditional effect on that point on the continuum was -0.075 (unstandardized), 95% CI [-0.1494, -0.0006]. Solid lines indicate significant paths ($p < 0.05$) and dashed lines indicate nonsignificant paths ($p < 0.05$).