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Transgenerational Trauma: How Caregiver Trauma Predicts Trauma of the Child Within the University of Chicago's REACT Clinic Patient Population

By:

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Abstract

Community violence is a pervasive problem that disproportionately affects low-income families of color. Chronic exposure to violence impacts a person's social, emotional, and physical health and is often passed down through generations. The present study aimed to explore the ways in which the caregiver's trauma subsequently impacts their offspring's trauma history. Medical charts of 118 patients seen at the University of Chicago Medicine's Recovery & Empowerment After Community Trauma (REACT) Clinic were utilized to determine the trauma histories of youth and their caregivers. The results indicated that the trauma histories of mothers are associated with the trauma histories of their offspring and that certain psychiatric diagnostic categories children are placed into are correlated to the mother's trauma as well. Future research to create a more thorough understanding of the phenomenon of transgenerational trauma in underserved communities and populations is needed to best inform the clinical approaches of assisting patients with deep-rooted histories of trauma.

Introduction

Community violence in the United States is considered a public health concern that significantly impacts children, adolescents, and their families. Decades of research have highlighted the disruptive effects of community violence on child development as well as the adverse effects on communities as a whole (Centers for Disease Control and Prevention, 2021; Chen et al., 2017; Clark et al., 2008).

Community violence is characterized by interpersonal acts of violence such as assaults, homicides, sexual abuse, and gang wars, that causes substantial harm and more frequently occurs racially segregated and impoverished areas (Centers for Disease Control and Prevention, 2021; National Child Traumatic Stress Network, n.d.; Ujima The National Center on Violence Against Women in the Black Community, n.d.). Exposure to community violence can occur through direct personal victimization, witnessing another individual or group's victimization, or hearing about violence within one's community (Chen, 2010). Children and adolescents who experience high levels of community violence report more fears, internalizing behaviors, post-traumatic stress, anxiety, and negative life experiences than those in areas of lower community violence exposure (Cooley-Quille et al., 2001).

The history of racial and economic disparities in community violence exposure and health outcomes is well-documented (Stolbach & Anam, 2017). For example, gun violence results in over 33,000 deaths annually in the U.S., with the majority of the deaths befalling individuals in economically segregated areas with high poverty rates (Fredrick, 2018). A study conducted by Zimmerman & Messner (2013) found that in Chicago the likelihood of being exposed to violence was was 74% higher for Hispanic and 112% higher for Black youths compared to their White same aged peers. Racial and economic segregation has commonly

been associated with violent crime, with communities of color facing the consequences most significantly (Krivo et al., 2009; Siegler & Rogers, 2020), especially in Chicago, Illinois (Fredrick, 2018, McCrea et al., 2019).

Where one resides can contribute to life expectancy, chances of experiencing violence, socioeconomic status, and overall health (Fredrick, 2018). According to data collected in 2018, Chicago, Illinois, is the third most racially segregated city in the United States (Fredrick, 2018). Community violence in Chicago is linked with poverty and inequity, primarily created by racial segregation within the city's neighborhoods (Fredrick, 2018; Siegler & Rogers, 2020). In Chicago, the location one grows up in, plays a role in their life path and whether one will be bound to experience poverty and be exposed to violence (Fredrick, 2018). The Chicago Police Department's most recent annual report for 2020 documented 26,038 reported incidents of violent crime in the city, and especially of note, a 55.24% increase in criminal homicide reports since the previous year (CPD, 2020). Thus, with Chicago, Illinois, as a U.S. city with high levels of violence and racial and economic segregation, it is an appropriate location to center investigation on the adversities that occur as a result.

Transgenerational Trauma

According to the American Psychological Association, "trauma is an emotional response to a terrible event" (APA, n.d). Transgenerational trauma, also referred to as intergenerational trauma, is defined as trauma passed down from one generation to the next in the form of attitudes, behaviors, experiences, and genetics (Mohn, 2020; Suah & Williams, 2021). The theory of transgenerational trauma is based on observations that populations subjected to long-term mass trauma display a higher prevalence of disease, even after multiple generations have passed since the initial traumatic event (Sotero, 2006). Further, transgenerational trauma

can present as maladaptive social and behavioral patterns generated as a result of the trauma experience that is transmitted as learned behavior over generations (Sotero, 2006).

The after-effects of significant historical events such as the Holocaust or other genocides allowed for a focus on the concept of historical trauma (Lev-Wiesel, 2007). These studies show that children whose parents experienced trauma are at risk of developing emotional, cognitive, and behavioral issues, including post-traumatic stress disorder (PTSD) and anxiety (Aviad-Wilchek et al., 2013; Felsen, 1998; Grand & Salberg, 2021; Scharf, 2007). The progeny of parents exposed to stress or trauma may be at a greater risk for physical, cognitive, behavioral, and mental health issues than children of non-trauma-exposed parents (Bowers & Yehuda, 2016). In a study of the Lakota Native American tribe, findings showed that features of trauma experienced by descendants of genocides, massacres, and displacement were characterized by a feeling of being acutely aware of one's generational trauma, having anger and concern towards one's aggressive impulses, experiencing impaired bonding due to neglect and abandonment, transposition and identification with the dead, survivor's guilt, self-destructive behaviors, suicidal ideation, and somatic symptoms (Brave Heart, 2000). Trauma passed down through generations can also result in high rates of child and domestic violence, alcoholism, mood and trauma-related disorders, among a variety of health disparities and physiological and psychological problems (Brave Heart & DeBruyn, 1998; Mohatt et al., 2014). Connections between transgenerational trauma and the Latinx community have also been explored, as they represent a group that is particularly vulnerable due to colonialism, political unrest, and stressors related to migration; findings suggest that ongoing structural violence allows for the Latinx community to be vulnerable to intergenerational trauma (Cerdeña et al., 2021). Transgenerational trauma can be observed in exploring pregnancy and fetal development as well,

with research on the impacts of poor mental health during pregnancy due to maternal trauma demonstrating cognitive, emotional, and behavioral developmental effects on youth (Roy, 2014).

African Americans have had to face long-lasting impacts of trauma derived from slavery, racism, and discrimination that can manifest across generations (Williams-Washington & Mills, 2016). Even with slavery being legally terminated over a century ago, countless other traumatic events such as massacres, unethical medical experiments, the school-to-prison pipeline, and police brutality, the generations of psychological impacts on African Americans remain salient (Williams-Washington & Mills, 2016). In efforts to better understand how historical traumas are transmitted to subsequent generations, three phases have been described: first, a dominant group inflicts mass trauma on non-group members that cause societal, economic, and cultural devastation to befall them; next, the minority group has a psychological reaction to the trauma that can have physiological and social complications, and third, later generations are negatively impacted (Sotero, 2006). Racism and discrimination, as a result, can affect health, and intensive investigation into the concept of transgenerational trauma as it pertains to racial and ethnic groups in the United States could provide insight into eradicating health disparities (Sotero, 2006; Williams & Mohammed, 2008).

Racism & Community Violence

Racism is defined as the discrimination of a person or people based on their belonging to a specific ethnic or racial group that can impact them on an individual or larger systemic level, including institutional policies and social norms (CDC Health Equity, 2021; Mohn, 2021). The impacts of racism, both interpersonal and structural, negatively affect the mental and physical health of millions and are classified as a public health crisis (CDC Health Equity, 2021). Health inequities between Whites and African Americans in the United States are seen when

stress-related biological mechanisms linking racism and health in African Americans are examined (Goosby et al., 2018). The impacts of racism and discrimination prompt a cascade of biological processes that cause higher levels of stress hormones measured in African Americans than in Whites which can stimulate a variety of morbidities and negative health trajectories (Goosby et al., 2018). Poor psychological outcomes are also seen when examining race-related stress (Franklin-Jackson & Carter, 2007).

Residential racial segregation, a historical example of structural racism preserved today, impacts a variety of factors, including employment and education, thereby affecting health, well-being, and exposure to violent crime (Krivo et al., 2009; Williams & Collins, 2001). Economically disadvantaged areas are often characterized by low-quality schools, poor health, low salaries, and insecure employment, which serve as disadvantages tying urban poverty to crime and violence (Gaitán-Rossi & Velázquez Guadarrama, 2021). The connections between poverty and racial segregation among the U.S. Black community and violent crime seal them into contexts that offer little mainstream economic, political, and cultural opportunities (Massey, 1993), as social capital and income inequality are robust predictors of violent crime in the U.S. (Anser et al., 2020). The unique position held by Whites in the U.S. aids in their ability to live in the most advantaged areas, while African Americans and Latinxs are more likely to live in the most disadvantaged urban neighborhoods where they experience the most community violence (Krivo et al., 2009). The roots of violence are tied to economic inequalities and the disadvantages of poverty that cause strain and disorganization (Blau & Blau, 1982; Hannon, 2002). In racially segregated areas, youth are more likely to face economic inequality, increasing their risk of exposure to community violence and trauma (Stolbach & Anam, 2017). Exposure to racial discrimination as a form of violence and concurrent exposure to other types such as

domestic or community violence may be chronic sources of trauma that negatively influence the health outcomes of children and adolescents (Sanders-Phillips, 2009).

There exists a need to investigate the ties between community violence and transgenerational trauma within underserved communities of color to supplement the minimal literature on the topic. How racism contributes to poor overall health outcomes and transgenerational trauma and how racial and economic segregation are triangulated with community violence, create compounded mental health disparities that should be examined.

The Present Study

This study was conducted using data from the University of Chicago Medicine Recovery & Empowerment After Community Trauma (REACT) Clinic. The REACT Clinic is composed of a multidisciplinary team made up of social workers, psychologists, and psychiatrists who provide a trauma-informed assessment to individuals and families recently exposed to community violence. The REACT program primarily services Black and Brown youth and families that reside on Chicago's south side. This study aimed to broadly explore the concept of transgenerational trauma related to patients treated at the University of Chicago Medical Center through patient chart review. More specifically, the goal was to investigate how the trauma experienced by the caregiver predicts youth offspring trauma exposure and subsequent mental health diagnoses.

Methods

Subjects

A retrospective medical chart review was conducted using data collected from patients who participated in psychological and psychiatric needs assessment services at the REACT

Clinic from January 17, 2017, through the end of January 2022. Charts were reviewed for 118 children and adolescents seen through the REACT Program and some who participated in both the REACT Clinic and The Child and Family Traumatic Stress Intervention (CFTSI). The majority of patients seen are Black and Brown youth, aged from four to twenty-three years old. The exclusion criterion for this study was patients not seen through the REACT Clinic at the University of Chicago. As a retrospective chart review study, this research presented no risks to participants; patient chart information was de-identified, and any identifying information such as names and birth dates were redacted. Unique identifiers were used for each subject in order to connect them to their caregiver and maintain confidentiality. This study was approved by the Institutional Review Board of the University of Chicago Biological Sciences Division.

Procedure

Data for this study was collected through the University of Chicago Medicine's electronic health records and clinical charts stored in the medical record software, Epic. Patient medical charts contained extensive trauma histories, psychotherapy notes from therapy services provided by REACT staff, patient diagnoses, some caregiver trauma information, and general demographics about each patient. Additional information was extrapolated from questionnaires posed to patients and caregivers, such as the UCLA PTSD Reaction Index, Trauma Symptom Checklist for Young Children, Community Violence Exposure Checklist, and the PCL-5 (See Appendix A & B). These questionnaires provided details about child and caregiver trauma that supplemented patient charts.

From the medical charts and questionnaires, the demographic information gathered is as follows: patient age at the time of the first encounter with the REACT Clinic, age group, race/ethnicity, sex, education, insurance type, city/state of residence, and zip code. The clinical

variables collected about the patient were: the start date of treatment, treatment recommendations from REACT providers, patient's specific trauma exposures, the total number of patient trauma exposures endorsed, the patient's UCLA PTSD Reaction Index score, the patient's Trauma Checklist for Young Children total score if applicable, patient symptoms, and the patient's DSM-5 diagnosis and DSM-5 diagnostic categories. Patients of the REACT Clinic typically receive a formal diagnosis in their chart on the first or second meeting with REACT staff; however, as diagnoses are susceptible to change over time, such as how Adjustment Disorder or Acute Stressor Disorder can become Post-traumatic Stress Disorder when the amount of time since the traumatic event and the patient exhibiting symptoms is lengthened, this study collected data on the diagnosis given by clinicians in their last note. Fourteen possible diagnostic categories within the DSM-5 were considered for this population and are as follows: (1) Neurodevelopmental, (2) Depressive, (3) Anxiety, (4) Bipolar and Related, (5) Obsessive-Compulsive and Related, (6) Trauma- and Stressor-Related, (7) Dissociative, (8) Somatic Symptom and Related, (9) Feeding and Eating, (10) Sleep-Wake, (11) Parasomnias, (12) Disruptive, Impulse-Control, and Conduct, (13) Substance-Related and Addictive Disorders, (14) Neurocognitive, (15) Other. Some categories within the DSM-5 were excluded, such as Schizophrenia Spectrum and Other Psychotic Disorders, Personality Disorders, Paraphilic Disorders, and Sexual Dysfunctions, as they are not applicable to this population or are uncommon. Diagnostic categories represent valuable data to collect due to the fact that each category encompasses multiple specific diagnoses and can more accurately display the distribution of patients' diagnoses.

Patients' trauma histories were collected by indicating which experiences from a list they endorsed based on combining the Adverse Childhood Experiences (ACES), Trauma Exposures

from the UCLA PTSD Reaction Index, and the Community Violence Exposure Checklist (See Appendix A & C). This list encompassed 53 specific types of traumatic experiences (see Appendix D for the entire list). In addition to gathering information on which traumatic stressors/ACES/community violence exposures were endorsed by each patient, the 53 individual types were divided into categories to avoid redundancy. The categories included the following: (1) Witnessed violence in the community, (2) Victim of violence in the community, (3) Victim of domestic violence, (4) Witnessed domestic violence, (5) Childhood traumatic stressors, (6) Other lifetime traumatic stressors, (7) Traumatic loss, (8) Homelessness, (9) Other childhood adversity (see Appendix E for which traumatic stressors/ACES/community violence exposures were identified for each category). Endorsement of any of the specifiers that fall into a category would be conveyed by indicating endorsement for the category. This study also collected the total number of types of community violence exposure for each patient. The maximum number of types was four in total, including gun violence, physical violence, stabbing, and school violence. Additionally, the total number of ACES a patient endorsed was collected (see Appendix C for the ACES attended to at REACT).

The parent and caregiver variables included specific trauma exposures endorsed, the total number of trauma exposures, and the biological parent or caregiver's score for the PTSD PCL-5 if known. The trauma histories of mothers, fathers, and other caregivers of REACT patients (such as relatives or adoptive parents) were gathered through a mix of self-reports, family histories collected by clinicians during psychological and psychiatric needs assessments, and information provided by the patient or another caregiver about the biological parents. This information was detailed in the patient's chart and was examined note-by-note for this study and supplemented through questionnaire responses. To better understand the possibility of an

association between mothers' trauma histories and the child's trauma histories, it was necessary to also situate the traumatic stressors/ACES/community violence exposures endorsed by mothers into the same nine distinct categories created for the patients to decrease the amount of redundancy. These categories are as follows: (1) Witnessed violence in the community, (2) Victim of violence in the community, (3) Victim of domestic violence, (4) Witnessed domestic violence, (5) Childhood traumatic stressors, (6) Other lifetime traumatic stressors, (7) Traumatic loss, (8) Homelessness, (9) Other childhood adversity (see Appendix E for which traumatic stressors/ACES/community violence exposures were identified for each category). If the mother experienced any of the specifiers that fall into a category, it would be conveyed by indicating endorsement for the category.

Data Analysis

For this study, the statistical analyses included descriptive statistics to describe and summarize the data of the REACT patients and their caregivers and correlational and linear regression analyses to examine the trauma histories of both the patient and the parent. Descriptive statistics, including frequencies and percentages, were calculated for each demographic variable, such as race/ethnicity, sex, and age of the patients seen through REACT. Information about diagnoses and diagnostic categories was also studied. Further, to gain a better understanding of what specific traumatic events and stressors are experienced by this population seen at REACT, the frequency of each type of traumatic event was assessed. Additionally, the frequencies of mothers, fathers, and other caregivers who endorsed traumatic events and stressors were also determined. Along with this, the average number of total categories endorsed, total ACES, and total number of community violence types were determined for patients and mothers.

Further, Pearson 2-tailed correlations and linear regression were used to generate results about how parents' trauma exposure relates to a child's trauma exposure and diagnosis. In order to investigate how the trauma experienced by caregivers predicts youth offspring trauma exposure, a linear regression was run with the predictor of the total number of mother's traumatic stressors/ACES/community violence categories endorsed exposures and the child's total number of traumatic stressors/ACES/community violence exposures as the dependent variable. To account for shared trauma history determined in patient charts, such as a mother and child witnessing a shooting together, the linear regression run also included a variable of total categories endorsed by the mother independent of shared trauma with their child.

To examine the diagnosis portion of the hypothesis and how caregivers' trauma histories may be associated with the complexity of a child's diagnostic outcome (indicated by the number of diagnoses a patient has), Pearson 2-tailed correlations were generated. The Pearson 2-tailed correlations assessed the following variables: the total number of categories of trauma types the mother endorsed, the total number of diagnoses the child received at REACT, and each diagnostic category. The statistical threshold used to assess the results was an alpha level of 0.05. Descriptive statistics, Pearson 2-tailed correlations, and linear regressions were generated by SPSS version 28.0.1.1 (14).

Results

REACT Clinic Patient Demographics & Descriptives

This investigation reviewed the medical charts and corresponding questionnaires of 118 patients seen at the REACT Clinic. Patients' ranged from four to twenty-three years of age (M = 13.64, SD = 4.117). Table 1 displays the breakdown of ages by developmental category.

Table 1

Youth Developmental Category of REACT Clinic Patients

n=118

Ages	Frequency	Percent
5 and under	7	5.9
6-8 years old	7	5.9
9-11 years old	19	16.1
12-14 years old	27	22.9
15-17 years old	41	34.7
18-19 years old	10	8.5
20-25 years old	7	5.9
Total	118	100.0

Of the patients seen, 57 were female, and 61 were male (48.3% and 51.7%, respectively). One-hundred-thirteen patients currently reside in Illinois, primarily in Chicago, and five live in Indiana. Of the 118 children and adolescents, 79.7% identified as Black or African American, 9.3% were Hispanic/Latino, 4.2% declined to disclose, 2.5% were White, and 4.2% identified in the "Other" category, typically as Biracial or Multiracial. (See Table 2 for Race/Ethnicity information).

Table 2

Race/Ethnicity Demographics of REACT Patients

n=118

Race/Ethnicity	Frequency	Percent
Black or African American	94	79.7
Hispanic/Latino	11	9.3
Other	5	4.2
Declined	5	4.2
White	3	2.5
Total	118	100.0

Additionally, 55.7% were insured by Medicaid, followed by 28.6% of uninsured patients, and the rest indicated private insurance, such as Blue Cross Blue Shield, Aetna, or Cigna.

Patient Trauma Histories

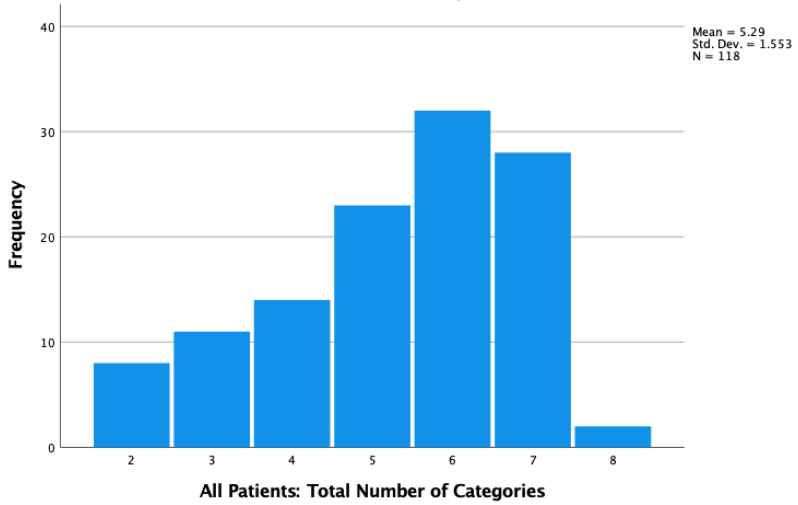
Findings from the patient's endorsements of traumatic stressors/ACES/community violence exposures indicated that the most common type of trauma experienced by this population is community violence, such as hearing gunshots in the neighborhood, witnessing community violence, witnessing or hearing about the violent death or serious injury of a friend or loved one, and themselves or a loved one have been hurt by violence. Specifically of note, out of 118 patients, 63 had at least one family member killed, 53 had at least one close friend killed, and 36 had both a family member and close friend killed. The second most common types were a caregiver being impaired by mental illness or substance abuse and a parental loss through separation or death. In addition to the 53 traumatic stressors/ACES/community violence exposures asked about, the category of "Other" was created to encompass other types of trauma that do not fit precisely with the ones outlined by the ACES or other trauma and community violence questionnaires. "Other" traumas were indicated through questionnaires or recorded by REACT clinicians. The most common experiences for the "Other" category were bullying and traumatic encounters with police.

The average number of categories a patient endorsed was 5.29 (*SD* = 1.553, *Range* = 2-8). For patients' total number of endorsed ACES, the average number was 3.27 (*SD* = 2.091, *Range* = 0-8). The average number of types of community violence was 2.38 (*SD* = 1.070, *Range* = 0-4). The frequencies for the total number of categories endorsed, the total number of ACES endorsed, and the total number of community violence types endorsed are visible in Figures 1, 2, and 3, respectively. See Table 3 for the frequency of specific category endorsements.

Figure 1

Frequency of Total Number of Traumatic Stressors/ACES/Community Violence Exposure Categories Endorsed by Patients

n=118



Note. The frequency refers to the category endorsement reported by the 118 patients, not how many incidents of specific traumatic events or stressors within that category occurred. For example, a patient may indicate having been shot on multiple occasions and having been stabbed, but it will only be counted once in the category of "victim of violence in the community."

Figure 2

Frequency of Total Number of ACES Endorsed by Patients

n=118

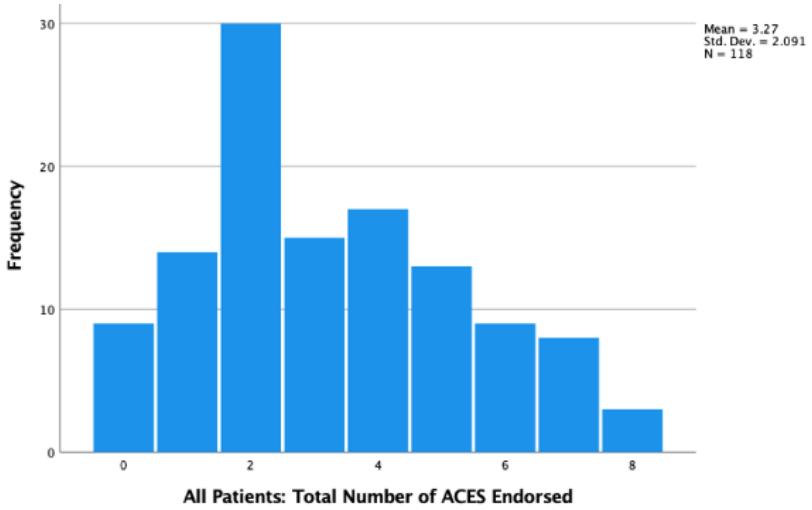
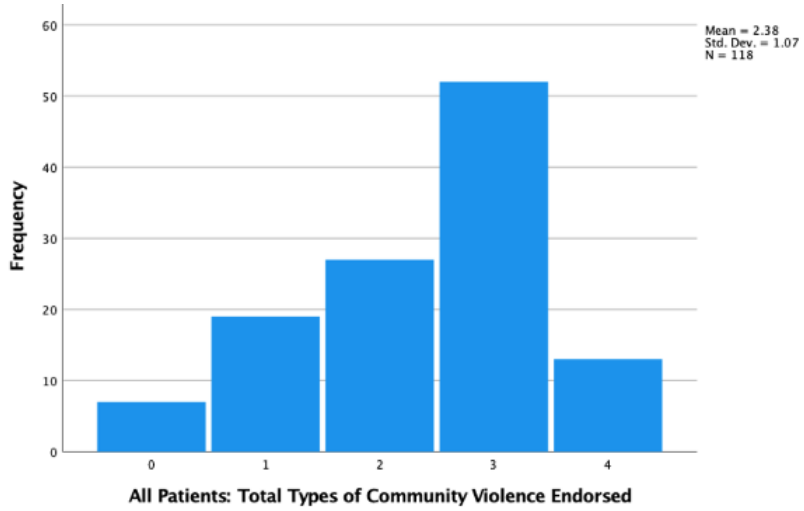


Figure 3

Frequency of Total Number of Types of Community Violence Experienced by Patients

n=118



Note. The number of types of community violence does not reflect the number of each individual instance of community violence a patient may have experienced. For example, a patient may have been shot, witnessed a shooting, and been shot at on three separate occasions, but it would be counted as one type of community violence: gun violence.

Table 3

Frequency of Specific Categories Endorsed by Patients

n=118

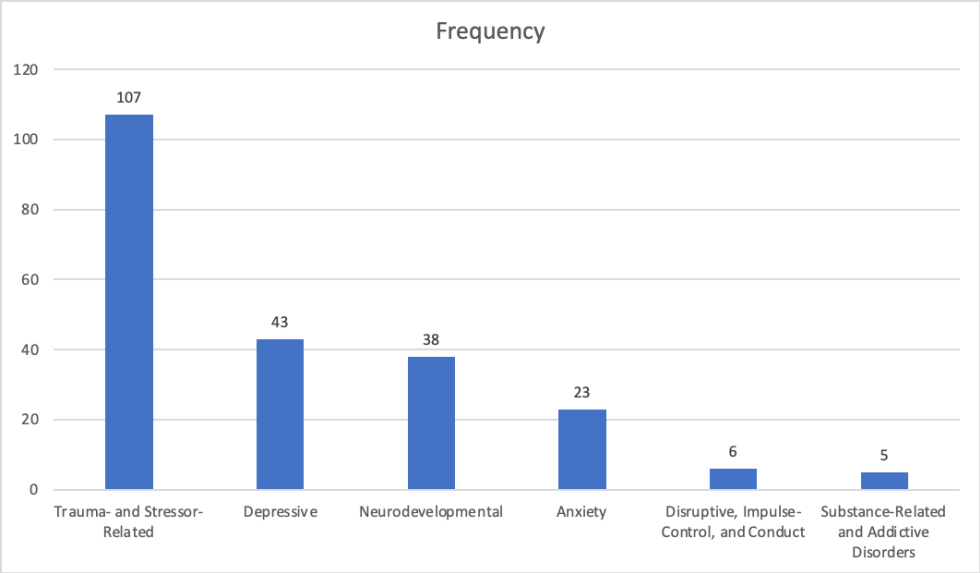
Category	Frequency	Percent
Witnessed violence in the community	111	94.1
Other childhood adversity	105	89.0
Traumatic loss	94	79.7
Victim of violence in the community	85	72.0
Other lifetime traumatic stressors	85	72.0
Childhood traumatic stressors (physical/sexual abuse)	71	60.2
Witnessed domestic violence	45	38.1
Homelessness	23	19.5
Victim of domestic violence	5	4.2

Patient Diagnostic Categories and Diagnoses

Within the diagnostic categories that were included, the most common were: Trauma- and Stressor-Related (*n*=107), Depressive (*n*=43), and Neurodevelopmental (*n*=38).

Figure 4

Diagnostic Categories



Note. This figure only displays the diagnostic categories that were represented at least once in patient charts.

Patients often had more than one diagnosis determined by REACT clinicians, and in some cases, up to five in total ($M = 1.97$, $SD = 0.938$). The most common diagnosis among all patients was PTSD. As seen in Table 4, there appears to be some overlap in specific diagnoses. For example, there are multiple diagnoses that would fit into the diagnostic category of "Anxiety," such as "Anxiety disorder unspecified" and "GAD." This discrepancy lies in the lack of consistency in clinicians reporting patient diagnoses. Table 4 is included to display the scope of diagnoses given to REACT patients.

Table 4

Specific Diagnoses Given to REACT Patients

Diagnosis	Frequency
PTSD	59
ADHD	32
Trauma-and Stressor Related Disorder	26
MDD	24
Other Specified Trauma-and Stressor Related Disorder	14
Anxiety Disorder Unspecified	12
Unspecified Trauma-and Stressor Related Disorder	6
GAD	5
Adjustment Disorder	4
Adjustment Disorder with Anxiety and Depressed Mood	3
Depression Unspecified	4
Depression	3
Unspecified Mood Disorder	3
ODD	3
ASD	3
Cannabis Use Disorder	3
Substance Use Disorder	2
Depressive Disorder	2
Panic Disorder	2
Adjustment Disorder with Depressed Mood	2
No Diagnosis Given	2

Note. Many diagnoses were only represented once in patient charts and thus were not included in Table 4. The diagnoses omitted are: ADHD-C, Adjustment disorder with mixed disturbance of emotions and conduct, PTSD with dissociative symptoms, Complex PTSD, Disruptive mood dysregulation disorder, MDD unspecified, MDD with psychosis, Anxiety disorder, Impulse, control disorder, Learning disorder, Learning disabilities, Inattention, Academic underachievement, Disruptive behavior disorder, Cognitive development delays, Anxiety with somatic features, Cannabinoid hyperemesis, Unspecified binge eating disorder, Alcohol use disorder, Subthreshold OCD. Additionally, the two instances where no specific diagnosis was given apply to the two patients who did not return to the REACT clinic for feedback after their initial psychological and psychiatric needs assessment.

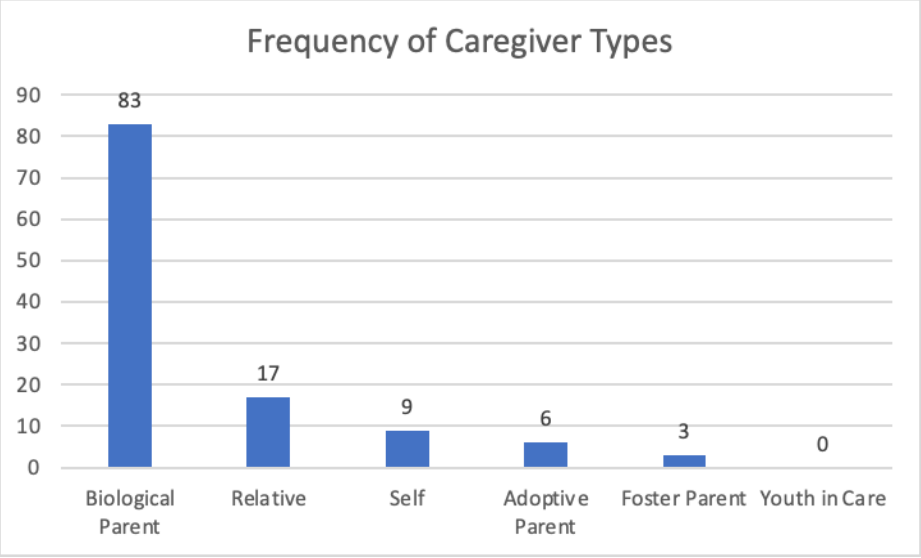
Parent/Caregiver Trauma Histories

The categories for the type of caregiver that accompanied a patient were: (1) Adoptive Parent, (2) Biological Parent, (3) Foster Parent, (4) Relative, (5) Self, and (6) Youth in Care. If a patient were above the age of 18 and seen at the REACT Clinic without a caregiver, they would be considered in the "Self" category, even if, within their patient chart, it was possible to garner details about the trauma history of their biological parents or caregivers. Figure 5 shows the distribution of caregivers accompanying patients, with biological parents (*n*=83) being the most common caregiver type to be seen at REACT with their child, followed by a relative (*n*=17), self (9), adoptive parent (*n*=6), and foster parent (*n*=3). The category of "Relative" was further investigated and determined that the most common type of relative to accompany a patient was a grandmother (*n*=9) or an aunt (*n*=8).

Figure 5

Caregiver Types Accompanying Patients

n=118



Parent and Caregiver Trauma

It is impossible to provide a complete picture of what each parent or caregiver experienced, as some traumatic stressors may have occurred but could not be accounted for through this chart review. From the information that was gathered, however, this study found trauma information for 66 mothers (for the 68 children who had data for the mother's trauma history, there were two mothers whose children had a sibling also seen at REACT, so data for those two were omitted as to not count each mother twice). The average number of total categories of traumatic stressors/ACES/community violence exposure endorsed by mothers was 1.97 (*SD* = 1.067, *Range* = 1-6). Table 5 displays the frequency for each category.

Table 5

Frequency of Specific Categories Endorsed by Mothers

n=66

Category	Frequency	Percent
Witnessed violence in the community	31	26.3
Victim of domestic violence	29	24.6
Traumatic loss	29	24.6
Other childhood adversity	22	18.6
Victim of violence in the community	12	10.2
Homelessness	12	10.2
Other lifetime traumatic stressors	12	10.2
Childhood traumatic stressors (physical/sexual abuse)	4	3.4
Witnessed domestic violence	0	0

For the 15 biological fathers (excluding 103 of those who had "No Information Found"), the most common specific traumatic stressors/ACES/community were "Been shot at" and "Stabbed." From the information garnered, this study found that out of the 35 other caregivers, trauma history information was determined for only 8 of them. "You or someone you care about was hurt by violence" was the most common endorsement for other caregivers.

Correlations & Linear Regression

Analyses of Trauma

The linear regression indicated that the total number of categories for mothers' traumatic stressors/ACES/community violence exposures was not predictive of the total number of categories for their child's traumatic stressors/ACES/community violence exposures. The results of the regression showed that the predictor variables of the total number of categories for mothers' traumatic stressors/ACES/community violence exposures only explained 9.5% of the variance ($R^2 = 0.095$, $F(2,68) = .579$, $p = 0.450$). It was found that the mother's trauma did not significantly predict child trauma ($\beta = 0.127$, $p = 0.450$). Similarly, when shared trauma between mother and child was accounted for, and a linear regression tested the dependent variable of child's total categories to the predictor of mothers' total categories independent of shared trauma, the results remained insignificant, $p > 0.05$. Thus, the total number of categories of traumatic stressors/ACES/community violence exposures for mothers does not contribute statistically significantly to the total number of traumatic stressors/ACES/community violence exposures for the child, and a prediction cannot be suggested.

In examining the total number of categories that a mother endorsed to compare it to the child's total number of categories, a statistically significant correlation was uncovered using a Pearson 2-tailed correlation analysis ($r(65) = 0.242$, $p = 0.05$).

Analysis of Diagnoses

The complexity of psychiatric presentation can be uncovered by indicating the number of diagnoses a patient has received. As highlighted earlier in the results subsection of "Patient Diagnostic Categories and Diagnoses" and in Figure 4 and Table 4, patients exhibited a variety of diagnoses from REACT clinicians. However, comparing the number of diagnoses a patient

received to the number of categories of traumatic stressors/ACES/community violence exposures endorsed by mothers did not find a statistically significant correlation, $p > 0.05$.

Nonetheless, one statistically significant correlation was noted in completing a correlational analysis that utilizes the specific diagnostic categories and the total number of mothers' endorsements of categories of traumatic stressors/ACES/community violence exposures. A correlation existed between the total number of mother's categories and Substance-Related and Addictive Disorders ($r(68) = 0.388$, $p = 0.01$).

Discussion

This research study sought to explore the concept of transgenerational trauma within the University of Chicago Medicine's REACT Clinic patient population through the process of medical chart review. Two primary hypotheses were outlined for this study; first, that trauma experienced by the caregiver predicts youth offspring trauma exposure, and second, that child's mental health diagnoses are related to trauma exposure of the caregiver.

Overall, the findings were not wholly in line with the hypotheses but shed light on the shortcomings of small-scale medical chart reviews and the lack of standardization of how clinicians evaluate patients. In terms of predicting patient trauma exposure based on that of the parent, a linear regression did not uphold the hypotheses; it was not possible in this study to make such predictions. Much of the imperfection of this review comes from the lack of extensive trauma histories for parents and caregivers, with much of their information not being self-reported; thus, copious details are omitted or unknown completely. Particularly for the parents and caregivers, the entirety of their trauma histories could not be accounted for, as the majority of caregivers who brought in the patients spoke at length about the patient's history and

not their own. What is endorsed by the parents and caregivers in this study is not comprehensive and does not reflect their complete trauma exposure history; it cannot be assumed that specific traumatic events or stressors that were not mentioned did not ever occur. This result lends itself to further investigation of the predictive properties of caregiver trauma history and child trauma history. A large-scale study with more accurate, extensive, and numerous caregiver self-reported histories would potentially allow for a differing result more in line with this study's initial hypothesis about transgenerational trauma in patient populations.

While predictions were not possible given the statistical analyses results, a statistically significant correlation between trauma histories of mothers and children's trauma histories was indicated. Specifically, it was found that the total number of categories of traumatic stressors/ACES/community violence exposures that a mother endorsed was associated with the child's total number of categories of traumatic stressors/ACES/community violence exposures. Although this cannot provide predictions, it can show that trauma from the caregiver is connected to their child's trauma and that the two are not entirely isolated or without association.

The trauma history of mothers was used without including fathers because mothers represented the most common type of caregiver that accompanied patients at REACT. Thus, most information about caregiver trauma histories was collected about mothers. For fathers, while the information about their trauma histories is compelling, there is not enough data collected through this chart review to make strong claims about connections to child's trauma histories. The lack of information about fathers within this type of research on caregiving and trauma transmission reflects their being underrepresented and in need of more focus in future research directions. While the trauma histories of other caregivers that are not biological parents, such as relatives or adoptive parents, are not necessarily able to convey any genetic

predisposition, the information on their traumatic stressors/ACES/community violence exposures is beneficial to know, as it can paint a picture of the patient's environmental factors that may impact a child's development and general information about violence in the community.

Results on the presence of community violence in this patient population confirm previous research on the impacts of living in racially segregated and economically disadvantaged areas. The over 94% frequency of patients endorsing witnessing violence in the community and 72% endorsing being a victim of violence in the community relates to the claim that youth are at high risk of community violence in racially segregated and economically unequal areas (Stolbach & Anam, 2017). These findings also connect to the 107 out of 118 patients diagnosed under the trauma- and stressor-related disorder category, with additional research finding that exposure to community violence can be a chronic source of trauma with negative health impacts on youth (Sanders-Phillips, 2009).

Findings related to patient diagnosis were somewhat conflicting. The absence of a clear standard on how patient diagnoses should be written in charts creates a lack of generalizability in the data that must be noted. There was no statistically significant correlation in comparing the number of diagnoses a patient received to the number of categories of traumatic stressors/ACES/community violence exposures endorsed by mothers. This finding describes that the more or less trauma categories endorsed by mothers do not indicate more or less diagnoses for the child. In other words, the number of diagnoses a child is given could be indicative of a variety of different factors, such as how each clinician chooses to evaluate a patient, which can differ. Diagnoses, when considered as categories instead of a total number of diagnoses, did indicate statistically significant correlations with the total number of mothers' categories for substance-related and addictive disorders. Revisiting or adding to the literature on parent trauma

and child substance-related and addictive disorders could help describe this phenomenon, such as with research from Brave Heart et al. and Mohatt et al., that indicated that trauma passed down could result in high rates of alcoholism among a variety of other health disparities and psychological issues (1998, 2014). These findings support the idea that children whose parents are exposed to trauma have a greater risk of developing PTSD and other mental health issues (Aviad-Wilchek et al., 2013; Bowers & Yehuda, 2016; Felsen, 1998; Grand & Salberg, 2021; Scharf, 2007). Future directions of investigation may look more closely at what specific traumatic stressors/ACES/community violence exposures experienced by parents could be associated with the presentation of substance abuse issues in youth, among other types of diagnostic categories.

In general, the drawbacks of a chart review study and the lack of information on caregivers did not allow for the best chance of finding results that confirm this study's hypotheses. However, this study did display a clear direction for future lines of research to further enrich the literature on transgenerational trauma, especially in underserved communities and areas. Specifically, suppose future studies were able to collect complete information on caregivers' trauma histories. In that case, claims could be made for predictive features of the trauma exposures of parents and their offspring and how transgenerational trauma translates into psychiatric diagnosis in children. Findings in that realm could suggest advantages for psychiatry clinicians conducting more thorough background and family histories on children presenting with trauma to better understand how transgenerational trauma manifests in individuals, families, and communities.

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Appendix A: Questionnaires Used at REACT for Patient Trauma Histories Utilized in this Study

UCLA PTSD Reaction Index for Children/Adolescence

1. Natural disaster
2. Bad accident
3. Exposed to war
4. Physical abuse
5. Witness to physical abuse
6. Beaten up, shot at, or threatened to be badly hurt
7. Witness to someone beaten up, shot at, or killed
8. Seen a dead body
9. Sexual molestation/rape
10. Witness to or heard about the violent death/serious injury of a loved one/friend
11. Painful or scary medical treatment
12. Loss of a loved one
13. Other

Community Violence Exposure Checklist - Youth

1. Impaired caregiver
2. Exposure to prostitution or other developmentally inappropriate sexual behavior or material in the home
3. Exposure to criminal behavior in the home
4. Neglect
5. Foster placement

6. Substitute care
7. Homelessness
8. Incarceration
9. Incarceration of family member or significant other
10. Family member gang affiliation
11. Death of family member or significant other
12. Unresolved trauma history in caregiver
13. Emotional/psychological abuse
14. Witnessing school violence
15. Burned
16. Physical abuse
17. Witness to physical abuse
18. Direct victim of violent crime in the community
19. Exposure to domestic violence
20. Traumatic loss
21. Witnessing community violence
22. Sexual victimization
23. Fire
24. Witnessing homicide
25. Natural disaster
26. Motor vehicle accident
27. Dog attack
28. Medical trauma

29. Abduction
30. Torture
31. Self or loved one hurt by violence
32. Witnessed shooting
33. Shot or shot at
34. Witnessed jumping or beating
35. Jumped or beaten
36. Witness to stabbing
37. Family member killed
38. School mate killed
39. Close friend killed
40. Gunshots in neighborhood
41. Injured someone in a fight without weapons
42. Injured someone with a knife
43. Injured someone with a gun
44. Carried a gun for protection
45. Gang affiliation
46. Other

Appendix B: Questionnaires Used at REACT for Caregiver Trauma Histories Utilized in This Study

Community Violence Exposure Checklist - Caregiver

1. Impaired caregiver
2. Exposure to prostitution or other developmentally inappropriate sexual behavior or material in the home
3. Exposure to criminal behavior in the home
4. Neglect
5. Foster placement
6. Substitute care
7. Homelessness
8. Incarceration
9. Incarceration of family member or significant other
10. Family member gang affiliation
11. Death of family member or significant other
12. Unresolved trauma history in caregiver
13. Emotional/psychological abuse
14. Witnessing school violence
15. Burned
16. Physical abuse
17. Witness to physical abuse
18. Direct victim of violent crime in the community
19. Exposure to domestic violence

20. Traumatic loss
21. Witnessing community violence
22. Sexual victimization
23. Fire
24. Witnessing homicide
25. Natural disaster
26. Motor vehicle accident
27. Dog attack
28. Medical trauma
29. Abduction
30. Torture
31. Self or loved one hurt by violence
32. Witnessed shooting
33. Shot or shot at
34. Witnessed jumping or beating
35. Jumped or beaten
36. Witness to stabbing
37. Family member killed
38. School mate killed
39. Close friend killed
40. Gunshots in neighborhood
41. Injured someone in a fight without weapons
42. Injured someone with a knife

43. Injured someone with a gun
44. Carried a gun for protection
45. Gang affiliation
46. Other

Life Events Checklist

1. Natural disaster
2. Fire or explosion
3. Serious accident
4. Exposure to toxic substances
5. Physical assault
6. Assault with a weapon
7. Sexual assault/Rape
8. Exposed to war
9. Abduction
10. Life-threatening illness or injury
11. Sudden violent death
12. Sudden accidental death
13. Caused serious injury, harm, or death
14. Other

Appendix C: Adverse Childhood Experiences (ACES) attended to at REACT

1) Physical Abuse
2) Sexual Abuse
3) Impaired Caregiver
4) Incarcerated Family Member
5) Neglect (physical and emotional and medical)
6) Emotional Abuse
7) Untreated Mental Illness in Family
8) Addiction in Family
9) Witness Domestic Violence

Appendix D: Compiled Trauma History Questions

1. Natural disaster (earthquake, wildfire, hurricane, tornado, flood)
2. Exposed to war
3. Tortured
4. Witnessed torture
5. Abduction
6. Bad accident (motor, fall, etc.)
7. Medical trauma
8. Burned
9. Fire
10. Dog attack
11. Physical abuse (hit, punched, or kicked at home)
12. Witnessed physical abuse
13. Emotional/psychological abuse
14. Sexual abuse
15. Witnessed sexual abuse
16. Exposure to prostitution/other developmentally inappropriate sexual behavior or material in home
17. Exposure to criminal behavior in the home (e.g., drugs, weapons)
18. Neglect (physical, medical)
19. Homelessness
20. Impaired caregiver (e.g., depression, mental illness, substance abuse)
21. Unresolved trauma in caregiver

22. Parental loss (like divorce/separation, death)
23. Foster placement
24. Substitute care (not living with bio parent)
25. Incarcerated family member/significant other
26. Family member belonged to street organization
27. Experienced domestic violence
28. Witnessed domestic violence
29. Have you or someone you care about been hurt by violence?
30. Witnessed community violence
31. Direct victim of violent crime in the community
32. Seen school violence
33. Someone at school died due to violence
34. Jumped or beaten up
35. Witnessed jumping or beating
36. Stabbed
37. Witnessed stabbing
38. Gunshots in neighborhood
39. Witnessed shooting
40. Witnessed homicide
41. Been shot at (but not shot)
42. Been shot
43. Seen a dead body
44. Have you injured someone in a fight without weapons?

45. Have you injured someone with a knife?

46. Have you injured someone with a gun?

47. Have you ever carried a gun for protection?

48. Have you belonged to a street organization?

49. Witnessed/heard about violent death/serious injury of a friend/loved one

50. Experienced traumatic loss

51. Close friend killed

52. Family member killed

53. Other trauma

Appendix E: Categories of Traumatic Stressors/ACES/Community Violence Exposures

1. Witnessed violence in the community
    a. Exposed to war
    b. Witnessed community violence
    c. Seen school violence
    d. Witnessed jumping or beating
    e. Witnessed stabbing
    f. Gunshots in neighborhood
    g. Witnessed shooting
    h. Witnessed homicide
    i. Witnessed torture
2. Victim of violence in the community
    a. Direct victim of violent crime in the community
    b. Jumped or beaten up
    c. Stabbed
    d. Been shot at (but not shot)
    e. Been shot
    f. Tortured
3. Victim of domestic violence
    a. Experienced domestic violence
4. Witnessed domestic violence
    a. Witnessed domestic violence
5. Childhood traumatic stressors

   a. Physical abuse (hit, punched, or kicked at home)
   b. Witnessed physical abuse
   c. Sexual abuse
   d. Witnessed sexual abuse

6. Other lifetime traumatic stressors
   a. Natural disaster (earthquake, wildfire, hurricane, tornado, flood)
   b. Bad accident (motor, fall, etc.)
   c. Medical trauma
   d. Burned
   e. Fire/explosion
   f. Dog attack
   g. Other trauma
   h. Abduction
7. Traumatic loss
   a. Experienced traumatic loss
   b. Close friend killed
   c. Family member killed
8. Homelessness
   a. Homelessness
9. Other childhood adversity
   a. Emotional/psychological abuse
   b. Exposure to prostitution/other developmentally inappropriate sexual behavior or material in home

c. Exposure to criminal behavior in the home (e.g., drugs, weapons)

d. Neglect (physical, medical)

e. Impaired caregiver (e.g., depression, mental illness, substance abuse)

f. Unresolved trauma in caregiver

g. Parental loss (like divorce/separation, death)

h. Foster placement

i. Substitute care (not living with bio parent)

j. Incarcerated family member/significant other

k. Family member belonged to street organization