Prevalence and Potential Buffers of Intergenerational Trauma in African American and Latinx Parent-Child Dyads

Kandace Thomas

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ACKNOWLEDGEMENTS

A dissertation, like any other big project, is never a solo endeavor. It takes a team of people working closely with the student, teaching the student, and supporting the student to accomplish the task. There were many people who served in all of these roles for me. Central to the completion and success of this dissertation is my advisor and committee chair Amanda J. Moreno. Amanda has the spirit and substance of a scholar mentor and friend. She continually and consistently mentored this process, actively tutored me, and financially supported this work. Most importantly, Amanda truly believed in this project; she nurtured my interest and helped me trust this bumpy process.

Along with Amanda, I would like to thank my committee members, Jon Korfмacher, Marva L. Lewis, and Noni Gaylord-Harden. It has been an honor to work with and learn from your expertise and knowledge. It has been especially notable to work with Jon and Marva, both of whom I’ve had the privilege of working with in other capacities and have been able to extend our relationship with this project.

This dissertation developed from my deep interest and commitment to further understand intergenerational trauma and its potential buffers. This interest solidified while working with Amanda when she was applying for the United States Department of Education I3 Grant which funded the Calm Classroom Kindergarten - Second Grade (K-2nd grade; CCK2) Research Project. As Amanda’s student, I was involved with CCK2 from the very beginning and was able to build off it to develop my own research study. As part of the CCK2 team, I contributed to the
curriculum, facilitated mindfulness in two schools over three years, and developed and led the Family Engagement work. I am so grateful for the K-2nd grade students I learned from every Monday. I continue to be inspired by their grit, humor and tenderness. I thank their parents and caregivers who attended CCK2 Family Engagement Events to learn more about our work integrating mindfulness into their schools, and especially thank those parents and caregivers who participated in the CCK2 Parent Study, this dissertation. Their voices and faces will forever be etched in my memory. I am thankful for the support and friendship of the CCK2 team, Lisa Wartemberg, Maria Kontoudakis, and Adenia Linker, and all of the CCK2 Facilitators for their support with this project.

Thank you Stephen Baker, Carolyn Vessel and Cynthia Cook-Connelly for graciously offering me a space to collect data. Stephen, thank you for all of your help with REDCap and the University of Chicago’s Institutional Review Board. Your time and generosity is greatly appreciated. Thank you Erika Gustafson, David Doan, and notably Malika Gujrati for all of your help with quantitative analysis. I thank Jeanette Banashak and Yvette Camacho for your careful work translating materials into Spanish. Thank you to the parents who participated in the pilot focus group to test the feasibility of the survey packet.

Thank you Irving Harris Foundation for exposing me to the world of infant and early childhood mental health that helped inspire some of this work.

And, finally, thank you to my friends and family who supported me through this process. I really appreciate all of you for listening to me, answering my random questions, encouraging me, coaching me, and for all of your support and brilliance during this time.

I am honored by all of you who contributed to this project.
For the students and their families in the Chicago Public Schools
Calm Classroom Kindergarten - 2nd Grade Project
If we carry intergenerational trauma (and we do), then we also carry intergenerational wisdom.

—Kazu Haga
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<table>
<thead>
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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACEs</td>
<td>Adverse Childhood Experiences</td>
</tr>
<tr>
<td>BPM-P</td>
<td>Brief Problem Monitor - Parent</td>
</tr>
<tr>
<td>CBCL</td>
<td>Child Behavior Checklist</td>
</tr>
<tr>
<td>CCK2</td>
<td>Calm Classroom Kindergarten - 2nd Grade Project</td>
</tr>
<tr>
<td>CSC</td>
<td>Contemplative Self-Care</td>
</tr>
<tr>
<td>CTE</td>
<td>Child Traumatic Effects</td>
</tr>
<tr>
<td>FFMQ</td>
<td>Five Facet Mindfulness Questionnaire</td>
</tr>
<tr>
<td>IGT</td>
<td>Intergenerational Trauma</td>
</tr>
<tr>
<td>mACEs</td>
<td>Modified Adverse Experiences Survey/Family Stressful Experiences Survey</td>
</tr>
<tr>
<td>PSAM</td>
<td>Parenting Self-Agency Measure</td>
</tr>
<tr>
<td>RCT</td>
<td>Randomized Controlled Trial</td>
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ABSTRACT

Buffering intergenerational trauma (IGT) is of great interest to researchers, policy makers and interventionists working to reduce the experience of trauma across generations within the family. IGT has been well studied among families who experienced the Holocaust and there is emerging IGT literature describing the impact of historical events and societal-based adverse experiences across generations. This study expanded upon the IGT literature by exploring and confirming the existence of IGT in a sample of primarily low-income African American and Latinx\textsuperscript{1} parents and their 6-year-old children; exploring pre-existing strengths and qualities in parents, such as Contemplative Self-Care (CSC) and Parent Self-Efficacy as IGT buffers; and, exploring parents’ mindful-like behavior that may help reduce stress and trauma in their families. This study broke new ground as one of the first to describe the prevalence of IGT with a quantitative index signifying overlap in trauma between parents and children. It was also one of the first to explore parent traits as potential reducers of IGT and one of the first to intentionally integrate sociocultural context trauma items in a modified Adverse Childhood Experiences measure. A sample of 109 caregivers participated in this mixed methods study employing quantitative surveys and 60-minute qualitative interviews. The study found a high prevalence of IGT in this sample. The study did not find evidence for CSC as a moderator or buffer of IGT, although Parent Self-Efficacy partially mediated the relationship between child trauma and child negative behavior, suggesting that child trauma may impact parenting, even though the direction

\textsuperscript{1}The use of pronouns will be inclusive of all gender identifications and expressions.
of effects is typically thought of the other way around. Qualitative findings additionally showed that parents actively engaged in “conscious buffering” strategies to help their children avoid the trauma from their own childhoods. Results from this study can inform future research, policy and practice related to IGT, particularly with African American and Latinx families, and suggest parent strengths and qualities that may help reduce IGT.
CHAPTER ONE
INTRODUCTION

In recent years, researchers, interventionists and policy makers have become increasingly aware of the impact of trauma across generations in a family. Commonly referred to as intergenerational trauma transmission (IGT), this phenomenon is the experience of the same trauma, or psychological or psychic manifestations of trauma, across generations in the family (Andermahr, 2015; Connolly, 2011). IGT can be transmitted within families biologically, via family culture, caregiver behavioral patterns, experiencing and/or witnessing maltreatment, and/or experiencing trauma via the sociocultural context. Studies show that African American children across the age spectrum are more likely to witness and/or experience higher exposure to interpersonal trauma than other children across the United States; and that African American and Latinx children in poor urban environments are particularly vulnerable to experiencing trauma due to high rates of poverty, drug use and crime (Center for Disease Control and Prevention, 2009; Hammack, Richards, Luo, Edlynn, & Roy, 2004; Hunt, Martens, & Belcher, 2011). With the projected amount of children of color in the United States reaching approximately 50% by 2035 (United States Department of Commerce, 2015; United States Census Bureau, 2008) and their likelihood of experiencing IGT, moderating or reducing IGT should be of considerable concern to researchers, policy makers and interventionists.

The research literature posits several psychodynamic and behavioral interventions intended to help reduce IGT (Connolly, 2011; Eyberg & Robinson, 1982; Follette, Palm, &
Pearson, 2006; Lieberman & Van Horn, 2004). While many have proven to be promising, especially in helping to reduce trauma effects in one generation, interventions may be inaccessible for primarily low-income African American and Latinx communities, groups that have been historically ignored by or negatively impacted by systems of care. Furthermore, given that interventions are dominated by psychodynamic and/or behavioral lenses, they may be better suited for addressing the sequelae of trauma in each generation individually, than for addressing the multi-faceted and sociocultural dynamics of IGT per se. As such, I developed interest in understanding how parents’ pre-existing strengths of mindfulness characteristics or traits, and self-care strategies, may be conditions that would buffer against entrenched sociocultural conditions that tend to perpetuate IGT, and potentially inform future interventions.

This document contains five chapters. The present chapter provides an introduction to the study. This includes a brief review of the central themes and background related to the study, and a presentation of the research questions. Chapter Two presents a literature review which includes a theoretical framework and review of IGT and adverse childhood experiences (ACEs) literature, a review of literature on mindfulness and self-care as variables in the compound construct, Contemplative Self-Care (CSC) and a review of Parent Self-Efficacy. Chapter Three provides a detailed description of the methodology, including the sample, research design, description of the instrumentation, and the analyses conducted. Chapter Four presents the results of the analysis, which is organized according the study’s questions. Finally, Chapter Five presents a summary of the findings and a series of suggested theoretical and practice implications, discussion of the study limitations, and methodological reflections.
Central Themes and Background

The major constructs in this study included IGT and its manifestation of the experience in children dubbed Child Traumatic Effects (CTE), and the possible buffers of IGT including the compound construct of Parent Trait Mindfulness and Parent Self-Care (CSC) and Parent Self-Efficacy. To help strengthen approaches to reduce IGT, there should be investments in “unpacking” the specific mechanisms and sources of buffering within the parenting relationship upon which future interventions can build. Figure 1 offers a conceptual model of the study.

Figure 1. Contemplative Self-Care and/or Parent Self-Efficacy Moderates or Reduces Intergenerational Trauma

Why CSC and Parent Self-Efficacy? CSC and Parent Self-Efficacy are potential intra- and inter-personal strengths that may increase the potential of African American and Latinx parents to serve as buffers of negative experiences for their children. CSC describes actual intentional and behaviorally manifested contemplative self-care practices. I developed an interest in contemplative characteristics and self-care as important possible mechanisms because of their evidence-based ties to the stress system (Grossman, Niemann, Schmidt, & Walach, 2004). Simply put, it seems likely that a parent who has strengths in the ability to manage their own
stress would be better able to apply emotional protectiveness in their parenting even when stress is high. Parent Trait Mindfulness was a variable used in the present study that described dispositional characteristics or traits of mindfulness in parents. Mindfulness is a theoretical construct, way of being, and/or dispositional state that supports mind-body awareness, self-regulation and present-moment awareness. An often-cited definition of mindfulness is paying attention in a particular way: on purpose, in the present moment, and non-judgmentally (Kabat-Zinn, 1994). It is argued that mindfulness is a natural human capacity (University of California San Diego Center for Mindfulness) that can alleviate psychological stress and promote well-being (Bodenlos, Wells, Noonan, & Mayrsohn, 2015; Cosme & Wiens, 2015). Self-reported mindfulness has been positively correlated with adaptive emotion regulation strategies (Feldman, Hayes, Kumar, Greeson, & Laurenceau, 2007) and negatively correlated with self-reported difficulty in emotion regulation (Roemer et al., 2009). Mindfulness and mindfulness-based interventions are promising ways of being and practices that have been shown to improve psychological functioning and decrease depression, anxiety, and stress (Baer, 2003; Bishop, 2002; Grossman et al., 2004; Kabat-Zinn, 1990; Khory et al., 2013) because of its central tenets of present moment awareness, self-regulation, and intention, all of which interrupt maladaptive behaviors (Shapiro, Carlson, Astin, & Freedman, 2006). Activities that improve self-regulation, self-observation and intentional action are plausible reducers of IGT.

However, mindfulness is not the only way to reduce stress. Self-care is the ability to care for one-self and to regulate one’s emotions especially in the context of caring for others (Orem, 2001). It is important to examine a broader definition of self-care and stress reduction practices to acknowledge the fact that there may be many ways in which parents care for themselves.
Other common self-care practices include prayer, exercise, obtaining social support, or journaling (Bowen, Edwards, Lingard, & Cattell, 2013). These and other forms of self-care in combination with trait mindfulness (e.g., the ability to focus on the present moment) were examined for whether they constituted a coherent single construct of CSC.

Parent Self-Efficacy is a characteristic or strength important to explore as a buffer of IGT. It is parents’ beliefs in their ability to perform parenting roles successfully and competently to influence the development of their children (Bandura, 1989; Coleman & Karraker, 2003; Wittkowski, Garrett, Calam, & Weisberg, 2017). Studies show that self-efficacy can be enhanced under stressful circumstances (Wittkowski et al., 2017) like some of the traumatic experiences outlined in this study. Parents who are self-efficacious are hypothesized to persevere in the face of adversity, initiate difficult tasks, and resolve problems with their children (Bandura, 1997; Dumka, Stoerzinger, Jackson, & Roosa, 1996). Related to this study, Parent Self-Efficacy has been showed to have a negative relationship with child behavior problems, a manifestation of CTE (Sanders, Montgomery, & Brechman-Toussaint, 2000; Sofronoff & Farbotko, 2002).

The central aim of this study was to explore whether under the pre-existing qualities of CSC and Parent Self-Efficacy, IGT (the relationship between Parent mACEs/Trauma and CTE) would be buffered/reduced in the family. As part of the exploration, the proposed study first described the prevalence of IGT in primarily low-income African American and Latinx families and explored ways in which this population of parents engaged in mindful-like activities.

The research questions and corresponding hypothesis were:

Q1. What is the prevalence of intergenerational trauma in a population of primarily low-income African American and Latinx parents and their 6-year-old children?
Research Hypothesis 1a. Intergenerational trauma is prevalent in a population of low-income African American and Latinx parents and their 6-year-old children.

Research Hypothesis 1b. There is a significant positive correlation between parent trauma and child trauma; there is a significant positive correlation between parent trauma and child negative behavior.

Q2. To what extent do parental strengths of Contemplative Self-Care and/or Parent Self-Efficacy buffer the relationship between parent trauma and child traumatic effects (i.e., IGT)?

Research Hypothesis 2. Contemplative Self-Care and Parent Self-Efficacy are significant moderators of the relationship between parent trauma and child traumatic effects, i.e., IGT.

Q3. In what ways are primarily low-income African American and Latinx parents engaging in mindful-like activities and ways of being to alleviate stress in themselves and their children? (No specific hypothesis as this research question was exploratory.)

A triangular mixed methods design was used to explore these questions. Triangular mixed methods allowed quantitative and qualitative data to be collected on the same topic to bring together the strengths of both research methods to validate and corroborate findings (Creswell & Plano Clark, 2011).
CHAPTER TWO
THEORETICAL FRAMEWORKS AND LITERATURE REVIEW

This chapter offers a theoretical framework of IGT, a review of IGT and ACEs literature, and a review of literature on the noted parent strengths that buffer IGT. It should be noted that it is beyond the scope of this study to ascertain exactly how or why trauma may have been passed down from parent to child (e.g., there are possible genetic links I did not examine). Nevertheless, I present the theoretical model below, which includes several possible mechanisms of IGT transmission, to provide the necessary context for how IGT plays out in families.

Intergenerational Trauma

IGT was first introduced in the literature by Freud, known as the founder of Western psychoanalysis. Freud posited that following a traumatic event parents’ past and present circumstances – including early attachments and trauma history – influence their ability to function as a developmentally critical protective shield for the child (Bowlby, 1973, 1980, 1982; Connolly, 2011; Hesse & Main, 2006). Later, the study of IGT became prominent in the literature in the 1960s through its application to the subsequent generations of families of Holocaust survivors (Danieli, 1998; Davidson, 1992; Felsen, 1998; Felsen & Erlich, 1990; Frazier, West-Olatunji, St. Juste, & Goodman, 2009; Krysinska & Lester, 2006; Lev-Wiesel, 2007; Weiss & Weiss, 2000). Brave Heart’s (2003) seminal work linked IGT and present day levels of substance use in Native American communities and populations. Researchers are currently studying IGT and its transmission mechanisms in families affected by sexual abuse,
natural disasters, and other groups who have experienced collective trauma and systemic oppression such as the descendants of enslaved African people in the United States (Frazier et al., 2009).

At least with respect to a single generation, the ACE Study (Felitti et al., 1998) helped change the dialogue about the prevalence and consequences of trauma in society. The ACE study surveyed more than 17,000 adults in the 1990s and found that more than half of the respondents reported at least one ACE, and one-fourth reported two or more ACEs, which included but were not limited to childhood emotional abuse, sexual abuse and various types of household dysfunction (Felitti et al., 1998). The ACE study found a dose-response relationship between ACE scores and risky health behaviors, such as smoking, physical activity and multiple sexual partners (Cronholm et al., 2015). Follow-up studies have shown that ACEs are common, highly interrelated, and have a strong cumulative effect on health and development including a 20-year life expectancy reduction with six or more ACEs (Anda, Butchart, Felitti, & Brown, 2010).

Notably, the ACE study was conducted with a predominately White, middle-class population. However, samples of low-income groups and/or African Americans or Latinx reveal disproportionately higher ACE scores (Baglivio et al., 2014; Cronholm, et al., 2015). To more accurately calculate the ACE score of African Americans and others living in low-income urban communities, the Philadelphia (PHL) ACEs Survey was developed. The PHL ACEs included stressors associated with growing up in low-income urban communities, including:

- Witnessing violence in one’s neighborhood;
- Feeling discrimination based on race/ethnicity;
- Feeling unsafe in one’s neighborhood;
• Being bullied; and,
• Living in foster care (Cronholm et al., 2015; Public Health Management Corporation, 2013).

As shown, the PHL ACEs Survey added stressors that are related to the sociocultural context. Because of my interest in both sociocultural context and the experiences of African American and Latinx communities, this study sought to understand the prevalence of IGT in both populations.

While the proliferation of ACEs research has certainly indicated how trauma from childhood can be carried forward within an individual to adulthood, very little research has extended to the question of how those sequelae may affect an individual’s children, should they become a parent. In the following sections, I review the theoretical and limited empirical literature on the topic of IGT, and the different ways in which the trauma of a parent may “get under the skin” of a child. Table 1 offers a summary I created from an integration of the literature, and each following section discusses transmission mechanisms highlighted in this study – caregiver behavioral pattern, experiencing and/or witnessing trauma and sociocultural context trauma.
Table 1. Intergenerational Trauma Summary

<table>
<thead>
<tr>
<th>Transmission Mechanism</th>
<th>Theoretical Underpinning</th>
<th>Medium of Transmission</th>
<th>Process of Transmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological</td>
<td>Epigenetics</td>
<td>Biological changes and markers in utero</td>
<td>Direct</td>
</tr>
<tr>
<td>Caregiving behavioral patterns</td>
<td>Attachment theory; infant mental health theory</td>
<td>Conscious or unconscious attachment and caregiving patterns</td>
<td>Relational/indirect</td>
</tr>
<tr>
<td>Familial culture</td>
<td>Family systems theory</td>
<td>Unconscious behavioral and relational patterns shaped by familial emotional system</td>
<td>Relational/indirect</td>
</tr>
<tr>
<td>Experiencing maltreatment and/or witnessing interpersonal violence</td>
<td>Social learning theory</td>
<td>Action, learned behavior, modeling, bifurcated development</td>
<td>Direct</td>
</tr>
<tr>
<td>Sociocultural context</td>
<td>Ecological systems theory; critical race theory; intersectionality theory</td>
<td>Sociocultural, sociopolitical, action</td>
<td>Direct and indirect</td>
</tr>
</tbody>
</table>

Note. This table was created by the author to offer the literature a intergenerational trauma transmission framework. This study's mACEs questions were related to caregiving behavioral patterns, experiencing and/or witnessing trauma and sociocultural context.

Transmission Mechanism: Caregiving Behavioral Patterns

The attachment literature has arguably played a central role in articulating and defining IGT. Pioneers of the infant mental health field, Fraiberg, Adelson, and Shapiro (1975), were among the first to bring attention to the impact of one generation experiencing trauma on another generation via the caregiver-child dyadic relationship. Attachment theory is based on Bowlby’s conception of the caregiver’s sensitivity and responsiveness to the infant’s cues, signals and availability in times of distress, and the development of trust and security in the infant toward the caregiver (Bowlby, 1973, 1980, 1982). Attachment theorists proposed that repeated experiences of rejection, disassociation, and/or disengagement may lead to patterns of behavior related to
disorganized attachment and emotional dysregulation (Bowlby, 1973, 1980, 1982; Hesse & Main, 2006). A core concept of infant mental health is the influence of the previous generations’ ‘angels’ and ‘ghosts’ on the secondary generation. As articulated by Lieberman, ‘angels’ is a metaphor to describe the caregiving experience of transmitting the good care and affection from one’s childhood to their children, the shared affection between parent and child, and the child’s feelings of being understood, accepted and loved (Lieberman, Padròn, Van Horn, & Harris, 2005). ‘Ghosts’ is the experience of parents reenacting their experiences of helplessness, fear and other negative feelings or behaviors with their children (Fraiberg, 1980). In essence, ‘ghosts’ is the presence of trauma that is embedded within caregivers and comes alive through their role as parents.

**Disorganized attachment.** IGT is transmitted by conscious or unconscious relational patterns that may negatively impact caregiver-child relationships. Disorganized attachment describes caregiver-child relational patterns in which the infant displays apprehension or fear toward the caregiver and contradictory, interrupted, stereotypic or dissociated behaviors when their attachment system is activated (Main & Solomon, 1990). These behaviors place the infant in a paradoxical situation in which the person who should provide a secure base and to whom the infant instinctively turns to for comfort and protection at times of stress simultaneously serves a source of stress (Connolly, 2011; Hesse & Main, 2006). Over time, these ‘micro-moments’ lead to compromised relationship patterns of fear and apprehension.

The caregiver’s sustained emotional dysregulation as a result of their own trauma is both a risk factor for IGT as well as a predictor of poor child emotional and behavior outcomes when the child is confronted with adverse life events (Holden & Ritchie, 1991; Laor, Wolmer, &
Cohen, 2001; Schechter et al., 2007; Yehuda, Halligan, & Bierer, 2001). In the present study, I correlated Child mACEs/Trauma with Child Negative Behavior to understand the relationship between the two variables and to determine whether trauma-based behavior forms the construct CTE. It was hypothesized that parent trauma (as recorded by the mACEs) will in turn be associated with CTE. The level of this association was the indicator of the prevalence of IGT in this sample.

Transmission Mechanisms: Experiencing Maltreatment and/or Witnessing Interpersonal Violence

Intergenerational cycles of abuse and neglect are well established in the research literature as transmitters of trauma through direct action of abuse and/or witnessing trauma, through learned behavior, and modeling within the family unit (Osofsky, 2003). Evidence indicates that abusive or neglectful parents are more likely to report a childhood history of abuse or neglect (Kim, 2009; Putallaz, Costanzo, Grimes, & Sherman, 1998), and that a history of witnessing violence increases the risk of being the victim of intimate partner violence (Bandura, 1971, 1977, 1986; Black, Sussman, & Unger, 2010; Hines & Saudino, 2002; Kaufman & Zigler, 1987; Kaufman & Zigler, 1989; Kernsmith, 2006; Osofsky, 2003). The co-occurrence of witnessing and experiencing violence also leads to greater risk of perpetuating violence and abuse in the next generation (Hamby, Finkelhor, Turner, & Ormrod, 2010; Osofsky, 2003).

The research literature demonstrates that IGT is also transmitted via learned behaviors of violence and/or maltreatment. As the main socializing unit, the family is a primary source of childhood learning (Black et al., 2010) and as such, behaviors are learned via modeling within the family system (Bandura, 1977; Kernsmith, 2006). Violent behavior, whether inflicted upon
the child or on a spouse and witnessed by the child, can be internalized by the child. Children learn that violence is a way of relating to others, of solving conflict, and that violence and maltreatment are an expected part of familial relationships (Ehrensaft et al., 2003; Kernsmith, 2006; Osofsky, 2003). Furthermore, children may learn about the legitimacy of violence, its efficacy or its validity as a strategy for problem solving and stress management (Ehrensaft et al., 2003; Kernsmith, 2006), and they are more likely to orient themselves toward behaviors that lead to a desired result (Bandura, 1977). In this context, children learn that abusive behaviors may be “effective” expressions, and therefore learn to perpetuate similar behaviors.

Importantly, experiencing or witnessing violence in the family of origin does not guarantee that the experience will be perpetrated in future generations. Kaufman & Ziegler (1987, 1989) argue that the research on child abuse and neglect has been misleading in this regard. Most children who experience abuse in their families will not perpetuate intimate partner violence in the future, and some adults who never experience abuse in their families of origin will abuse their partner (Widom, 1989). Seminal studies have found a range between 18% to 70% of abusing parents had a history of abuse; between 20% and 30% adults who were abused as children abuse their own children (Kaufman & Ziegler, 1989; Widom, 1989). The use of self-reports of childhood sexual abuse from individuals who, themselves, have committed child abuse naturally raises questions about the reliability of these data (Kaufman & Ziegler, 1987, 1989). Thus violence is not 100% predictive of perpetuating violence. This current study explored whether or not traumatic experiences in parents are experienced in children in the form of traumatic experiences themselves and/or negative behaviors.
**Transmission Mechanism: Sociocultural Context**

Trauma can also “get under the skin” of both parents and children in more distal ways, such as through factors and patterns within the sociocultural context. The sociocultural context refers to societal structures and cultural context in which we live (Thomas, 2016); it includes all of the beliefs, ideologies, attitudes, and, historical and cultural trauma that may exist within society (Thomas, 2016). The sociocultural context is experienced by engaging with community systems and institutions that encode reminders of the social order rooted in discrimination, racism, genocide and other systems of oppression, and via interpersonal interactions that are shaped by the sociocultural context. The social order is organized around axes such as socioeconomic status, race and ethnicity, citizenship status, and other factors of the political economy.

Trauma is part of the cultural and political configuration in the United States as seen in its history of genocide, enslavement, and indentured servitude, Jim Crow, and internment camps. In addition, many of its peoples migrated to the country to escape religious and ethnic persecution or to seek opportunity after their own country was ripped of resources as a result of colonialism. As such, trauma reaches far beyond individual experiences to group or collective experiences that are embedded into the cultural memory (Duran & Duran, 1995). Trauma is further exacerbated by personal reminders related to historical trauma that can be individually experienced. As population-based experiences, cultural and historical trauma are often shaped by social policy that may lead to punitive criminal justice systems, housing regulations and practices that result in deeply impoverished and isolated communities, and harmful child welfare and family dissolution policies. As noted, in the mACEs questionnaire, sociocultural context factors
have been added to previously existing ACEs items, to explore the prevalence of these experiences within primarily low-income African American and Latinx families.

**Historical trauma.** Coined by Maria Yellow Horse Brave Heart, the phrase “historical trauma” refers to the collective and complex experience of cumulative emotional and psychological wounding over a lifespan and across generations by a group of people who share an identity, affiliation or circumstance (Brave Heart & DeBruyn, 1998; Brave Heart, 2003; Crawford, 2014; Evans-Campbell, 2008; Gone, 2013; Sotero, 2006). Historical trauma can be perpetuated by sociocultural context, including government policies, and is reproduced through forms of interpersonal trauma, systemic trauma such as incarceration, and other forms of familial dissolution. Historical trauma was formally conceptualized in the literature to understand the experiences of Holocaust survivors and their children (Auerhahn & Laub, 1998; Felsen, 1998; Kellermann, 2001; Solomon, Kotler, & Midulincer, 1998). Subsequently, the framework was used to describe the collective experience of populations and groups that have experienced colonialism, institutional racism, and present-day genocide (Atkinson, 2002; DeGruy, 2015; Faimon, 2004; Nagata, 1998; Sotero, 2006). Although, as noted, mechanism of IGT transmission are not being assessed in this study, several items on the mACEs survey could have historical implications such as colorism and racism.

**Cultural trauma.** Cultural trauma describes experiences that may not inherently be traumatic but rather the cultural template through which the occasion or situation is experienced renders the experience traumatic. Cultural trauma is a theoretical framework introduced in the sociological literature to describe trauma as a social theory in which the traumatic experience of a collective group reshapes the groups’ identity, cultural expression, and group consciousness.
(Alexander, 2012; Hudnall Stamm, Stamm, Hudnall, & Higson-Smith, 2003). This approach to trauma redirects our attention from looking at the nature of the event, to looking at the collective representation of the event and the cultural template in which the event or experience is understood. The experience and the traumatic representation are embedded into cultural memory and absorbed by individuals, families and communities and therefore experienced intergenerationally. Cultural trauma is distinct from historical trauma as the event does not have to be in the past, it may be underway.

We absorb the sociocultural context through our beliefs, activities, and ideologies as well as through social and political structures that govern our life. In the context of the United States, some families and racial ethnic groups have experienced cultural trauma via the immigration process, documentation status and the acculturation process. Being undocumented is particularly challenging for children and their caregivers since their “illegal” status often leaves them feeling afraid and deprived (Noroña, 2011). This also leads to feelings of invisibility, marginalization and vigilance in order to preserve physical and emotional safety (Fong & Earner, 2007). The experiences of being treated differently because of immigration status, hiding immigration status, and living with anyone who did not have legal immigration status or was undocumented were explored in the mACEs questionnaire.

The mACEs questionnaire used in this study explored IGT related to the mentioned transmission types – caregiver behavioral pattern, experiencing maltreatment and/or witnessing trauma, and sociocultural context trauma. While it can be conceived that some of the mACEs items were related to other transmission mechanisms outlined in Table 1. However, it is beyond the scope of this study to explore biological mechanisms of IGT. The proposed study sought to
unpack IGT as a construct to understand experiences within a family, and to understand the prevalence of IGT in African American and Latinx parent-child dyads.

**Potential Buffers of Intergenerational Trauma**

This study may also be the first to examine whether parent strengths like mindful traits, self-care, and self-efficacy help to stop or lessen the passage of trauma from one generation to the next. As noted, self-care is a multidimensional framework (Becker, Gates, & Newsom, 2004; Jackson, 2015) for understanding how one cares for themselves. Trait mindfulness refers to a person’s baseline or average mindfulness and is described as a person’s natural tendency to be aware of present-moment experiences in a nonjudgmental and accepting manner (Baer, Smith, & Allen, 2004). As noted, Parent Self-Efficacy describes parents’ beliefs in their ability to competently execute parenting roles (Bandura, 1989; Coleman & Karraker, 2003; Wittkowski et al., 2017). It was presumed that all three strengths could be employed to reduce stress and could be especially enhanced when activated under stressful conditions. These characteristics are hypothesized to reduce the experience of trauma in both generations. Background literature on self-care, trait mindfulness and Parent Self-Efficacy will be explored separately in the following pages.

**Self-Care**

Self-care is the process of actively initiating a method to promote one’s own well-being and manage stress (Bressi & Vaden, 2016; Godfrey et al., 2011; Lee & Miller, 2013; Newell & Nelson-Gardell, 2014). This definition implies an array of potential activities that fall under the category of self-care, such as healthy eating, exercise, mindfulness, engaging in hobbies or leisurely activities, maintaining a sufficient sleep schedule, and using adaptive coping strategies.
(Carroll, Gilroy, & Murra, 1999). The definition also implies a purposeful effort to engage in these activities to maintain wellness in multiple domains. Self-care practices are therefore regulatory, preventive, reactive, and restorative (Becker et al., 2004). Over the past 30 years, self-care has been shown to help adults and children tolerate, minimize or eliminate stress (Lazarus & Folkman, 1984; Orem, 2001).

Compared to the research literature on self-care for helping professionals, there is little research on self-care for the general population. In the few studies that review self-care holistically, studies find that adults employ multiple strategies for self-care (Bowen et al., 2014) and that self-care is an expression of cultural practices (Becker et al., 2004). Bowen and colleagues (2014) found a range of self-care strategies among White employed adults. These included:

- physical exercise;
- engaging in hobbies;
- socializing with family and friends;
- engaging in various forms of entertainment; and,
- seeking support (from supervisors, coworkers, and others).

In the same study, they found that African Americans and Latinxs employ different self-care strategies and have higher rates of engagement in prayer and religious activity compared to the White participants (Bowen et al., 2014). Comparatively, in a qualitative study understanding self-care amongst chronically ill African Americans, Becker et al. (2004) found that their self-care practices include social support, spirituality and religious practices and holistic healing.

It is more common in the research literature to study self-care through a one-dimensional
framework (i.e., spirituality, or exercise, or prayer) instead of the multidimensional framework typically used to define it. For example, the following self-care strategies have been studied one-dimensionally (all listed have been well-documented as effective): spirituality (Chow & Kalischuk, 2008; Clement, Jankowski, Bouchard, Perreault, & Lepage, 2002); physical activity (Gallup & Castelli, 1989; Riordan & Washburn, 1997; Seo, Nehl, Agley, & Ma, 2007; Shriver & Scott-Stiles, 2000; Stark, Manning-Walsh, & Vliem, 2005; Thayer, Neuman, & McClain, 1994); exercise (Jackson, 2015; Thayer et al., 1994); and, social support (Bowen et al., 2014; Thayer et al., 1994). This current study explored self-care strategies of low-income African American and Latinx parents, a group that has received little attention in the self-care literature, using the Caring for Myself Questionnaire (Self-Care Assessment Worksheet; Saakvitne, Pearlman, & Staff, 1996). In contrast to some of the research literature, the questionnaire explored the many different self-care strategies one may employ.

**Trait Mindfulness**

Trait mindfulness is a natural potential that can be further cultivated by the practice of mindfulness meditation techniques (Brown & Ryan, 2003; Cobb, Kor, & Miller, 2015). Similar to the impact of mindfulness-based interventions, trait mindfulness has been demonstrated to improve well-being (Brown & Ryan, 2003; Daubenmier, Hayden, Chang, & Epel, 2014; Masicampo & Baumeister, 2007). Higher levels of trait mindfulness have been associated with health benefits, lower negative mood states, more satisfying relationships, better sleep, healthier eating habits, and other measures of well-being (Barnes, Brown, Krusemark, Campbell, & Rogge, 2007; Bodenlos et al., 2015; Branstrom, Duncan, & Moskowitz, 2011; Roberts & Danoff-Burg, 2010; Tamagawa et al., 2013). Higher levels of trait mindfulness have also been
shown to be indirectly related to lower levels of youth internalizing and externalizing behaviors (Parent et al., 2010; Parent, McKee, Rough, & Forehand, 2015). White practitioners studying Buddhism and mediation brought mindfulness practices to the United States in the 1960s from Southeast Asia (Blum, 2014). Since, these practices have not yet spread equitably despite their popularity in the popular press (Blum, 2014). Two methods were chosen to attempt to reveal pre-existing “mindful-like” strengths in this low-income, African-American and Latinx sample. First, trait mindfulness was examined via the well-known Five Factor Mindfulness Questionnaire (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006), and second, a sub-sample was interviewed in-depth in order to maximize opportunities for parents to describe their mindful-like mindsets or practices in their own words.

Mindfulness has become secularized from a Buddhist concept and way of life to a psychological construct, approach, and way of being in American life. Much of mindfulness’ secularization and integration into American society is due to the success of mindfulness-based interventions including mindfulness based stress reduction (MBSR; Baer, 2003) programs, the central role of mindfulness in dialectical behavior therapy (Bishop et al., 2004), as well as acceptance of and integration of yoga, tai chi and other mindfulness practices. Often confused with meditation, mindfulness is actually a state of being that the practice of meditation can help cultivate (Shapiro, Carlson, Astin, & Freedman, 2006).

With the considerable focus and attention on mindfulness, researchers have proceeded in developing an operational definition that specifies testable theoretical predictions for the purpose of validation and refinement (Bishop et al., 2004). The operational definition articulates five facets of mindfulness that build off and complement one another, including:
- Present Moment Awareness – attending to one’s activities of the moment (Bishop et al., 2004);
- Observation – noticing or attending to experiences, such as sensations, thoughts and emotions (Bodenlos et al., 2015);
- Description – labeling internal experiences with words (Bodenlos et al., 2015);
- Nonjudgment of experience – taking a nonevaluative stance toward thoughts and feelings (Dimidjian & Linehan, 2009; Ivanovski & Malhi, 2007); and,
- Nonreaction to inner experience – allowing thoughts and feelings to come and go (Bodenlos et al., 2015).

Accordingly, the FFMQ used in this study was created after the articulation of the above noted operational definition of mindfulness.

Trait mindfulness was chosen as a potential buffer of IGT because of the inherent strengths people with dispositional mindfulness can potentially enact during moments of stress or experiences of trauma. The literature suggests that the different facets of mindfulness improve well-being, and interpersonal and intrapersonal function.

Overall, the research suggests mindful awareness reduces negative and automotive behaviors that may stem from trauma and IGT. For example, present moment awareness moves us from automation (Bishop et al., 2004), and in some cases maladaptive behaviors (Bishop et al., 2004) to more intentional actions and positive behaviors (Shapiro et al., 2006). These behaviors may decrease the transmission of trauma and maladaptive behaviors within families. Studies show the connection between higher levels of trait mindfulness and reduced emotional regulation difficulties (Hill & Updegraff, 2012; Prakash, Hussin, & Schilder, 2015; Roemer et
al., 2009). Mindfulness also enables us to become more self-observant (Cahn & Polich, 2009; Goldin & Gross, 2010; Ortner, Kiner, & Zelazo, 2007; Siegel, 2007a, 2007b), intentionally enable us to bring awareness, attention and acceptance to experience the emotion in the present moment, and enable us to use a wider more adaptive range of coping skills (Brown & Ryan, 2003; Shapiro et al., 2006; Williams, 2010). The capacity to observe or witness the contents of one’s consciousness enables a person to experience very strong emotions with greater objectivity and less reactivity (Shapiro et al., 2006), which serves as a counter to the habitual tendency to respond to, avoid or deny difficult emotional states. Mindfulness may reduce IGT from parent to child as contemplative traits help with self-regulation, decrease depressive symptoms, and reduce rumination. This study added to the research literature on secular mindfulness, by studying trait mindfulness within an African American and Latinx population, and sought evidence to understand how these two groups engaged in mindful-like activities and ways of being, even if they are not engaging in White American defined mindfulness practices per se.

**Parent Self-Efficacy**

As noted, Parent Self-Efficacy describes parents’ beliefs in their ability to perform parenting roles successfully and competently to positively influence the development of their children (Bandura, 1989; Coleman & Karraker, 2003; Wittkowski et al., 2017). Rooted in Bandura’s (1997) social cognitive theory, parents with high efficacy are hypothesized to have high levels of motivation to perform well, high likelihood of initiating difficult tasks, and high investment of effort and perseverance in the face of adversity. These factors tend to predict competent implementation of tasks and achievement of desired outcomes in children (Dumka, Gonzales, Wheeler, & Millsap, 2010). Moreover, Bandura’s postulates that self-efficacy is not a
fixed trait, but rather fluctuates in response to changing demands (e.g., developmental changes in
children, demands of society), and personal development (e.g., parenting skill acquisition;
Dumka et al., 2010). Related to this research study, the salience of self-efficacy beliefs as a
predictor of overt behavior tends to be enhanced under stressful circumstances such as adverse
experiences in childhood (Bandura, 1982, 1989; Meunier & Roskam, 2009). Given these
theoretical approaches and research findings, Parent Self-Efficacy seemed to be an important
characteristic or strength in parents that could buffer IGT.

Researchers have found evidence linking Parent Self-Efficacy and various positive
parenting practices and child outcomes. Specifically related to CTE and its variables Child
mACEs/Trauma and Child Negative Behavior in this study, research in Parent Self-Efficacy has
been shown to have a negative relationship with child behavior problems (Sanders et al., 2000;
Sofronoff & Farbotko, 2002). Parenting Self-Efficacy extends to parents’ ability to manage their
child’s behavior and to resolve problems with their child (Dumka et al., 1996). Jackson and
Scheines (2005) assessed African American single mothers’ overall self-efficacy (not parenting
self-efficacy) and positive parenting at Time 1 and found these to be significantly related. This
study also found that Time 1 parenting had a direct effect, and Time 1 self-efficacy had an
indirect effect, on young children’s behavior problems at Time 2 (Jackson & Scheines, 2005). In
a longitudinal study among Mexican American families, results indicated that Parent Self-
Efficacy predicted future positive control practices in parent-adolescent relationships (Dumka et
al., 2010). The current hypothesis that Parent Self-Efficacy is a buffer of CTE is consistent with
these research studies and theoretical analyses suggesting that parenting self-efficacy and child
behavior are transactionally related (Bandura, 1977, Coleman & Karraker, 2001; Gecas, 1989;
Meunier & Roskam, 2009).

On the contrary, poor parental self-efficacy has been found to result in opposite effects in child outcomes and the parent-child relationship. Low maternal self-efficacy has been correlated with:

- Maternal depression (Cutrona & Troutman, 1986; Teti & Gelfand, 1991);
- Behavioral problems in children (Gibaud-Wallson & Waudersman, 1978, cited in Johnston & Mash, 1989);
- Maternal perceptions of child difficulty (Johnston & Mash, 1989);
- Passive coping style in the parental role (Wells-Parker, Miller, & Topping, 1990);
- High levels of stress (Wells-Parker et al., 1990).

Furthermore, when confronted with stress, parents with low self-efficacy may give up easily, may internalize failures, and may experience anxiety (Coleman & Karraker, 2003).

Interestingly, Parent Self-Efficacy seems to have roots in childhood as the parent may apply their early internal patterns to their daily experiences of being a parent (Grusec, Hastings, & Mammone, 1994). This interpretation is in line with the noted attachment and infant mental health theory which posits that early internal modeling influences later behavior (Ainsworth et al. 1978 in Coleman and Karraker 1997). This theory further demonstrates how intergenerational wisdom is passed down across generations. Overall, parental self-efficacy seems to be an important characteristic or strength in parents that can buffer IGT.
The Present Study

In summary, although IGT is of great theoretical interest, it has not yet been studied in the parent and child generations simultaneously. This study sought to understand the prevalence of IGT in an African American and Latinx sample by testing a new quantitative approach to IGT that includes sociocultural context trauma. Prevalence of Post Traumatic Stress Disorder (Kilpatrick et al., 2013), ACEs in adults (Gilbert et al., 2010; Mersky, Janczewski, & Topitzes, 2017; Metzler, Merrick, Klevens, Ports, & Ford, 2017), and ACEs in children (Bethell, Carle, Hudziak, Gombojav, Powers, Wade, & Braveman, 2017; Bethell, Newacheck, Hawes, & Halfon, 2014; Bright, Alford, Hinojosa, Knapp, & Fernandez-Baca, 2015; Burke, Hellman, Scott, Weems, & Carrion, 2011; Caballero, Johnson, Muñoz Buchanan, & DeCamp, 2017; Ghosh Ippen, Harris, Van Horn, & Lieberman, 2011; McKelvey, Whiteside-Mansell, Conners-Burrow, Swindle, & Fitzgerald, 2016; Sacks & Murphey, 2018; Wing, Gjelsvik, Nocera, & McCaid, 2015) have been studied in the literature. However, the prevalence of IGT has been scantily explored outside of the important literature describing IGT in native communities (Bombay, Matheson, & Anisman, 2014), IGT in refugee families in the United States (Sangalang & Vang, 2016) and IGT within the families of Holocaust survivors (Danieli, 1998; Davidson, 1992; Felsen, 1998, Felsen & Erlich, 1990; Frazier et al., 2009; Krysinska & Lester, 2006; Lev-Wiesel, 2007; Weiss & Weiss, 2000). This study defined IGT as the relationship between Parent mACEs/Trauma and Child mACEs/Trauma and as the relationship between Parent mACEs/Trauma and Child Negative Behavior as other measurements of IGT have not yet been developed. Notably, this study takes a further step in studying IGT with the inclusion of salient sociocultural context trauma indices in its mACEs measure. Interest in understanding potential
parent strengths as buffers of IGT led to the exploration of pre-existing strength-based conditions of trait mindfulness, self-care, and self-efficacy as IGT moderators. All three strengths likely lead to less maladaptive behaviors, less automatic negative behaviors, higher levels of self-regulation, and overall well-being, making these variables a reasonable place to start to explore ways of mitigating IGT between the parent and child generation. This sample comprises African American and Latinx parents as the two groups are disproportionately more likely to live with IGT and are also understudied populations in the self-care and mindfulness literature.
CHAPTER THREE

METHODOLOGY

This chapter presents a description of the research design, participants, study procedures and ethical considerations used to understand the prevalence and potential buffers of IGT in African American and Latinx parents and their 6-year-old children. Recall that the specific research questions and corresponding hypotheses were:

Q1. What is the prevalence of intergenerational trauma in a population of primarily low-income African American and Latinx parents and their 6-year-old children?

Research Hypothesis 1a. Intergenerational trauma is prevalent in a population of low-income African American and Latinx parents and their 6-year-old children.

Research Hypothesis 1b. There is a significant positive correlation between parent trauma and child trauma; there is a significant positive correlation between parent trauma and child negative behavior.

Q2. To what extent do parental strengths of Contemplative Self-Care and/or Parent Self-Efficacy buffer the relationship between parent trauma and child traumatic effects (i.e., IGT)?

Research Hypothesis 2. Contemplative Self-Care and Parent Self-Efficacy are significant moderators of the relationship between parent trauma and child traumatic effects, i.e., IGT.
Q3. In what ways are primarily low-income African American and Latinx parents engaging in mindful-like activities and ways of being to alleviate stress in themselves and their children? (No specific hypothesis as this research question was exploratory.)

**Research Design**

This study implemented a triangular mixed methods design to explore the noted research questions. As described, triangular mixed methods allow quantitative and qualitative data to be collected on the same topic to bring together the strengths of both research methods to validate and corroborate findings (Creswell & Plano Clark, 2011). As such, quantitative survey data was first collected from the whole sample followed by qualitative data collection via 60-minute semi-structured interviews from a sub-sample of parents for deeper exploration of some of the themes captured by the quantitative measures. This approach also allowed quantitative data to inform some of the questions and probes in the qualitative interviews.

**Study Procedures**

Following approval from the University of Chicago’s Institutional Review Board and Chicago Public Schools (CPS) Research Review Board, the approving institutions for this research, data collection began. Recruitment and data collection will be reviewed in this section.

**Recruitment**

The sample of parents were recruited from their participation in one or more Calm Classroom K-2nd Grade (CCK2) Family Engagement Events in which they learned about CCK2, their school’s new social-emotional program. CCK2 was a randomized controlled trial (RCT) of the impact of school-based mindfulness on children’s executive functioning, self-regulation, attention and absorption of academic content as well as improved interpersonal climate and
decreased behavior management challenges in classrooms (see Appendix K through O for further details on study recruitment materials). The schools in the current study (also referred to as the Parent Study) were the RCT intervention group schools in which mindfulness programming was integrated school-wide with additional resources allocated for K-2\textsuperscript{nd} grade classrooms (vs. the control group, which implemented the district’s standard social-emotional program; this study did not seek to engage caregivers of children in the control schools). CCK2 was a collaboration between Erikson Institute, Chapin Hall at the University of Chicago, Luster Learning Institute, and CPS.

Participants included parents or guardians of children involved in CCK2 (regardless of whether or not they consented to their child’s participation in the RCT), and parents, guardians and family-friends who participated in the CCK2 Family Engagement Events at the suggestion of their school or family member. Given that all of the study participants have been involved at least one of the semi-annual CCK2 Family Engagement Events, it can therefore be assumed that this population had at least rudimentary exposure to mindfulness and the CCK2 program, and may be knowledgeable about or experienced with the phenomenon of interest (Creswell & Plano Clark, 2011; Palinkas et al., 2013). Nevertheless, concerns that this sample would be unrepresentatively aware of and biased towards the field of mindfulness were unfounded, as it was shown that 83\% of the interviewed sub-sample had “never heard of” mindfulness (see Chapter Four Results for further detail).

The demographics of this sample of primarily low-income African American and Latinx families matched the CCK2 school and family population. Schools in the study were designated tier 1 schools, which, on average, enroll families with incomes below $30,000 per year and have
low parental educational attainment (Chicago Public Schools Tiers; Walker Burke, 2018). The student population qualified for free or reduced lunch at a rate of at least 70%. CPS students are overwhelmingly Black and Latinx. Of the Latinx population, the proportion of elementary school students who are English Language Learners is approximately 85% (Gwynne, Stitziel Pareja, Ehrlich, & Allensworth, 2012).

Data Collection

Overall, data collection for this study occurred from June 2017 thru February 2018. Specific details are discussed below.

Quantitative data collection. Quantitative data collection occurred at 15 of the 16 CCK2 schools; while recruitment was attempted several times at the 16th school no parents from that school participated. Quantitative data was collected at the schools’ Spring 2017 or Fall 2017 CCK2 Family Engagement Event, and online via REDCap. Quantitative recruitment incentives included one parent at each school receiving a $100 visa gift card via lottery; all family members in attendance received dinner, childcare, a mindfulness book, and a one-day unlimited Ventra card.

For those parents who agreed to participate, Consent Forms (see Appendix P), overview forms, and the noted surveys were distributed and generally discussed. Parents were informed that identifying information would be separated from the surveys; they were offered the opportunity to ask questions. All respondents completed the University of Chicago approved informed Consent Form and received a blank copy for their records. To allow for confidentiality, some parents were asked to space out their seating. After the forms and surveys were complete, parents were reminded about anonymity and confidentiality of the data. Information about next
steps including interviews and research follow-up was also discussed. For those parents who did not participate, they were provided with CCK2 Mindful Coloring Pages and colored pencils to occupy their time while other parents were completing the surveys.

The quantitative surveys were also available online via REDCap for parents who were unable to attend the CCK2 Family Engagement Event and for the two schools in which their CCK2 Family Engagement Event had occurred prior to data collection. Parents accessed the surveys by entering the website created for this study: https://redcap.uchicago.edu/surveys/?s=43PT9L3EWE. Once the website was accessed, parents were directed to the Parent Information Form and the online Consent Form. Upon giving consent, participants were directed to complete the surveys sequentially. Five parents completed the surveys online.

All survey data was entered and/or transferred to The Statistical Package for the Social Sciences (SPSS) software 25 (SPSS, Inc., Chicago, IL) for storage and subsequent analysis.

**Qualitative data collection.** To obtain the interviewed sub-sample, participants were asked on the Parent Information Form and Consent Form to indicate their interest in learning more about participating in a follow-up 60-minute in-person interview to further understand stress in the family and how they cared for themselves and their children. Each qualitative sample participant received a $25 visa gift card for their participation and a one-day unlimited travel card if the participant traveled to the interview. The total cost for participant incentives was $2,207 (see Appendix O for Budget for Participant Incentives). Of the 128 quantitative participants, 105 parents indicated their interest in learning more information about the interview and 19 of them were Spanish speaking. Potential Spanish speaking interviewees were removed
from the eligible sample due to funding constraints and therefore the inability to hire Spanish speaking interviewers, Spanish translation, and transcription services.

To select the qualitative sample from the eligible interviewees, an “extremes analysis” of Parent Trait Mindfulness and Parent Self-Care was conducted to ensure adequate variance on these two constructs of interest. Interviewees were initially selected at the extremes, however, since there was restricted variance in both measures and a fair amount of clustering near the median, selection occurred at the extremes and then moved toward the median until the desired interview sample size was achieved. Interviewees were also chosen with consideration of selecting at least one in each CCK2 school, and an even distribution of African American and Latinx parents.

Of the first 42 eligible parents, approximately 30 parents were contacted via phone or text, to be interviewed. Contact was made with approximately 25 respondents and all responded affirmatively. Once a parent elected to participate they were sent a confirmation text with the day and time, reminder about confidentiality, voluntary nature of the interview, and the $25 visa gift card. One parent did not show up for the interview and one interview did not occur because of scheduling conflicts. Qualitative interviews were conducted with 23 participants. The interviews were recorded using a digital voice recorder (Sony ICD-PX440); no identifying information was captured in the recording. Digital files were saved and subsequently transcribed into verbatim text by a transcription service (Verbal Ink). Interviews were conducted at the best times for participants. Fourteen interviews were conducted at their children’s school; four interviews were conducted via phone or FaceTime; two interviews occurred at the family’s home; and three interviews were conducted at Erikson Institute a city-center downtown location. The Consent
Form was reviewed with each interviewee; confidentiality and voluntary nature of research were discussed. As noted, all interviewees received a $25 visa gift card for their time; for those that traveled to Erikson Institute, they were also provided with a one-day unlimited Ventra Card. Recruitment and interviews were conducted from September 2017 thru February 2018.

**Instrumentation**

This mixed-methods study employed survey measurements and semi-structured interviews to explore its research questions and hypotheses. All surveys were available in English and Spanish; as noted, interviews were conducted in English only.

**Surveys**

**Personal information and demographic data.** Developed for this study, the Personal Information Form and the Demographic Information Form were used to gather key information and demographic characteristics such as age, race, income, and education level about each study participant. The Personal Information Form (see Appendix D) asked for parent/guardian name; parent guardian age; CCK2 child’s name; CCK2 child’s age; and, CCK2 child’s grade. The form also asked, “Are you interested in participating in the interview portion of the study?” If the parent indicated interest, they were prompted to provide phone number, the best time to call, as well as email address. The Demographic Information Form (see Appendix E) was a ten-item demographic survey used to collect data on age, race/ethnicity, relationship status, education level, income range, employment status, and religious affiliation.

**Intergenerational trauma.** IGT was examined via relationships among two measures in this study: 1) Family Stress Experiences Survey (mACEs Questionnaire; see Appendix A), a modified PHL ACEs Survey (Cronholm et al., 2015), which included parents’ endorsements of
Traumatic events for themselves, retrospectively through age 18, and for their 6-year-old children through the present; and 2) Brief Problem Monitor - Parent (BPM-P; Achenbach, McConaughy, Ivanova, & Rescorla, 2017; Penelo, de la Osa, Navarro, Domenech, & Ezpeleta, 2017; see Appendix F). This study adds to the literature as one of the first to calculate IGT using quantitative measurements.

**Trauma scores for parent and child - mACEs questionnaire.** The mACEs Questionnaire is a three-column, 26-item survey exploring ACEs in parents, their 6-year-old children and members of their racial/ethnic group (please note, racial/ethnic group data was not analyzed for this research study). This measure was created for this study to include the range of ACEs indicated in the Original ACEs, questions created for the PHL ACEs, and additional questions newly created. The Original ACEs has demonstrated satisfactory internal consistency with Cronbach’s alpha greater than or equal to .74 (as of this writing internal consistency has not been published for the PHL ACEs). The additional questions created by the author to further understand sociocultural context trauma included (See Appendix A for full measure):

- “People treated differently because of skin color and/or hair texture”;
- “Hide immigration status”;
- “People treated differently because of immigration status”; and,
- “Non-bullying bad experience in school”.

For consistency with previous ACEs literature, participants answered using a yes/no-dichotomous scale (Bethell et al., 2017); the number of yeses equal the mACEs score for each column in the survey (parent adverse events, child adverse events, perception of racial/ethnic
group adverse events). For the combined mACEs measure used here, the maximum score for parent or child was 26.

**Child negative behavior.** Because trauma may be transmitted not only through traumatic experiences themselves, but also via indirect effects on children’s behavior, this study measured child behavior challenges using the BPM-P (Achenbach et al., 2017). The BPM-P is a validated short version of the 120-item Child Behavior Checklist. The BPM-P is comprised of 19 items, six each for internalizing, externalizing and attention, as well as an additional item in the externalizing dimension to assess disobedient behavior at home separately from disobedient behavior at school (Penelo et al., 2017). The BPM-P has demonstrated satisfactory internal consistency (Cronbach’s alpha greater than or equal to .74), test-retest reliability in an eight - 16 day interval (r greater than or equal to .77), criterion-related validity (greater than or equal to 25%), and low or moderate cross-information agreement (Achenbach et al., 2017; Penelo et al., 2017). The BPM-P has also been validated in Spanish (Penelo et al., 2017). Confirmatory factor analysis of the expected three-factor model (attention, externalizing and internalizing) showed adequate fit (Root Mean Square Error of Approximation, less than or equal to .057), and measurement invariance across sex and age was observed. Internal consistency for the derived scores was satisfactory (with greater than or equal to .83). Concurrent validity with the equivalent scale scores of the original full Child Behavior Checklist (r greater than or equal to .84) and convergent validity was good (r greater than or equal to .84). The BPM-P was ordered from the Achenbach System of Empirically Based Assessment (www.aseba.org). Going forward, BPM-P will be referred to as Child Negative Behavior.

Parents answered each item on a three-point Likert-type scale (0 = not true; 1 =
somewhat true; and 2 = very true) that described the child. Example items included:

- “Acts too young for his/her age”;
- “Can’t sit still”;
- “Restless or hyperactive”; and,
- “Feels worthless or inferior”.

Items were summed into eight narrowband and two broadband syndrome scales and a total score, with higher scores reflecting higher behavior problem levels (Penelo et al., 2017). Child Negative Behavior (and Child mACEs/Trauma) was correlated with Parent mACEs/Trauma to assess IGT within this population of low-income African American and Latinx parents and children.

**Trait mindfulness.** Trait mindfulness was measured using the FFMQ (Baer et al., 2006; see Appendix G), a self-report measure of mindfulness as a trait rather than a practice. The FFMQ includes 39 items measured on a five-point rating scale from 1 (never or very rarely true) to 5 (very often or always true). Self-report is the primary method of measuring mindfulness (Williams, Dalgleish, Karl, & Kuyken, 2014).

FFMQ was developed through factor analysis with the aim of identifying the key facets of mindfulness using items from the five independently developed, theoretically derived mindfulness scales in the research literature (Baer et al., 2008; de Bruin, Topper, Muskens, Bögels, & Kamphuis, 2012). As noted in Chapter Two, these factors include: non-reactivity to inner experience, observing/noticing, acting with awareness, describing or labeling internal experiences, and non-judgment (Quaglia, Braun, Freeman, McDaniel, & Warren Brown, 2016; Williams et al., 2014). The five facets are combined to yield a total score. Higher total scores
reflected higher trait mindfulness. Example items in the survey include: “I perceive my feelings and emotions without having to react to them”; “I watch my feelings without getting lost in them”; and, “It’s hard for me to find the words to describe what I’m thinking.” This questionnaire has good internal consistency, construct validity, and reliability in clinical and nonclinical English and Spanish samples (Baer et al., 2006; Cebolla et al., 2012). Cronbach’s alpha for FFMQ subscales in the Spanish and English version ranged from .75 to .91 and the FFMQ has proven to be an effective instrument for measuring mindfulness in Spanish samples (Cebolla et al., 2012).

**Self-care.** To understand common activities or strategies for promoting self-care, the Caring for Myself Questionnaire (Saakvitne et al., 1996, see Appendix H) was utilized. Caring for Myself Questionnaire is a modified Self-Care Assessment Worksheet. The Self-Care Assessment Worksheet is a 70-item self-report measure that measures self-care on a five-point rating scale from 1 (*it never occurred to me*) to 5 (*frequently*). The worksheet is organized into five areas of self-care including:

- Physical self-care;
- Psychological self-care;
- Emotional self-care;
- Spiritual self-care; and,
- Workplace or professional self-care.

Examples of items include:

- “Take time off when sick”;
- “Attend to minimize stress in my life”;
• “Find things to make me laugh”;
• “Meditate”; and,
• “Cherish optimism and hope” (Saakvitne et al., 1996).

The original measure was created to support self-care strategies in professional adults that may be exposed to vicarious trauma. For the purposes of this study, a modifier was added so the respondents could skip the last section of the survey, workplace or professional self-care, if they did not have a paid job outside of the home. To date, this is the first attempt to comprehensively study Parent Self-Care in a group of primarily low-income African American and Latinx caregivers.

**Parenting self-efficacy.** Parenting Self-Efficacy was assessed using the Parenting Self-Agency Measure (PSAM; Dumka et al., 1996; see Appendix I). The PSAM is a ten-item measure that requires the respondent to identify self-agency on a seven-point scale from 1 (*never*) to 7 (*always*). Negative items were reverse scored to allow all items to be averaged such that higher scores closer to seven indicate higher parental self-efficacy.

The PSAM evaluates confidence in the parenting role, feelings of helplessness in the face of challenging child behavior, and degree of parenting effort and persistence (e.g., “I know I am doing a good job as a mother/father”). The scale was developed and validated with two samples: nonimmigrant European American mothers and immigrant Mexican American mothers (Dumka et al., 1996). The scale has strong reliability (.81) and construct validity, as demonstrated through correlations with other measures of generalized efficacy and parenting efficacy that ranged from .50 to .78 (e.g., Coleman & Karraker, 2000).
**Pilot study.** A face validity pilot study was conducted with five low-income African American adults with children age four. The purpose of this phase was to assure a basic level of relevance, readability, and reasonable time burden for the measures. It was found that the survey measures required at minimum 20 minutes to complete. The pilot focus group parents had no questions or concerns about completing the survey packet.

**Interviews**

Semi-structured interviews were conducted (see interview protocol, Appendix K) with a sub-sample of parents to explore constructs in the survey data at a deeper level, and to look for possible explanations of any unexpected findings in the quantitative data. The interviews examined the following constructs:

- Mindfulness in school;
- Moderating stress in children;
- Stress and trauma in the family; and,
- Mindful-like activities as practices to alleviate stress.

Study participants were asked identical initial questions, and follow-up probes varied. Parents’ quantitative surveys were used to occasionally stimulate conversation or to assist parents’ recall. Most interviews took approximately 50 minutes to complete.

**Data Analysis**

A total of 128 survey packets were collected from participants. However, after data clean-up, including removing respondents who completed the surveys but indicated that they did not want to participate in the study on the Consent Form (N=10), removing duplicates (N=4), and removing survey packets with 50% incomplete surveys (N=5), there were 109 remaining...
participants as the final study sample. The sample size met the a priori power analysis (see Appendix C for Power Analysis) conducted using G*Power (Faul, Erfelder, Buchner, & Lang, 2009) to estimate an appropriate sample size. Using Cohen’s (1988) criteria, a medium effect size of 0.3 was assumed. With power (1−β) set at 0.80 and α=.05, two-tailed, the projected sample size needed with this effect size was indicated as N=84.

Analyses Overview

After discussion of the demographic information and study variables, data analysis will be described for each research question.

**Demographic data.** Descriptive statistics including means and frequencies were calculated for the whole sample (N=109) and interview sample (N=23). This included:

- Parenting role;
- Gender of child(ren);
- Age of parent;
- Race/Ethnicity;
- Citizen status;
- Relationship status;
- Employment;
- Education; and,
- Religious preferences.

Independent sample t-tests were conducted to check whether there were significant differences between the non-interview sample and interview sample.

**Study variables.** Descriptive statistics were calculated for the means, standard deviations
and ranges for each study variable. This includes the independent variable (Parent mACEs/Trauma), buffering variables (Parent Self-Care, Parent Trait Mindfulness, and Parent Self-Efficacy), and dependent variables (Child mACEs/Trauma and Child Negative Behavior). Note that *summary* scores were calculated for the Child Negative Behavior (BPM-P) scale. Internal consistencies were calculated for new measures only (mACEs and Self-Care). Given this study’s emphasis on trauma and ACEs, frequencies at the item-level of the mACEs measure were explored in detail.

Pearson’s Correlation analyses were conducted to determine if the demographic characteristics were related to both the buffering variables and dependent variables.

**Q1. What is the prevalence of intergenerational trauma in a population of primarily low-income African American and Latinx parents and their 6-year-old children?**

The prevalence of IGT was analyzed in multiple ways. First, Pearson’s Product-Moment Correlation analyses were run to assess the quantitative relationship between Parent mACEs/Trauma and Child mACEs/Trauma, and between Parent mACEs/Trauma and Child Negative Behavior. Both relationships were analyzed as the first quantitative measure of IGT in the research literature. To further understand shared trauma experiences and therefore IGT prevalence, mACEs scores were analyzed at the item level to assess amount of overlap of mACEs between parent’s report of self and child.

**Q2: To What Extent Does Contemplative Self-Care, and/or Parent Self-Efficacy buffer the relationship between Parent mACEs/Trauma and Child Traumatic Effects, i.e., IGT?**

The proposed conceptual model of this mixed methods study (see Figure 1) sought to understand the proposed latent variable CSC’s role in buffering the relationship between Parent
mACEs/Trauma and CTE, i.e., to what extent parent strengths reduced IGT. The first step in the analysis was to test the central hypothesis by first determining if the composite variables, CSC and CTE, should have been created. As noted, Pearson’s Product-Moment Correlation analyses were conducted to see if there was a moderate to strong relationship ($r=0.6$) between Parent Self-Care and Parent Trait Mindfulness to create the composite CSC. Similarly, a Pearson’s Product-Moment Correlation was conducted to see if there was a moderate to strong relationship ($r=0.6$) between Child Negative Behavior and Child mACEs/Trauma.

A correlation matrix among all primary variables examined the bivariate relationships among the primary variables before going on to conduct the multivariate moderation analysis. To analyze the buffering relationships, a mean-split was created with every proposed parent strength variable/moderator and then subsequently correlations were conducted between parent trauma and child trauma and Child Negative Behavior separately for the high and low groups on the parent strengths variables. This was intended to provide a simplified, visual inspection of whether the moderation analysis held promise. Such promise would be indicated if the relationships indicating IGT (Parent mACEs/Trauma-Child mACEs/Trauma correlation; Parent mACEs/Trauma-Child Negative Behavior correlation) were lower in the portion of the sample with higher mindfulness or higher self-care, i.e., IGT is reduced in the presence of higher parent buffers. Subsequent to the mean-split, a moderation analyses using multiple regression (where the significance of the interaction term between the independent variable and moderator variable indicates moderation or buffering) was conducted to assess formally analyze whether moderation of IGT was present.
As explained further in Chapter Four, the mean-split and moderation analyses provided no hint of supporting the primary hypothesis (i.e., that mindfulness, self-care, or self-efficacy would reduce IGT), and thus the remainder of the relationships among variables were analyzed on a purely exploratory basis, in case the importance of relationships other than those hypothesized were underestimated. A Path Analysis was employed to determine whether or not this set of variables fit well as a model (Pedhazur, 1997). These analyses were conducted and interpreted with caution as some statistically significant relationships may emerge due to chance.

Q3. In what ways are primarily low-income African American and Latinx parents engaging in mindful-like activities and ways of being to alleviate stress in themselves and their children?

The triangular mixed methods design employed in this study allowed quantitative data to inform the questions and probes in the qualitative interviews (Creswell & Plano Clark, 2011). The qualitative data analysis followed a systematic approach including familiarizing oneself with the data, initial coding, and creation of the code book, focused coding, reliability coding using intraclass correlations coefficients (ICC), and coding the complete set of transcripts.

First, after the transcripts were received from the transcription service (Verbal Ink) the transcripts were cross-checked with the audio file. Subsequent to the test transcripts, all interview transcripts were reviewed while also listening to their audio files to understand the spirit and tone of each interview, to ensure accurate coding and to immerse myself in the data to enhance familiarity with the depth and breadth of the content (Braun & Clark, 2006; Chapman, Hadfield, & Chapman, 2015). The data were stored and analyzed in Atlas.ti, a qualitative software package. Microsoft Excel was used to develop and manage the code book.
Thematic analysis (Braun & Clarke, 2006) was employed to analyze the qualitative data. Consistent with the spirit of thematic analysis, an inductive and deductive data analytical approach ensued which included creating an initial set of codes from the Interview Protocol (see Appendix J) as well as creating themes and categories that emerged from the data (Braun & Clarke, 2006). The initial themes included:

- CCK2;
- Parent Aspirations;
- Parent Stress;
- Child Stress;
- Child School Experience;
- Parent School Experience;
- Helping Child Deal with Stress;
- Parent Wisdom;
- Sociocultural Context;
- Parent Self-Care;
- Trauma;
- Mindfulness; and,
- Mindful-Like Activities.

Once a draft code book was complete, analysis began with a line-by-line examination of the first set of three interviews.

Coding proceeded in a two-stage process allowing for codes and categories to be added and removed throughout. Codes are short statements that capture the meaning of the phrase, and
can be used to index the data and group together phrases with similar ideas or meanings (Boyatzis, 1998). An initial set of 241 codes that corresponded with the noted themes were created from the first three interviews. After the review of the first set of transcripts, a Research Assistant (who was familiar with the study and qualitative methods, and was CITI certified in the ethical protection of human subjects) was engaged. Using the first set of 241 codes, both the Research Assistant and I coded the first set of three interviews as a form of training. A series of revisions were conducted over a three-month period, including refining the code book and categories to a final set of 83 codes and 11 categories (list of categories and major thematic codes can be found in Table 14). Using the final code book, the Research Assistant and I independently coded 12 of 23 (or 52%) of the transcripts, meeting biweekly to discuss any disagreements and themes found in the data. These series of meetings identified Conscious Buffering and Contemplative Self-Care as emergent categories in the qualitative data. I then used the final code book and category list to code the remaining 8 or 35% of the interviews.

**Qualitative rigor.** While qualitative research offers rich and compelling data, it is susceptible to criticism regarding its objectivity and rigor (Yin, 2009). As a result of these critiques, there has been significant attention paid to measures such as applicability, consistency and neutrality, which establish a study's findings as trustworthy (Lincoln & Guba, 1985). In order to promote measures of trustworthiness, I engaged in the following strategies throughout the qualitative portion of this study:

- Reviewed the interview guide with committee members to detect possible biases that may lead participants to answer interview questions in a certain way;
- Continued to assess the interview guide, and identified topics that needed further
clarification and/or probing and detected possible biases or questions that may be too leading for participants;

- Shared initial and revised code books with Dissertation Chair and Research Assistant;
- Coded the first three interviews with Research Assistant and Dissertation Chair; and,
- Sought the ongoing guidance of Dissertation Chair as coding and categorizing the qualitative data continued.

In addition, to promote rigor and enhance reliability of the qualitative data, a measurement of inter-rater reliability - ICC - was conducted, after training indicated high agreement, for the 12 transcripts that were coded independently. Hektner, Schmidt and Csikszentmihalyi (2007) recommend double coding 10% of the data or three interviews in this case. This parameter was far exceeded as 12, or 52%, of the interviews were double coded. Inter-coder reliability was calculated using intra-class correlations at the level of the 11 major qualitative constructs. That is, for each of those variables (e.g., mindfulness, parent stress), an ICC was calculated across the two coders’ frequencies, for the 15 double-coded cases. The average ICC across the 11 variables was .81, indicating a satisfactory level of independent agreement across the coders.

**Ethical Considerations**

Given the study design of conducting research in schools with a population of vulnerable parents and asking questions about trauma in themselves and their children, ethical considerations were central to this study design. Researchers are mandated to abide by principles of autonomy, beneficence, and justice to ensure participant independence, safety, and equity respectively (Israel & Hay, 2006). As such, in this study research participants completed Consent Forms, which outlined the nature of the study, including study incentives, addressed their rights
as participants including noting that participation as a voluntary service, and acknowledged their potential risk and benefits. Anonymity was maintained throughout by assigning unique identification numbers used throughout the study. In regards to quantitative data, participants were encouraged to sit and complete the survey packets with physical space between them to encourage confidentiality and anonymity among their school community, as previously discussed. Quantitative surveys were stored on my password protected computer with paper files destroyed. In regards to qualitative data, only myself, my Dissertation Chair and Quantitative Tutor had access to the quantitative dataset. Interview participants were reminded of anonymity and confidentiality. All interviews were conducted in a location that allowed for confidentiality. No identifying information was used in the interview transcripts. The audio files of the interview transcripts, transcripts, electronic files of the surveys were stored on my password protected computer in which no one had access. Only myself, my Dissertation Chair and Research Assistant had access to discussed interview transcripts.

While efforts were taken to ensure ethical considerations were met, participants may have been subject to minimal risk, including feelings of discomfort while completing both the surveys and participating in interviews where stress and trauma were discussed.

In addition, this research project intentionally included primarily African American and Latinx research participants to honor their lived experiences, and to help diversify the population studied in human subject research. This project met the federal mandate issued by the National Institute of Health Revitalization Act (1993) which calls for researchers to bridge health disparities by including women and people of color in human subject research.
Summary

This research investigation employed a mixed methods study on a sample (N=109) of African American and Latinx parent with children aged 6. Participants were recruited from their participation in their school’s CCK2 Family Engagement Event where they were informed about their school’s new social-emotional learning program and its related RCT. The research design included survey administration to the whole sample (N=109) and semi-structured interviews with a sub-set of the sample (N=23). This study is the first to offer a quantitative evaluation of IGT. Given that the no evidence was found for parent strengths buffering IGT (Q2), the final methodological approach added an exploratory strategy that included a Path Analysis and mediation analysis using the Sobel Test. Issues of research trustworthiness, validity and reliability were addressed. Chapter Four describes the results of these analyses.
CHAPTER FOUR

RESULTS

This study sought to understand the prevalence of IGT and the potential buffering role that parent strengths including mindfulness characteristics or traits, self-care strategies, and/or parenting self-efficacy would play in reducing IGT. This chapter presents all analytic results including descriptive statistics of the study variables.

Descriptives: Demographics

Whole Sample

One hundred and nine caregivers participated in this study. As expected, 91% of the sample were Black/African American or Latinx; 51% and 40% respectively. Of the Latinx sample, 41% were first generation immigrants. Of the total sample, 81.5% were between the ages of 25 and 44 years old. Eighty-one percent of the parents/caregivers were mothers with the gender of the child reported approximately equal, i.e., 46.8% girls and 50.9% boys. More than half of the sample was coupled, i.e., 61% of the caregivers were married or lived with a partner. As noted in the Methods Chapter, the sample was recruited from CCK2 Family Engagement Events at schools with 70% or more of the population eligible for free and reduced lunch. Under half of the sample was employed - 43% of the respondents reported full- or part-time employment, whereas 21% reported being homemakers and 16% reported being unemployed. Almost 1/3, or 29%, of the sample had a college degree or greater. The whole sample
represented caregivers with children in 15 of the 16 schools in the larger study. Complete demographic data for the sample appear in Table 2.

**Qualitative Sample**

Of the 109 participants, 23 caregivers, or 21%, partook in the semi-structured 60-minute interviews for further exploration of some of the themes captured by the quantitative measures. The interview sample represented parents or caregivers with children in 13 of the 16 schools in the RCT. Independent samples t-tests comparing the interviewed and non-interviewed samples demonstrated a significant demographic difference in participants born in the United States \( t(106)=2.657, p<.01 \); i.e., the interviewed sample contained fewer immigrants because the interviews were conducted in English. None of the other differences between the two subsamples were significant.

**Descriptives: Study Variables**

In Table 3 below, the descriptive statistics of the substantive study variables are presented. This includes the independent variable (Parent mACEs/Trauma), buffering variables (Parent Self-Care, Parent Trait Mindfulness, and Parent Self-Efficacy), and dependent variables (Child mACEs/Trauma and Child Negative Behavior). Individual sections follow to discuss the descriptive results in more detail and provide a rich picture of the sample. The mACEs/Trauma variables are explored in greatest detail to interpret Q1 in full context; i.e. to understand how much trauma this group of parents and children shared, it is important to understand how much trauma was experienced in each generation separately.
Table 2. Demographic Data for the Whole Sample (N=109) and Interview Sample (N=23)

<table>
<thead>
<tr>
<th>Role in Child’s Life</th>
<th>Whole Sample</th>
<th>Interview Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Mother</td>
<td>88</td>
<td>80.7%</td>
</tr>
<tr>
<td>Father</td>
<td>7</td>
<td>6.4%</td>
</tr>
<tr>
<td>Grandparent</td>
<td>9</td>
<td>8.3%</td>
</tr>
<tr>
<td>Foster Parent</td>
<td>2</td>
<td>1.8%</td>
</tr>
<tr>
<td>Aunt/Uncle</td>
<td>1</td>
<td>0.9%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1.8%</td>
</tr>
<tr>
<td>Child Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>55</td>
<td>50.9%</td>
</tr>
<tr>
<td>Female</td>
<td>51</td>
<td>47.2%</td>
</tr>
<tr>
<td>Twins</td>
<td>2</td>
<td>1.9%</td>
</tr>
<tr>
<td>Parent Age</td>
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</tr>
<tr>
<td>25-34 years old</td>
<td>47</td>
<td>43.5%</td>
</tr>
<tr>
<td>35-44 years old</td>
<td>41</td>
<td>38.0%</td>
</tr>
<tr>
<td>45-54 years old</td>
<td>9</td>
<td>8.3%</td>
</tr>
<tr>
<td>55-64 years old</td>
<td>6</td>
<td>5.6%</td>
</tr>
<tr>
<td>65-74 years old</td>
<td>2</td>
<td>1.9%</td>
</tr>
<tr>
<td>75-84 years old</td>
<td>3</td>
<td>2.8%</td>
</tr>
<tr>
<td>Racial/Ethnic Background</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American or Black</td>
<td>56</td>
<td>51.4%</td>
</tr>
<tr>
<td>Hispanic or Latinx</td>
<td>44</td>
<td>40.4%</td>
</tr>
<tr>
<td>Asian American or Pacific Islander</td>
<td>1</td>
<td>0.9%</td>
</tr>
<tr>
<td>White or European American</td>
<td>4</td>
<td>3.7%</td>
</tr>
<tr>
<td>Biracial or Multiracial</td>
<td>4</td>
<td>3.7%</td>
</tr>
<tr>
<td>Born in the United States**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>81</td>
<td>75.0%</td>
</tr>
<tr>
<td>No</td>
<td>27</td>
<td>25.0%</td>
</tr>
<tr>
<td>Parents Born in the United States</td>
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<td></td>
</tr>
<tr>
<td>Yes</td>
<td>64</td>
<td>59.3%</td>
</tr>
<tr>
<td>No</td>
<td>44</td>
<td>40.7%</td>
</tr>
<tr>
<td>Relationship Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>46</td>
<td>42.6%</td>
</tr>
<tr>
<td>Single</td>
<td>36</td>
<td>33.3%</td>
</tr>
<tr>
<td>Divorced</td>
<td>2</td>
<td>1.9%</td>
</tr>
<tr>
<td>Living with a partner</td>
<td>18</td>
<td>16.7%</td>
</tr>
<tr>
<td>Have partner, live separately</td>
<td>1</td>
<td>0.9%</td>
</tr>
<tr>
<td>Separated</td>
<td>1</td>
<td>0.9%</td>
</tr>
<tr>
<td>Widowed</td>
<td>3</td>
<td>0.9%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.9%</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed full-time</td>
<td>31</td>
<td>28.4%</td>
</tr>
<tr>
<td>Employed part-time</td>
<td>16</td>
<td>14.7%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>17</td>
<td>15.6%</td>
</tr>
<tr>
<td>Homemaker</td>
<td>23</td>
<td>21.1%</td>
</tr>
<tr>
<td>Student/Job training</td>
<td>4</td>
<td>3.7%</td>
</tr>
<tr>
<td>Disabled</td>
<td>7</td>
<td>6.4%</td>
</tr>
<tr>
<td>Retired</td>
<td>5</td>
<td>4.6%</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>5.5%</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graduated elementary school</td>
<td>1</td>
<td>1.0%</td>
</tr>
<tr>
<td>GED or vocational certificate</td>
<td>12</td>
<td>11.5%</td>
</tr>
<tr>
<td>Graduated high school</td>
<td>28</td>
<td>26.9%</td>
</tr>
<tr>
<td>Some college courses</td>
<td>32</td>
<td>31.7%</td>
</tr>
<tr>
<td>College degree</td>
<td>22</td>
<td>21.2%</td>
</tr>
<tr>
<td>Post-College degree</td>
<td>8</td>
<td>7.7%</td>
</tr>
<tr>
<td>Religious Preference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>85</td>
<td>78.7%</td>
</tr>
<tr>
<td>Muslim</td>
<td>1</td>
<td>0.9%</td>
</tr>
<tr>
<td>Non-Religious</td>
<td>17</td>
<td>15.6%</td>
</tr>
<tr>
<td>Jewish</td>
<td>1</td>
<td>0.9%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>3.7%</td>
</tr>
</tbody>
</table>

Note. **. T-test indicating a significant difference at the 0.01 level (2-tailed). The T-test compared the non-overlapping interviewed sample vs. non-interviewed samples, not the whole sample and the interviewed sample. However, the whole-sample descriptives are presented as assumed they are of greatest importance.
Table 3. Descriptive Statistics of the Study Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Trauma/mACEs</td>
<td>109</td>
<td>6.90</td>
<td>5.44</td>
<td>0-24</td>
</tr>
<tr>
<td>Child Trauma/mACEs</td>
<td>109</td>
<td>3.37</td>
<td>1.39</td>
<td>0-15</td>
</tr>
<tr>
<td>Racial/Ethnic Group Trauma mACEs</td>
<td>109</td>
<td>13.39</td>
<td>10.30</td>
<td>0-26</td>
</tr>
<tr>
<td>Child Negative Behavior (BPM-P)</td>
<td>107</td>
<td>8.93</td>
<td>6.13</td>
<td>0-31</td>
</tr>
<tr>
<td>Parent Self-Efficacy (PSAM)</td>
<td>109</td>
<td>5.65</td>
<td>0.73</td>
<td>3.5-7</td>
</tr>
<tr>
<td>Parent Self-Care (PSC)</td>
<td>107</td>
<td>1.90</td>
<td>0.53</td>
<td>1-3</td>
</tr>
<tr>
<td>PSC - Physical</td>
<td>107</td>
<td>2.10</td>
<td>0.50</td>
<td>1-3</td>
</tr>
<tr>
<td>PSC - Psychological</td>
<td>106</td>
<td>1.62</td>
<td>0.64</td>
<td>0-3</td>
</tr>
<tr>
<td>PSC - Emotional</td>
<td>104</td>
<td>1.98</td>
<td>0.60</td>
<td>0-3</td>
</tr>
<tr>
<td>PSC - Spiritual</td>
<td>104</td>
<td>1.93</td>
<td>0.61</td>
<td>0-3</td>
</tr>
<tr>
<td>PSC - Relationship</td>
<td>103</td>
<td>1.78</td>
<td>0.67</td>
<td>0-3</td>
</tr>
<tr>
<td>PSC - Workplace</td>
<td>65</td>
<td>2.04</td>
<td>0.68</td>
<td>0-3</td>
</tr>
<tr>
<td>Parent Trait Mindfulness (FFMQ)</td>
<td>107</td>
<td>3.51</td>
<td>0.47</td>
<td>2-5</td>
</tr>
<tr>
<td>FFMQ - Observing</td>
<td>107</td>
<td>3.37</td>
<td>0.74</td>
<td>1-5</td>
</tr>
<tr>
<td>FFMQ - Describing</td>
<td>107</td>
<td>3.54</td>
<td>0.80</td>
<td>2-5</td>
</tr>
<tr>
<td>FFMQ - Awareness</td>
<td>107</td>
<td>3.84</td>
<td>0.64</td>
<td>2-5</td>
</tr>
<tr>
<td>FFMQ - Non-Judging</td>
<td>107</td>
<td>3.60</td>
<td>0.67</td>
<td>2-5</td>
</tr>
<tr>
<td>FFMQ - Non-Reactivity</td>
<td>107</td>
<td>3.16</td>
<td>0.70</td>
<td>1-5</td>
</tr>
</tbody>
</table>

**Modified Adverse Childhood Experiences**

Recall that the mACEs Questionnaire surveyed the prevalence of ACEs among the reporting parents and their 6-year old children, and that it included questions from the following sources (see Appendix A): 1) Original ACEs study (Felitti et al., 1998); 2) PHL ACEs study (Cronholm et al., 2015) which added questions to the Original ACEs that were relevant to urban and low-income populations; and, 3) author-created questions that explored additional areas of interest around sociocultural trauma (e.g., colorism). The internal consistency of the mACEs, both Parent mACEs (26 items) and Child mACEs (26 items) was satisfactory with a Cronbach’s alpha of 0.87 and 0.82 respectively. Further review of the Cronbach’s alpha for each component of the mACEs was as follows: The Cronbach’s alpha of the Original ACEs for both parents and
children were satisfactory at 0.88 and 0.76. The Cronbach’s alpha for the Philadelphia items and
the items I added were lower than generally considered adequate reliability. The Cronbach’s
alpha for the Philadelphia items was 0.60 for the parent (7 items) and 0.68 (7 items) for the
children. The Cronbach’s alpha of items I added was 0.46 for both the parent (7 items) and 0.46
for the child (7 items). The numbers being lower than generally considered adequate reliability
for the items I added is likely the case as the author-created mACEs questions were added to
capture possibly discrete instances of sociocultural context trauma. It was therefore not presumed
that these items would hang together (e.g., colorism, bad experiences in school, lack of
opportunity in neighborhood). As shown above, on average in this sample, parents endorsed
more than the number of adverse experiences shown by Brown et al. (2009) to be associated with
a 20-year shorter life span than those exposed to no ACEs, i.e., 6, although it is not clear whether
that is a result of actually having more trauma or of there being more items to choose from (or,
conversely, the earlier measures not providing an adequate selection of traumatic events from
which to choose). The results also show that the children in this sample had already experienced
more than half that number by age 6; i.e., 3.37 mACEs on average. To examine single-generation
prevalence of each traumatic event, Table 4 documents the percent and number of parents and
children that experienced each individual trauma, according to parent report.

To help further understand the actual content of trauma in this sample, the top five
frequently experienced parent and child traumatic experiences were extracted from Table 4 and
highlighted in Tables 5 and 6. The Top Five tables also denote the categories of intergenerational
transmission type discussed in the theoretical model in Chapter One – caregiving behavior
patterns, experience and/or witness trauma, and/or sociocultural context. Notably, parents
reported experiencing or witnessing violence and sociocultural context trauma as the most prevalent traumatic experiences in their lives; caregiver behavioral pattern trauma type was least reported.

Table 4. Percentage of Sample Experiencing Each Trauma

<table>
<thead>
<tr>
<th>mACEs</th>
<th>Parent Mean</th>
<th>Child Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Neighborhood unsafety</td>
<td>31</td>
<td>33</td>
</tr>
<tr>
<td>Neighborhood lack of trust</td>
<td>26</td>
<td>27</td>
</tr>
<tr>
<td>No opportunities in neighborhood</td>
<td>31</td>
<td>33</td>
</tr>
<tr>
<td>Experience bullying by classmate</td>
<td>35</td>
<td>38</td>
</tr>
<tr>
<td>Experience bullying by school adult</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Non-Bullying bad experience in school</td>
<td>25</td>
<td>27</td>
</tr>
<tr>
<td>Witness neighborhood violence</td>
<td>51</td>
<td>54</td>
</tr>
<tr>
<td>Family food insecurity</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>Experience racism</td>
<td>50</td>
<td>54</td>
</tr>
<tr>
<td>Experience xenophobia</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>Experience colorism</td>
<td>42</td>
<td>45</td>
</tr>
<tr>
<td>Hide immigration status</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Mentally ill family member - general</td>
<td>27</td>
<td>29</td>
</tr>
<tr>
<td>Mentally ill family member - suicide</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Substance abuse household member - alcohol</td>
<td>34</td>
<td>37</td>
</tr>
<tr>
<td>Substance abuse household member - drugs</td>
<td>28</td>
<td>30</td>
</tr>
<tr>
<td>Incarcerated household member</td>
<td>28</td>
<td>30</td>
</tr>
<tr>
<td>Undocumented household member</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>Experience foster care</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Witness intimate partner violence - emotional</td>
<td>51</td>
<td>55</td>
</tr>
<tr>
<td>Witness intimate partner violence - physical</td>
<td>36</td>
<td>38</td>
</tr>
<tr>
<td>Experience emotional abuse</td>
<td>35</td>
<td>37</td>
</tr>
<tr>
<td>Experience physical abuse</td>
<td>24</td>
<td>26</td>
</tr>
<tr>
<td>Experience feeling afraid of adult in home</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>Experience sexual abuse - touching</td>
<td>25</td>
<td>26</td>
</tr>
<tr>
<td>Experience sexual abuse - sexual intercourse</td>
<td>18</td>
<td>19</td>
</tr>
</tbody>
</table>

Note. Percent of sample experiencing each trauma, N=109.
Sociocultural context trauma was noted to be predominately experienced by the children.

Table 5. Top Five Parent Adverse Childhood Experience Age 0-18

<table>
<thead>
<tr>
<th>mACEs</th>
<th>%</th>
<th>Transmission Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witness neighborhood violence</td>
<td>51</td>
<td>Sociocultural context</td>
</tr>
<tr>
<td>Witness intimate partner violence - emotional</td>
<td>51</td>
<td>Experience/Witness Violence</td>
</tr>
<tr>
<td>Experience racism</td>
<td>50</td>
<td>Sociocultural context</td>
</tr>
<tr>
<td>Experience colorism</td>
<td>42</td>
<td>Sociocultural context</td>
</tr>
<tr>
<td>Witness intimate partner violence - physical</td>
<td>36</td>
<td>Experience/Witness Violence</td>
</tr>
</tbody>
</table>


Furthermore, to understand ACEs in the parent generation in this sample relative to previous research, the author-created Parent mACEs/Trauma items were compared to the Original ACEs items and PHL ACEs items (see Table 7). Note, it was not possible to compare mACEs items to previous research as the mACEs Questionnaire was created for the current study. However, compared to the Kaiser ACE study, at an average of three Original ACEs, the current sample’s adults reported higher rates of most Original ACEs except for experiencing sexual abuse; the Kaiser sample experienced slightly higher rates of sexual abuse. Notably, the adult Chicago sample’s highest rate of Original ACEs items were witness domestic violence (43.2%), mentally ill household member (34.6%) and substance using household member (31.1%). Looking at the PHL ACEs items, the Chicago sample’s most reported were experiencing racism (50%), bullying (35.2%), and witnessing neighborhood violence (30.8%);
similar to the Philadelphia sample the least reported ACE in the adult Chicago sample is lived in foster care (Philadelphia sample = 2.5%; Chicago sample = 3.7%). Of the author-created items, the highest reported items were experience colorism (41.7%), lack of opportunity in neighborhood (31.4%) and non-bullying bad experiences in school (25%, e.g., asked for help and never received it). Note, the total number of Original ACEs in the mACEs measure was 12 as consistent with the PHL ACEs study (Cronholm et al., 2015); however, nine Original ACEs are listed in Table 7 for adequate comparison.

Overall, as indicated in Table 7, the adults in the Chicago sample experienced more ACEs than the Philadelphia sample with approximately 27% and 22%, respectively. Additionally, Table 7 shows that both the Chicago sample and Philadelphia sample experienced more Original ACEs than the Kaiser sample at 27%, 22%, and 14% respectively. This data supports the overall notion that higher levels of trauma exist in African American and Latinx low-income populations.

Previous studies examining ACEs have looked at the overall number of ACE indicators a person has accumulated and categorized ACE exposure as 0=no ACE; 1-3 ACEs; and, 4 or more ACEs. I will present the data in this form as well. Thirty or 28% of Chicago adults have no Original ACEs compared to 47.9% of the participants in the Kaiser sample and 30% of the participants in the Philadelphia sample (Public Health Management Corporation, 2013). Forty-four parents or 40% of the Chicago sample experienced between one and three ACEs. This is lower than the Philadelphia sample in which 48.4% experienced between one and three ACEs and 45.3% of the Kaiser sample which experienced between one and three ACEs. The Chicago sample’s numbers increase as the number of ACEs increase, however. Thirty-five (32%)
Chicago adults experienced four or more ACEs compared to 6.8% of Kaiser sample and 21.5% of the Philadelphia sample (Public Health Management Corporation, 2013). In sum, the Chicago adults exhibit a higher rate of trauma-related risk than both the original Kaiser sample and the Philadelphia sample.

Table 7. Prevalence of Original, Expanded, and mACEs in Kaiser, Philadelphia and Chicago Sample

<table>
<thead>
<tr>
<th>Adverse Childhood Experience</th>
<th>Kaiser Sample (N=8,056), %</th>
<th>Philadelphia Sample (N=1,784), %</th>
<th>Chicago Parent Sample (N=109), %</th>
<th>Chicago Child Sample (N=109) %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Original ACEs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experienced physical abuse</td>
<td>10.8</td>
<td>38.1</td>
<td>24.3</td>
<td>11</td>
</tr>
<tr>
<td>Substance using household member</td>
<td>25.6</td>
<td>34.8</td>
<td>31.1</td>
<td>7</td>
</tr>
<tr>
<td>Experienced emotional abuse</td>
<td>11.1</td>
<td>33.2</td>
<td>23.6</td>
<td>21</td>
</tr>
<tr>
<td>Mentally ill household member</td>
<td>18.8</td>
<td>24.1</td>
<td>34.6</td>
<td>8</td>
</tr>
<tr>
<td>Witnessed domestic violence</td>
<td>12.5</td>
<td>20.2</td>
<td>43.2</td>
<td>24</td>
</tr>
<tr>
<td>Experienced sexual abuse</td>
<td>22</td>
<td>16.2</td>
<td>21.2</td>
<td>0</td>
</tr>
<tr>
<td>Incarcerated household member</td>
<td>3.4</td>
<td>12.9</td>
<td>27.8</td>
<td>11</td>
</tr>
<tr>
<td>Experienced emotional neglect</td>
<td>14.8</td>
<td>7.7</td>
<td>23.6</td>
<td>6</td>
</tr>
<tr>
<td>Family food insecurity</td>
<td>9.9</td>
<td>7</td>
<td>17</td>
<td>12</td>
</tr>
<tr>
<td>Average Original ACEs</td>
<td>14.3</td>
<td>21.6</td>
<td>27.4</td>
<td>11.0</td>
</tr>
<tr>
<td><strong>Expanded ACEs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Witnessed neighborhood violence</td>
<td>N/A</td>
<td>40.5</td>
<td>30.8</td>
<td>24</td>
</tr>
<tr>
<td>Experience racism</td>
<td>N/A</td>
<td>34.5</td>
<td>50</td>
<td>21</td>
</tr>
<tr>
<td>Unsafe neighborhood</td>
<td>N/A</td>
<td>27.3</td>
<td>26.2</td>
<td>24</td>
</tr>
<tr>
<td>Experienced bullying by classmate</td>
<td>N/A</td>
<td>8</td>
<td>35.2</td>
<td>32</td>
</tr>
<tr>
<td>Lived in foster care</td>
<td>N/A</td>
<td>2.5</td>
<td>3.7</td>
<td>5</td>
</tr>
<tr>
<td>Average Expanded ACEs</td>
<td>21.9</td>
<td>28.0</td>
<td>14.5</td>
<td></td>
</tr>
<tr>
<td><strong>Modified ACEs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of opportunity in neighborhood</td>
<td>N/A</td>
<td>N/A</td>
<td>31.4</td>
<td>23</td>
</tr>
<tr>
<td>Experience bullying by teacher or school adult</td>
<td>N/A</td>
<td>N/A</td>
<td>9.5</td>
<td>9</td>
</tr>
<tr>
<td>Non-Bullying bad experiences in school</td>
<td>N/A</td>
<td>N/A</td>
<td>25</td>
<td>14</td>
</tr>
<tr>
<td>Experience xenophobia</td>
<td>N/A</td>
<td>N/A</td>
<td>23</td>
<td>10</td>
</tr>
<tr>
<td>Hidden immigration status</td>
<td>N/A</td>
<td>N/A</td>
<td>7.4</td>
<td>3</td>
</tr>
<tr>
<td>Parent immigration status</td>
<td>N/A</td>
<td>N/A</td>
<td>15.1</td>
<td>14</td>
</tr>
<tr>
<td>Experience colorism</td>
<td>N/A</td>
<td>N/A</td>
<td>41.7</td>
<td>19</td>
</tr>
</tbody>
</table>

Note. With exception of neglect data, all Kaiser and Philadelphia data are obtained from Felitti et al. (1998) and Cronholm et al. (2015). Neglect questions were not accessed on the original Kaiser ACEs survey, but were added in Wave 2 (N=8,667). For comparison purposes, neglect data from Wave 2 were added. Family food insecurity equals to physical neglect in the Original ACEs survey and Philadelphia survey. The percentage of substance using household member, mentally ill household member, witness domestic abuse and experience sexual abuse does not align exactly with Table 4 Means and Standard Deviation of mACEs Questionnaire because certain items had to be averaged to align with Kaiser and Philadelphia samples.

The 6-year-old children in this sample have experienced slightly more Original ACEs than national samples with children ages 0-17. Reported by their parents, 66 or 61% of the
children in the Chicago sample experienced no ACEs. Thirty-three children (30%) in the Chicago sample experienced between one and three ACEs; 10 children or 9% of the sample experienced four or more ACEs. However, other nationally representative samples found that approximately 68% of children experience no ACEs, approximately 33% of children experienced from one to three ACEs and 3% of children experienced four or more ACEs (Bethel et al., 2014; Bright et al., 2015; Wing et al., 2015). State-based data also reveal that the Chicago sample has experienced more Original ACEs than other children in Illinois - 20% of children ages 0-17 in Illinois, experience one ACE, 10% experience two ACEs, and 10% experience 3-8 ACEs (Sacks & Murphey, 2018). Note, Illinois data does not align with other ways of reporting ACEs data. Given this data, it is plausible that the current sample of children were at higher risk given that these data were reported by age 6, vs. the Illinois and national data which extended through age 17. The question of the association between parent trauma and child traumatic effects, i.e., IGT, will be addressed in Q1.

**Child negative behavior.** Recall that Child Negative Behavior was assessed using the BPM-P, a short version of the Child Behavior Checklist. The BMP-P subscales and their means are listed in Table 8. Using a previous study to compare BPM-P means and standard deviation (SD) between girls and boys ages six thru eight (Penelo et al., 2017), the same age range as the current sample, the current sample has higher Child Negative Behaviors. The mean internalizing child negative behavior was 1.62 in this sample compared to 1.45 in the Penelo et al. sample; externalizing child negative behavior was 3.63 in this sample compared to 1.74 in the Panelo et al. sample; and attention problems were 3.81 in this sample compared to 2.65 in the Panelo et al. sample. Thus, the rate of parent reported Child Negative Behavior in this sample appeared to be
relatively high, especially for externalizing behavior and attention problems.

Table 8. Child Negative Behavior Subscales Composite Mean, Standard Deviation and Range

<table>
<thead>
<tr>
<th>Subscale</th>
<th>N</th>
<th>Mean (SD)</th>
<th>Actual Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internalizing</td>
<td>104</td>
<td>1.62(1.67)</td>
<td>0-6</td>
</tr>
<tr>
<td>Externalizing</td>
<td>104</td>
<td>3.63(2.89)</td>
<td>0-13</td>
</tr>
<tr>
<td>Attention problems</td>
<td>103</td>
<td>3.81(2.90)</td>
<td>0-12</td>
</tr>
</tbody>
</table>

Note. The mean and standard deviation reflect the composites of the subscales.

**Parent self-efficacy.** Recall that Parent Self-Efficacy was assessed using the PSAM (Dumka et al., 1996). The mean PSAM of 5.65 (with a range of 4-7; SD=0.73) in this sample suggests that on average, these parents felt efficacious and confident in their parenting. The PSAM results were similar to other studies measuring parent self-efficacy. Among a study looking at both White and European American, English speaking, middle income population and a sample of Spanish speaking, Mexican American, low-income mothers, the PSAM means of 5.55 and 5.62 (Dumka et al., 1996) were similar to the means found in this study.

**Parent self-care.** Recall that Parent Self-Care was assessed using the Self-Care Assessment Worksheet (Saakvitne et al., 1996) that outlines six areas of self-care: physical, psychological, emotional, spiritual, workplace, and relationship. The internal consistency of the Self-Care Assessment Worksheet in this sample was excellent with a Cronbach’s alpha of 0.98 across the 73 items. Possible scores on each subscale depend on the numbers of items within that subscale (Alkema, Linton, & Davies, 2008). Higher total scores for each subscale indicate more engagement in self-care activities and lower scores indicate low engagement in self-care. On a scale from 0 = I never do this to 3 = I do this frequently, Parent Self-Care mean composite score for this sample was 1.90 (SD=0.53). While research with this tool is limited, it appears that parents in this sample engaged in a moderate amount of self-care.
Given the lack of previous research with this tool, a slightly more granular picture of Parent Self-Care activities in this sample is offered. Table 9 below presents the highest reported self-care activities in each subscale.

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>M(SD)</th>
<th>Subscale Highest Self-Care Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Self-Care Total Average Subscale</td>
<td>107</td>
<td>1.90(0.53)</td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>107</td>
<td>2.1(0.54)</td>
<td>Take baths</td>
</tr>
<tr>
<td>Psychological</td>
<td>106</td>
<td>1.62(0.64)</td>
<td>Listen to my thoughts, beliefs, attitudes and feelings</td>
</tr>
<tr>
<td>Emotional</td>
<td>104</td>
<td>1.98(0.61)</td>
<td>Love myself; stay in contact with important people in my life</td>
</tr>
<tr>
<td>Spiritual</td>
<td>104</td>
<td>1.93(0.62)</td>
<td>Pray</td>
</tr>
<tr>
<td>Relationship</td>
<td>103</td>
<td>1.78(0.67)</td>
<td>Schedule activities with my children</td>
</tr>
<tr>
<td>Workplace</td>
<td>65</td>
<td>2.04(0.68)</td>
<td>Make quiet time to complete tasks</td>
</tr>
</tbody>
</table>

Note. The subscale means reflect values between 0 = I never do this and 3 = I do this frequently. The means of the subscale is reported with the highest reported self-care activity.

Physical self-care is the highest reported self-care activity overall. This is consistent with the only published study (Fisackerly, Sira, Desai, & McCammon, 2015) using the Self-Care Assessment Worksheet. The current sample reported taking baths as the highest rated physical self-care activity. Of the parents who worked (43% of the sample), workplace self-care follows; in this vein, the sample reported the highest method of workplace self-care was making quiet time to complete tasks. Of the 57% of caregivers who did not work (unemployed, a homemaker, retired, disabled or a student/job training), both spiritual and emotional self-care followed physical self-care. This is similar to Fisackerly et al.’s research which ranked emotional self-care to be the second highest self-care method. Consistent with self-care research among African American and Latinx populations (Kim & Dee, 2017), this sample reported prayer among the highest levels of reported spiritual self-care items. Both Fisackerly et al. (2015) and the current study found psychological self-care to be one of the lowest reported self-care category.

**Parent trait mindfulness.** Recall that the FFMQ was used to analyze individual dispositional mindfulness. Studies report FFMQ results using both raw scores and composite
scores (Bodenlos et al., 2015; Schirda, Nicholas, & Prakash, 2015; Tomfohr, Pung, Mills, & Edwards, 2015). Possible raw scores on the FFMQ range from 39 to 195 with overall higher scores reflecting higher levels of mindfulness. For this sample, the average raw score was 138 (SD=18.30). The overall mean scale score (1-5 range) was 3.51. Subscale averages are reported in Table 10. The highest reported FFMQ subscale for the sample was “acting with awareness”, whereas the least reported FFMQ subscale for the sample was “nonreactivity to inner experiences.”

Table 10. Parent Trait Mindfulness Mean and Standard Deviation

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFMQ total average</td>
<td>107</td>
<td>3.51(.47)</td>
</tr>
<tr>
<td>Observing inner experience</td>
<td>107</td>
<td>3.37(.73)</td>
</tr>
<tr>
<td>Describing experience</td>
<td>107</td>
<td>3.52(.80)</td>
</tr>
<tr>
<td>Acting with awareness</td>
<td>107</td>
<td>3.84(.64)</td>
</tr>
<tr>
<td>Non-Judging of experience</td>
<td>107</td>
<td>3.57(.67)</td>
</tr>
<tr>
<td>Nonreactivity to inner experience</td>
<td>107</td>
<td>3.16(.70)</td>
</tr>
</tbody>
</table>

Note. The subscale averages reflect values between 1 = never or rarely true and 5 = very often or always true.

The FFMQ scores (raw scores) in this study were slightly higher than those reported in studies with a mostly non-clinical White samples. For instance Bodenlos et al. (2015) reported raw scores of 130 (SD=16.4), Schirda et al. (2015) reported raw scores of 132.8 (SD=22.2), and Tomfohr et al. (2015) reported the mean composite score of 3.42 (SD=0.40). The current sample also reported slightly higher FFMQ scores compared to a study with African American non-clinical samples (Davis et al., 2014); upon this writing there are no reported studies analyzing trait mindfulness with a non-clinical Latinx sample. In short, this sample appears to be as or slightly more mindful than shown in previous samples.
Finally, four key demographic variables (parent age, education, employment, and marital status) were selected to assess whether they were associated with the central study variables (parent and child trauma, the three parent buffers, and child negative behavior). None of the correlations between parent education and central study variables was significant, and none of the ANOVA’s associating marital status with central study variables was significant.

Parent/Guardian employment status and parent/guardian age both had a few significant and small associations, but not with either of the trauma variables. Specifically, the employment-Parent Trait Mindfulness correlation was \( r(107) = -0.26, p<.01 \) indicating that more employment (e.g., full-time) was associated with fewer mindful characteristics. Parent/Guardian Employment Status and Age were correlated with Child Negative Behavior \( r(107) = 0.24, p<.001 \) and \( r(107) = 0.21, p<.05 \), respectively) indicating that more employment and older parent age were associated with greater child behavior problems. Furthermore, Parent/Guardian Age had a small significant negative relationship with Parent Self Efficacy \( r(105) = -0.23, p<.05 \) indicating that the older parents were, the less self-efficaciousness they felt as parents.

**Results of Research Questions**

Having provided detailed descriptive statistics on major study variables above, I now turn to analyses of the substantive research questions.

**Q1: What is the Prevalence of Intergenerational Trauma in a Population of Primarily Low-Income African American and Latinx Parents and Their 6-Year-Old Children?**

Several analyses were conducted to examine the prevalence of IGT in this population. First, Pearson’s Product-Moment Correlation analyses were run to assess the relationship between the quantity of Parent mACEs/Trauma and Child mACEs/Trauma, and between Parent
mACEs/Trauma and Child Negative Behavior. There was a statistically significant, moderate to strong positive correlation between Parent mACEs/Trauma and Child mACEs/Trauma, \( r(109) = 0.62, p<.001 \). This finding indicates that as the amount of retrospective parent trauma from their childhood’s increases, so does the amount of trauma that their child has experienced.

Furthermore, Pearson’s Product-Moment Correlation was run to assess the relationship between Parent mACEs/Trauma and Child Negative Behavior. Recall that in Chapter One, it was argued that IGT consists of the transfer of trauma itself, as well as the child’s negative behavior that may be a manifestation of the child’s trauma or a child’s reaction to parent trauma. There was a small significant and positive correlation between Parent mACEs/Trauma and Child Negative Behavior, \( r(107) = 0.29, p<.001 \). Thus, what was defined as a behavioral extension of IGT was supported in this sample.

To further understand shared trauma experiences, it was also important to see if the parents and children shared certain mACEs, and if the children experienced new types of trauma their caregivers had not. Item-by-item percentages were analyzed to see which items parents endorsed for both themselves and their child, and which items were endorsed for the child only. (Note that the number and percentages of each trauma event for each generation separately were reported above in Table 4, Percentage of Sample Experiencing Each Trauma.)

As shown, on average, approximately 38% of the time there was an exact match between type of trauma parents experienced by age 18 and the type they reported their child experienced by age 6 (the average age of children in the sample; see Table 11). The highest endorsed shared items were experiencing bullying by a classmate (63.2%), living with an undocumented
household member (60%) and witnessing intimate partner violence – emotional (55.6%). A quote from the interviews illustrated the shared item of bullying in both generations:
Table 11. Intergenerational Trauma Prevalence - Matching and New Trauma in Children Relative to Parents

<table>
<thead>
<tr>
<th>mACEs</th>
<th>Parents Who Did Not Experience the Trauma</th>
<th>Parents Who Experienced the Trauma</th>
<th>Parent trauma experiences</th>
<th>Parent trauma repeats in child</th>
<th>Parent trauma does not repeat in child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neighborhood safety</td>
<td>39.4%</td>
<td>60.6%</td>
<td>20%</td>
<td>16.9%</td>
<td>12%</td>
</tr>
<tr>
<td>Neighborhood trust</td>
<td>44.0%</td>
<td>56.0%</td>
<td>14%</td>
<td>16.7%</td>
<td>12%</td>
</tr>
<tr>
<td>Opportunities in neighborhood</td>
<td>44.8%</td>
<td>55.2%</td>
<td>16%</td>
<td>14.7%</td>
<td>10%</td>
</tr>
<tr>
<td>Experience bullying by classmate</td>
<td>63.2%</td>
<td>36.8%</td>
<td>14%</td>
<td>12.7%</td>
<td>8%</td>
</tr>
<tr>
<td>Experience bullying by school adult</td>
<td>50.0%</td>
<td>50.0%</td>
<td>5%</td>
<td>4.5%</td>
<td>4%</td>
</tr>
<tr>
<td>Non-Bullying bad experience in school</td>
<td>22.2%</td>
<td>77.8%</td>
<td>21%</td>
<td>10.8%</td>
<td>8%</td>
</tr>
<tr>
<td>Witness neighborhood violence</td>
<td>29.4%</td>
<td>70.6%</td>
<td>36%</td>
<td>16.3%</td>
<td>8%</td>
</tr>
<tr>
<td>Family food insecurity</td>
<td>33.3%</td>
<td>66.7%</td>
<td>12%</td>
<td>6.0%</td>
<td>6%</td>
</tr>
<tr>
<td>Experience racism</td>
<td>44.0%</td>
<td>56.0%</td>
<td>28%</td>
<td>0.0%</td>
<td>0%</td>
</tr>
<tr>
<td>Experience xenophobia</td>
<td>34.8%</td>
<td>65.2%</td>
<td>15%</td>
<td>2.5%</td>
<td>2%</td>
</tr>
<tr>
<td>Experience colorism</td>
<td>46.5%</td>
<td>53.5%</td>
<td>23%</td>
<td>0.0%</td>
<td>0%</td>
</tr>
<tr>
<td>Hide immigration status</td>
<td>28.6%</td>
<td>71.4%</td>
<td>5%</td>
<td>1.1%</td>
<td>1%</td>
</tr>
<tr>
<td>Mentally ill family member - general</td>
<td>46.4%</td>
<td>53.6%</td>
<td>15%</td>
<td>1.4%</td>
<td>1%</td>
</tr>
<tr>
<td>Mentally ill family member - suicide</td>
<td>28.6%</td>
<td>71.4%</td>
<td>5%</td>
<td>1.1%</td>
<td>1%</td>
</tr>
<tr>
<td>Substance abuse household member - alcohol</td>
<td>19.4%</td>
<td>80.6%</td>
<td>29%</td>
<td>3.0%</td>
<td>2%</td>
</tr>
<tr>
<td>Substance abuse household member - drugs</td>
<td>10.3%</td>
<td>89.7%</td>
<td>26%</td>
<td>2.8%</td>
<td>2%</td>
</tr>
<tr>
<td>Incarcerated household member</td>
<td>34.5%</td>
<td>65.5%</td>
<td>19%</td>
<td>1.4%</td>
<td>1%</td>
</tr>
<tr>
<td>Undocumented household member</td>
<td>60.0%</td>
<td>40.0%</td>
<td>6%</td>
<td>6.0%</td>
<td>5%</td>
</tr>
<tr>
<td>Experience foster care</td>
<td>33.3%</td>
<td>66.7%</td>
<td>2%</td>
<td>4.1%</td>
<td>4%</td>
</tr>
<tr>
<td>Witness intimate partner violence - emotional</td>
<td>55.6%</td>
<td>44.4%</td>
<td>24%</td>
<td>10.6%</td>
<td>5%</td>
</tr>
<tr>
<td>Witness intimate partner violence - physical</td>
<td>27.0%</td>
<td>73.0%</td>
<td>27%</td>
<td>3.2%</td>
<td>2%</td>
</tr>
<tr>
<td>Experience emotional abuse</td>
<td>45.9%</td>
<td>54.1%</td>
<td>20%</td>
<td>6.3%</td>
<td>4%</td>
</tr>
<tr>
<td>Experience physical abuse</td>
<td>36.0%</td>
<td>64.0%</td>
<td>16%</td>
<td>2.7%</td>
<td>2%</td>
</tr>
<tr>
<td>Experience feeling afraid of adult in home</td>
<td>24.0%</td>
<td>76.0%</td>
<td>19%</td>
<td>0.0%</td>
<td>0%</td>
</tr>
<tr>
<td>Experience sexual abuse - touching</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience sexual abuse - sexual intercourse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>37.6%</td>
<td>62.5%</td>
<td>17%</td>
<td>6.0%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Note. Data for Child mACEs items experiencing sexual abuse - touching and - sexual intercourse were not reported by parents and therefore understanding intergenerational trauma for this mACEs item is void.
I was bullied. I was bullied for everything. For being too skinny, now, I’m too fat. For being Hispanic...which I’m not even really Hispanic. For being everything so yeah. And that’s why I know when [my son] is being bullied. I’m like, “I hated it and I don’t want my kid to be bullied.”...And as a parent, you’re like, “You know what?” You wanna keep your kid safe. You wanna keep them happy. I want everything to be easy for my kids and I know it’s not gonna be that way but that’s what I want.

Another quote from the interviews confirmed the prevalence of sociocultural context trauma, specifically, having undocumented family members:

*Dad does have a visa, but he doesn’t have immigration status. He’s not a resident or anything.*

The lowest endorsed shared items were non-bullying bad experience in school such as asked for help and never received it, (22%), substance abuse household member – alcohol (19%), and substance abuse household member – drugs (10%).

As noted, understanding child-only ACEs helps to further explain the full context of IGT. The data showed there was a low amount of brand new trauma type in the second generation; i.e. 6% on average, which suggests strongly that this trauma was not “passed down” by the parent generation. The highest endorsed child-only trauma experiences included lack of neighborhood safety (17%), lack of neighborhood trust (17%) and lack of opportunities in neighborhood (15%). Notably, all three of the highest child-only experiences were related to the sociocultural context trauma of lack of neighborhood safety and well-being suggesting that, at least for a portion of families in this sample, social conditions in their neighborhoods may have worsened across generations. To illustrate the experience of neighborhood violence, one caregiver noted:

*We’re out gunned. We’re out everything. My grandson knows that. We hear gunshots. One time they came down the block, chasing another car. And shooting down the block. My two boys was out in the back. They ran in the house, terrified.*
As hypothesized, the findings for Q1 demonstrate that IGT is indeed prevalent in this sample of African American and Latinx families. Prevalence was demonstrated by the statistically significant moderate positive correlation between Parent mACEs/Trauma and Child mACEs/Trauma, the trauma-type matching (i.e., the exact same trauma is passed down more than a third of the time), and the small positive correlation between Parent mACEs/Trauma and Child Negative Behavior, and the comparison to national and state-based data.

**Q2: To What Extent Does Contemplative Self-Care, and/or Parent Self-Efficacy buffer the relationship between Parent mACEs/Trauma and Child Traumatic Effects?**

Recall that the conceptual model of this mixed-method study (Figure 1) sought to understand the proposed latent variable CSC’s role in buffering the relationship between Parent mACEs/Trauma and CTE. As this was the central hypothesis of the study and involved multiple steps, each analytic step will be described in turn.

To first determine whether there were latent variables CSC (Parent FFMQ/Trait Mindfulness and Parent Self-Care) and CTE (Child Negative Behavior and Child mACEs/Trauma), Pearson’s Product-Moment Correlation analyses were conducted to see if there was a moderate to strong relationship thereby justifying the creation of these composites. There was a low to moderate positive correlation between Parent Self-Care and Parent FFMQ, $r(107) = 0.32, p<.01$ which did not meet the a priori criterion of $r=0.6$, therefore the composite CSC was not formed and the proposed buffering variables of Parent FFMQ and Parent Self-Care were analyzed separately in the subsequent analyses. Similarly, there was a low to moderate correlation between Child Negative Behavior and Child mACEs/Trauma, $r(107) = 0.41, p<.001$, which also did not meet our a priori criterion of $r=0.6$, therefore the composite CTE was not
formed and CTE variables, Child mACEs/Trauma and Child Negative Behavior, were also analyzed separately.

Next, a series of Pearson’s Product-Moment Correlations analyses were run to obtain a preliminary understanding of the bivariate relationships among the primary variables. The bivariate correlations among the variables analyzed for Q2 are displayed in Table 12.

Table 12. Correlation matrix of all research question two variables (N=109)

<table>
<thead>
<tr>
<th></th>
<th>Parent mACEs/Trauma</th>
<th>Child mACEs/Trauma</th>
<th>Parent Self-Efficacy</th>
<th>Child Negative Behavior</th>
<th>Parent Self-Care</th>
<th>Parent Trait Mindfulness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent mACEs/Trauma</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child mACEs/Trauma</td>
<td>.62**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Self-Efficacy</td>
<td>-.063</td>
<td>-.26**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Negative Behavior</td>
<td>.29**</td>
<td>.41**</td>
<td>-.54**</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Self-Care</td>
<td>-.13</td>
<td>-.05</td>
<td>.37**</td>
<td>-.29**</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Parent Trait Mindfulness</td>
<td>-.04</td>
<td>-.13</td>
<td>.38**</td>
<td>-.21*</td>
<td>.32**</td>
<td>1</td>
</tr>
</tbody>
</table>

* Correlation is significant at the 0.05 level (2-tailed).
** Correlation is significant at the 0.01 level (2-tailed).

Not surprisingly, the buffering variables indicating psychological strengths in the parent (mindfulness, self-care, and self-efficacy) were all moderately related to one another (i.e., significant correlations in the mid .3’s). With respect to the predictive relationships, there was a small statistically significant negative correlation between Parent Self-Care and Child Negative Behavior, \( r(106) = -0.29, p<.01 \). That is, more Parent Self-Care was associated with less Child Negative Behavior and vice versa. Otherwise, the correlations that would have indicated a
critical role for mindfulness or self-care in children’s outcomes (Parent FFMQ or Parent Self-Care with Child mACEs/Trauma or Parent FFMQ with Child Negative Behavior) were counter to expectations and non-significant.

Nevertheless, to test whether or not a buffering role might have been suppressed within the linear associations shown by the buffering variables (which were close to zero in several cases, sometimes indicating suppression of non-linear relationships), a mean split for the three parent strength constructs, mindfulness, self-care, and parenting self-efficacy were created. The same correlations were conducted separately for each group. To show signs of moderation, the associations indicating IGT (Parent mACEs/Trauma-Child mACEs/Trauma; Parent mACEs/Trauma-Child Negative Behavior) would be expected to be lower in that portion of the sample with higher parent strengths, i.e., signifying that higher presence of these variables “breaks” or “buffers” the cycle of passing down trauma. The results of those analyses are below in Table 13.

Table 13. Correlations by Low and High Buffering Variable Groups

<table>
<thead>
<tr>
<th></th>
<th>Low Trait Mindfulness</th>
<th>High Trait Mindfulness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent mACEs/Trauma-Child mACEs/Trauma</td>
<td>0.63**</td>
<td>0.60**</td>
</tr>
<tr>
<td>Parent mACEs/Trauma-Child Negative Behavior</td>
<td>0.23</td>
<td>0.35*</td>
</tr>
<tr>
<td>Parent mACEs/Trauma-Child mACEs/Trauma</td>
<td>0.53**</td>
<td>0.72**</td>
</tr>
<tr>
<td>Parent mACEs/Trauma-Child Negative Behavior</td>
<td>0.23</td>
<td>0.27*</td>
</tr>
<tr>
<td>Parent mACEs/Trauma-Child mACEs/Trauma</td>
<td>0.62**</td>
<td>0.65**</td>
</tr>
<tr>
<td>Parent mACEs/Trauma-Child Negative Behavior</td>
<td>0.25</td>
<td>0.37**</td>
</tr>
</tbody>
</table>

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

As shown, there is little to no evidence that higher values on the parent strength variables break the IGT cycle. That is, the association between parent trauma and child negative outcomes
should be lower for dyads with parents higher on the “buffering” variables. However, the relation goes in the opposite direction in several cases (higher on the protective variables seems to increase the association between Parent mACEs/Trauma and Child mACEs/Trauma or Child Negative Behavior). Although the relation goes in the predicted direction in one case (the Parent mACEs/Trauma-Child mACEs/Trauma relation is slightly lower for parents with higher trait mindfulness), the difference is not significant.

To confirm the findings of the mean-split and to test the hypothesis that parent strengths moderate IGT, a multiple regression analysis was conducted. As a first step, the relationships between the variables were reexamined (see Table 12). As noted, the correlations that would have indicated a critical role for mindfulness or self-care in children’s outcomes (Parent FFMQ or Parent Self-Care with Child mACEs/Trauma or Parent FFMQ with Child Negative Behavior) were counter to expectations and non-significant. Further, the correlation signified the importance of the variable Parent Self-Efficacy for both Child mACEs/Trauma and Child Negative Behavior. There is some indication here that as with the mean-split, the moderation analysis would be unfounded. Next, all three parent strengths were mean-centered (subtract the mean from every value to create a variable with a mean of zero) to avoid potentially problematic multicollinearity (Aiken & West, 1991) before creating the interaction terms (multiplying predictor and buffer). In all, 6 regression equations were conducted: three parent buffers X two child outcomes (trauma and negative behavior). In each case, we entered the significant demographic variables reported earlier (parent age and employment) as control variables, after which parent trauma, the buffer variable (mindfulness, self-care, or self-efficacy), and the parent trauma X buffer interaction term were entered, in that order. Significant unique variance
accounted for by the interaction term would indicate significant moderation. In short, the moderation regressions were wholly consistent with the mean-split analyses: Five out of six of the interaction terms were not significant, and the sixth was significant in the wrong direction, suggesting that when parents' self-care increases, so does IGT (i.e., the relation between parent trauma and child trauma). Therefore, self-efficacy, self-care nor trait mindfulness acted as buffers of IGT; the moderation hypothesis was not supported.

Given that the hypothesis for Q2 was not supported, an exploratory Path Analysis was conducted to examine for unanticipated multivariate relations among the key study variables. Only significant paths were retained for the model depicted below in Figure 2.

![Path Analysis of Significant Q2 Variables](image)

Note. Path analysis output diagram of significant Q2 variables. The arrows are proportional to the size of the path coefficients. Error or unexplained variance are omitted from this diagram. Correlation instead of standardized regression coefficients are reported for Parent mACEs/Trauma and Child mACEs/Trauma given that they are independent variables.

Figure 2. Path Analysis of Significant Q2 Variables

The results of the Path Analysis with the standardized regression coefficients ($p<.05$) are presented above. A chi-square test of goodness-of-fit was performed and acceptable fit on three measures was achieved, chi-square ($1.809, df=1, p=.179$), CFI (.992) and Root Mean Square
Error of Approximation (.087). Echoing the bivariate relationships, the path analysis confirmed the strong association between Parent mACEs/Trauma and Child mACEs/Trauma. The Path Analysis confirmed three other significant predictive relationships in this model: Child mACEs/Trauma and Child Negative Behavior ($\beta=0.20$, $p<.05$), Parent Self Efficacy and Child Negative Behavior ($\beta=-0.48$, $p<.05$) and Child mACEs and Parent Self-Efficacy ($\beta=-0.26$, $p<.05$).

Interestingly, the Path Analysis revealed that Parent mACEs/Trauma did not have a direct relationship with Child Negative Behavior contradicting the bivariate correlations. This may signify a somewhat unstable covariance matrix underlying these data.

Although Parent Self-Efficacy was initially envisioned as a covariate for inclusion in the moderation analysis, the results showed: 1) no evidence supporting a buffering role for Parent Trait Mindfulness and Parent Self-Care and therefore no relationship around which to control for another variable, and 2) larger than anticipated bivariate relationships between Parent Self-Efficacy and both theorized parts of Child Traumatic Effects, i.e., Child mACEs/Trauma itself ($r=-0.26$) and Child Negative Behavior ($r=-0.54$). Thus, in exploratory fashion, Parent Self-Efficacy was examined to understand if it was more critical in this model than anticipated. As described above, Parent Self-Efficacy was shown, like the other parent strengths, to not be a buffer of IGT. Given the unexpected results from the Path Analysis, then, Parent Self-Efficacy was then explored for its possible role as a mediator of a different relationship, i.e., that between the two negative child outcomes (evaluating whether Child mACEs/Trauma carried its effects on Child Negative Behavior through Parent Self-Efficacy for the sample as a whole). Thus, a Sobel Test (Preacher & Hayes, 2004) was conducted to determine the statistical significance of Parent Self Efficacy as a mediator.
Baron and Kenny (1986) require that in order to test for mediation, the predictor and mediator, mediator and outcome, and of course predictor and outcome, all need to have significant bivariate relations, which was confirmed in Table 12. Subsequently, a regression analysis was conducted in SPSS to calculate the raw regression coefficient and standard error between the independent variable (Child mACEs/Trauma) and the mediator (Parent Self-Efficacy) and between the mediator and the dependent variable (Child Negative Behavior) while adjusting for Child mACEs/Trauma. The raw regression coefficients and standard errors indicated in Figure 3 were entered into the Sobel Calculator (http://quantpsy.org/sobel/sobel.htm), which calculated the critical ratio as a test of whether the indirect effect of the independent variable (Child mACEs/Trauma) on the dependent variable (Child Negative Behavior) via the mediator is significantly different than zero.

The Sobel Test revealed a statistically significant mediation relationship between Child mACEs/Trauma, Parent Self-Efficacy and Child Negative Behavior, $z=2.51, p=.01$. That is,
Parent Self-Efficacy partially mediated the relationship between Child mACEs/Trauma and Child Negative Behavior. This means that part of the process by which Child mACEs/Trauma “gets under the skin” of children in the form of negative behavior, may be through the parent’s feelings of non-efficaciousness. Child mACEs/Trauma may make parents feel less able to control what happens to their child, which in turn may manifest in children’s negative behavior. See Discussion section for further explanation of this unexpected finding.

In sum, Q2 found no support for the primary hypothesis of this study, i.e., that parents’ strengths would act as buffers of the relationship between Parent mACEs/Trauma and either Child mACEs/Trauma or Child Negative Behavior. The signs of IGT (i.e., a close connection between parents’ and children’s levels of mACEs/Trauma) remained approximately equally as high or higher in the group of parents with higher levels of the buffering variables.

Exploratory analyses revealed that Parent Self-Efficacy unexpectedly proved to partially mediate the relationship between Child mACEs/Trauma and Child Negative Behavior indicating that children’s trauma or lack thereof may signify to parents their level of effectiveness in protecting their child, which in turn may manifest in children’s behavior.

Q3: In what ways are primarily low-income African American and Latinx parents engaging in mindful-like activities and ways of being to alleviate stress in themselves and their children?

Q3 sought to understand how primarily low-income African American and Latinx caregivers engaged in mindful-like activities and ways of being (originally conceived of as quantitative variable CSC in the proposed conceptual model) to alleviate stress and buffer IGT. While CSC was not confirmed in the survey data as a coherent latent variable, the qualitative
findings suggested that this sample of African American and Latinx caregivers engaged in CSC activities and ways of being, and consciously buffered IGT.

Table 14 presents the frequencies of major categories, thematic codes and example characteristics that emerged from the interviews. The major thematic categories described the ways in which parents in this sample were mindful, and sought relaxation and calm. The results demonstrated that this sample’s mindful-like ways of being were described as spirituality/religion, quiet, present moment awareness and social support. The first numerical column indicates the frequency with which the theme was mentioned across all 687 codes; the second numerical column indicates the number out of 23 participants who mentioned the theme at least once.

**Relationships between Quantitative and Qualitative Variables**

To determine whether or not there were any relationships between the qualitative constructs and quantitative variables, Pearson’s Product-Moment Correlation analyses were conducted with the most theoretically relevant constructs from the qualitative and quantitative data. Five qualitative constructs crossed with the six primary quantitative variables resulted in 30 correlations total. Four of the quantitative-qualitative correlations were statistically significant, mostly indicating a level of overlap between the two data collection methods on very similar constructs (see results in Table 15).
<table>
<thead>
<tr>
<th>Category</th>
<th>Major Thematic Codes</th>
<th>Frequency Distributions</th>
<th>Participants #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calm Classroom K-2nd Grade</td>
<td>Child behavior or communications change Child implements CCK2 learning at home Hope for what the program can do</td>
<td>74(11%)</td>
<td>23</td>
</tr>
<tr>
<td>Child School Experience</td>
<td>Negative Positive</td>
<td>22(3%)</td>
<td>11</td>
</tr>
<tr>
<td>Parent School Experience</td>
<td>Positive Negative Desire for more support</td>
<td>33(5%)</td>
<td>21</td>
</tr>
<tr>
<td>Community Self-Care</td>
<td>Social support Spirituality/Religion Self-medication</td>
<td>25(4%)</td>
<td>13</td>
</tr>
<tr>
<td>Conscious Buffering IGT</td>
<td>Intentionally not repeating the past Teaching child to make good decision Protecting child from harm Talking to child</td>
<td>47(7%)</td>
<td>17</td>
</tr>
<tr>
<td>Contemplative Self-Care (actual practice)</td>
<td>Present moment awareness Spirituality/Religion Quiet</td>
<td>59(9%)</td>
<td>20</td>
</tr>
<tr>
<td>Child Stress</td>
<td>Family stress Navigating friends and classmates Homework/Academics</td>
<td>77(11%)</td>
<td>23</td>
</tr>
<tr>
<td>Helping Child Deal with Daily Stress</td>
<td>Helping child strategize Family support Talking about the situation</td>
<td>74(11%)</td>
<td>22</td>
</tr>
<tr>
<td>Mindfulness Familiarity and Definition</td>
<td>Knew about it Thoughtfulness Present moment awareness</td>
<td>30(4%)</td>
<td>18</td>
</tr>
<tr>
<td>Parent Stress</td>
<td>Happened to me in the past Happening now Happening to others (past or present)</td>
<td>33(5%)</td>
<td>21</td>
</tr>
<tr>
<td>Parent Self-Care</td>
<td>Cultural participation Spirituality/Religion Social support</td>
<td>87(13%)</td>
<td>22</td>
</tr>
</tbody>
</table>

Note. Total number of qualitative codes is 687; N=23. The categories Calm Classroom K-2nd grade, Child School Experience, Parent School Experience, and Child Stress are not explored in this dissertation as it is beyond the scope of the work.
There was a moderate to strong significant relationship between qualitative CSC and Parent Trait Mindfulness, $r(20) = 0.47$, $p<.05$ indicating substantial overlap in the two self-report methods, as well as some support for how CSC was coded in the interviews. There was also a moderate to strong relationship between qualitative mindfulness definition and quantitative Parent Self-Care, $r(23) = 0.46$, $p<.05$. Interestingly, qualitative mindfulness definition and quantitative Parent Self-Care correlation was slightly higher than that of the Parent Self-Care and Parent Trait Mindfulness variables in the quantitative sample ($r(94) = 0.34$, $p<.01$). This may indicate that the interview allowed for additional signifiers of mindful traits in this population than captured by the FFMQ. Additional triangulation would be needed to understand this for certain.
Furthermore, the correlations revealed additional relationships with mACEs/Trauma. There was a moderate to strong significant relationship between qualitative Community Self-Care and Child mACEs/Trauma, \( r(23) = -0.46, \ p<.05 \), potentially indicating that parents who reported greater levels of mACEs/Trauma for their children saw this as being due in part to a lack of self-care in the community.

It was also important to explore whether the interviewed sample might have had more signs of buffering IGT than the quantitative data were able to reveal. Beyond coding for Mindfulness Definition and Parent Self-Care, a qualitative variable called Conscious Buffering was discovered and coded. Conscious Buffering was revealed when parents discussed intentionally trying to prevent the “ghosts of the past” from negatively impacting their children (interview quotes illustrating this concept are below in Qualitative Constructs section). In order to determine whether Conscious Buffering did, in fact, reduce IGT, a difference score, subtracting Child mACEs/Trauma from Parent mACEs/Trauma was calculated, suggesting that the higher this difference score was, the more trauma has been reduced in the younger generation\(^1\). Subsequently, a Pearson’s Product-Moment Correlation analysis between Conscious Buffering and the IGT difference score was conducted, which was moderate to strong: \( r(23) = 0.48, \ p<.05 \). This suggests that indeed, the more parents report consciously trying to prevent trauma from manifesting in their children, the greater the distance between parent’s trauma level and child’s trauma level.

In sum, the correlations between the major qualitative constructs and quantitative

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\(^1\)In 8 of 109 cases, Child mACEs/Trauma was reported as being higher than Parent mACEs/Trauma, resulting in a negative difference score for those dyads. This does not create a problem in interpretation as it is still consistent with assuming an improvement in the child generation the higher the value of the difference score.
variables affirm some of what was learned from the quantitative measures. This population of African American and Latinx caregivers were mindful in their characteristics, even if not familiar with mindfulness as a structured practice or way of being, and that their mindful traits and self-care behaviors may have a symbiotic relationship. Furthermore, the association between Conscious Buffering and greater reductions in Child mACEs/Trauma revealed partial support for one of the primary hypotheses of this study that was unsupported with the quantitative measures alone. Next, results for the major qualitative constructs will be discussed in turn:

**Qualitative Constructs as Evidence for Actual Contemplative Self-Care Practices and Mindfulness Ways of Being**

Mindfulness was a central theme of the semi-structured interviews. It was explored by asking caregivers about ways in which they and members of their community cared for themselves, and ways they found quiet and relaxation. These were coded by the following constructs – Mindfulness Definition, Parent Self-Care, Community Self-Care, and CSC, actual intentional contemplative self-care practices. As part of this exploration, interviewees were asked directly about their experience of mindfulness and how they defined mindfulness. Out of 23 interviewees, 20 had never heard of the term (see Figure 4).

![Figure 4](image_url)

Figure 4. Responses to question: Before your child’s involvement with the CCK2 program, had you ever heard of the term mindfulness?
This is notable as the quantitative data revealed that on average the qualitative sample was more mindful, in terms of traits, than the non-interviewed sample, M=3.64 (SD=0.53). The lack of mindfulness awareness was also notable since the qualitative data had evidence of mindfulness. There was a concern that this sample would be biased because of their child’s involvement in CCK2, the mindfulness-based school intervention program in which the students were involved, and the parents’ participation in at least one CCK2 Family Engagement Event where the definition of mindfulness was discussed. It was possible that the interview sample may have over-reported their knowledge of the definition of mindfulness and/or offered a definition because of exposure to the term at the event. However, their lack of mindfulness knowledge discussed in the interview revealed that the CCK2 intervention and Family Engagement events had very little influence. When asked how they defined mindfulness, two themes emerged – thoughtfulness and present moment awareness.

**Mindfulness definition - thoughtfulness.** As noted, most of the participants had never heard of the term mindfulness. When asked to guess the definition of mindfulness many parents explored the definition as a practice in which one was keeping another in mind, being thoughtful, considerate and/or respectful:

*Mindfulness is seeing your needs and other needs and try to help them, also...if I'm controlling, having the control of my mind enough, I can also help other people.*

*Mindfulness is like thinking of others, you know how will they feel, pay attention to their situation, but I never think of it as for me, I think of it like for everybody else, you know like how do they feel.*

*Um, mindfulness, when I hear that, I would think...understanding something that you probably really will make effort to understand something that you may not understand. It's just uh, like, if it's a situation that I feel like that I don't have that much sympathy for, I can, you know, have a little empathy for it, you know, just be mindful of it, and just be like, “Okay. Well, you know,” it’s like give a little outcome, even if it’s a bad one. That’s*
what I think if I hear mindful, just being open minded to a situation that could also have a little negative shine on it. You can just put a little positive to it, to be, to make it a better situation.

I would probably say maybe in relation being considerate of others and, uh, and their feelings maybe. That’s what helps the mind as it relates to calm class.

**Mindfulness definition - present moment awareness.** Of the very few parents familiar with the definition of mindfulness, they articulated present moment awareness as a main explanation of the term. Defining mindfulness as present moment awareness is consistent with the research literature (i.e., Bishop et al., 2004; Kabat-Zinn, 1990; Masicampo & Baumeister, 2007) therefore reflecting deeper mindfulness awareness from this sample of parents.

One thing is staying at the moment, like uh, seeing things that is happening right now. I mean, it is at the same time seeing the reality, just like things like that, now, right now. Nothing in the past, nothing in the future. So it helps you to evolve better, and even increase the efficiency. It helps me truly when I’m working or other things come to your mind, and you have to be powerful enough to let them go.

...Like being in the moment. That's the first thing that comes to mind – like, I'm in the interview here with you, and I'm here with you and not thinking about the 50 other things that I have to do at home.

Furthermore, parents unfamiliar with the term and guessed its meaning articulated other facets of mindfulness, including observing behavior and feelings in the moment (Bodenlos et al., 2015):

I would think it’s just to take a step back and think about the right now, or thinking about your feelings, think about what’s going on, um, and then just kind of like take all of that and then kind of like erase it like, like a slate. Like that’s how I think about it. Like you’re erasing it, and you’re just like trying to be in the here and the now, and not worrying so much about this is what I have to do in 10 minutes, this is what I have to do tomorrow, this is, you know, what just happened, and things like that.

When I hear the word mindfulness, to me it means, again, situational awareness, being able to read my own feelings, happy, sad, frustrated, being able to realize, hey, I’m feeling this way because why? Let me take a deep breath. Let me clear my mind for a second. Let’s look at the good things. I’m a little tired right now, but let’s take a couple of deep breaths and look at the bigger picture. I’ll get to bed a little earlier tonight, catch
up tomorrow, um, and also, again, that awareness of what’s going on around you, whether it’s a customer walking in the front door or – leaving through the front door, uh, realizing that, hey, something’s off with my children. One of them seems to be a little under the weather or, wow, what’s going on with this person right here? So to me, I guess mindfulness means being aware of your surroundings, your feelings, your emotions, your strengths and weaknesses.

**Parent self-care.** Mindfulness was further explored with questions related to parent self-care. When probed with questions about how they cared for themselves, parents shared a variety of self-care methods and strategies. The most highly noted self-care methods were cultural participation, social support and prayer/spirituality. Both cultural participation and prayer/spirituality were analyzed as mindful-like activities.

**Cultural participation.** Discussions on how parents cared for themselves led caregivers to share what relaxed them and helped them feel at ease. Parents described music, dance and sound as mechanisms to help them feel personally cared for:

*I love dancing. I love dancing. I love dancing. I love dancing. When I used to have free time, I liked to go out, you know, just to have free time away from work and my kids, and I loved to dance.*

For a few parents, music helped them decompress, feel relaxed and soothed:

*I go home and I turn on my inspirational music.*

And:

*I probably listen to the music, my – uh, my headphones and just be relaxed. You know, I don’t think about nothing. Like I don’t think about no kids. I don’t think about no mother. I like just be in my own little world, you know. Yeah. And it seem like I be there for a long time, but it only – it only be nothing but about like a hour or so, but it seems like I’ve been sitting there for about two or three hours.*

Books and television were also mechanisms that helped parents relax:

*I would watch TV. Um, and that sounds weird. [Laughs] I watch like, um, you know, like Criminal Minds and stuff like that, um, listen to music.*
Me personally, I can grab a book, lay back and my kids and husband will say, 'she on a island'. That mean don’t bother me for this weekend or – Yeah. She’s on the island. I be on the couch and I stay there until I’m finished with the book. So. And that’s the first thing they’ll say, ‘she on a island’. I don’t want to be bothered. Do not want to be bothered. No form, fashion, shape. Nothing. What are we eating? I don’t know.

Um, definitely – like for myself it’s reading. Um, so if I can like sit and read a book, or I can sit and, you know, like just kind of jump into a book, like that’s my relaxation time.

In all of these instances, parents described being focused and centered on the activity. Whether music, dance, television watching or reading, focusing on the activity with intention was mindfulness.

**Spirituality and religion.** Spirituality and religion were central components to many caregivers’ self-care practices. Some parents’ experiences with spirituality and religion were directly related to mindfulness.

Prayer was predominant to parents’ spiritual practice as validated in the Self-Care Assessment Worksheet (see Table 9, Highest Self-Care Activity). This sample described prayer as an action that helped them take care of themselves, focus on the positive and believe that in stressful times things will work out:

*I always pray. I pray so much girl. I know God know my name. Yes, God know my name.*

*I really pray a lot. I pray a lot and then I listen to my gospel music...that’s for guidance and direction, and because my spiritual beliefs, I believe that I – do get an answer whether it come directly through the word, or reading the Bible, or coming from unlikely source, somebody I don’t know walking up and giving me the word, because I don’t normally tell individuals what I’m praying about, so when that unlikely source come to me and give me their word, then I want to believe that God heard my prayer and answered my prayer, you know, or I could read the Bible and read whatever, you know. So I pray for direction, you know. That is my base. My spiritual belief, I believe in the word of God. You can’t pray, you can’t stay if you can’t pray. That’s just me...You know, I’m not trying to receive nothing negative during that time. You know, like I say, I normally put my gospel music on so it’s all spirituality around me, nothing negative. I try*
to block out all the negative stuff in that zone.

Believing in God and God’s plan helped caregivers release some of the stress of day-to-day life knowing that what they experienced were part of God’s plan:

*I’m a firm believer in God. [Laughter] God sees you through anything and everything that you goin’ through...So it’s like I’m gonna pray about this situation, put it in God’s hands.*

And:

*There are no mistakes or questions in God’s plan. He knows what is in store for all of us.*

One parent summarized the methods of parent self-care nicely:

*So between exercise, prayer, and spending time with people who you love, you know, who you love is – that’s the main stuff.*

*Social support. Support from family and friends was a central theme in how this sample of parents cared for themselves. Interviewees expressed how much talking with family members, friends and significant others helped them feel supported, calm down, and gain perspective. Two parents talked about how talking with their spouses helped them gain perspective and feel supported:*

...‘Calm down. You got this’ [he says]... And he does the same thing with [our six year old son] and with the baby too. So it’s just like, um, we’re like this perfect little pair there. Like, I don’t know. It’s weird. So he kind of, like, brings me down, gets me thinking rationally again, like, you know, it’s fine...

*I sit down and talk to my husband and vent to him about it [snapping sound] ... told my husband that by me venting to him and we talked about that like calmed me down...but when I have problems, do get stressed out, I just vent to my husband and I feel a lot better [laughs] about things...while I’m venting it kind of like calms [me] because it’s like I’m getting it off my chest.*

Talking through challenges with family members also helped parents feel less isolated and alone with their problems:
When I talk to my mom about like my problems. She’s like, “Oh yeah. You know, I went through this too,” and it’s like, “Well, why don’t we share these things instead of me feeling like, you know, I’m the only person who goes through it,” or I’m the weird one for going through it. And then eventually, like I said, I think that also helped, too, is, “Okay, like my mom went through this, like my, you know, like my dad had some anxiety,” and it’s like, “All right. I’m not like the weirdo.” And so I think now we’re able to talk about it, but as a child that was never brought up, or there was no like, “No, just go outside and play. You’ll be fine”.

Best friends were critical social supports:

I have my best friend, he motivates me, you know? And he’s the one that’s my backhand, or he’s not going to let me fall, and he won’t let me fall.

Community self-care. In addition to a conversation about how parents cared for themselves when times were stressful, there was a discussion about how the community – their friends, neighbors, family – cared for themselves. However, few of the caregivers reported on how members of their community care for themselves. It seemed the interviewees had a hard time answering the question.

I don’t know [how my husband cares for himself]. He work all the time.

Of the few that had an answer, their answers directly responded to the intention of the question – understanding how African American and Latinx parents engage in mindful-like activities including being present in the moment, seeking refuge, meditating and praying.

One participant shared that members of her community had parties. Parties gave them a chance to focus on something fun and not think about other issues and challenges in their lives:

We have football parties or, barbeques. And no, truthfully, not being mindful that other stuff is going on – Because at that present time I’m not thinking about what else is going on.

While this participant noted that her community was not mindful at the noted parties, it can be argued that her description of “not thinking about what else is going on” was being mindful.
Another participant shared how family can be a refuge. In particular, this came up when discussing some of the stress in the neighborhood:

…when she go to her – her grandmother’s house, I think that’s where she find her peacefulness at, you know...[when asked where is she, she responds] “Well, I’m at grandma house. I’m in my grandma house. I see all you guys probably tomorrow or Tuesday,” and then I know that’s where she – she’s comfortable at and she’s peaceful at.

One could argue that this person’s awareness of her need to seek refuge, in a place of peace, was seen as a mindfulness act.

As expected, the theme of religion and spirituality came up as part of the participants’ reflection on community self-care practices. Notably, both examples illustrated the intentional act of taking a needed moment, an indication of mindfulness:

Sometimes he prays. He told me I need like a moment for me just because I need to pray to feel relaxed and be comfortable. And sometimes he invites me to do it together.

Oh, sometimes my husband when it’s night he goes okay, turn the light off, and close your eyes. Breathe. And sometimes I fell asleep. But he tell me like five minutes or less...he tries to relax himself, and sometimes he shares his moment with me. Close your eyes. Put your mind here. Breathe. Yeah.

A few caregivers talked about community self-care practices that related to avoiding things and blocking issues out of one’s head. These practices related to the use of alcohol, smoking or other methods of coping:

I mean I have some friends that, you know, they, they smoke to, you know, to clear their mind, or just so they won’t have to think about things, that they just rather be high than – than thinking about stuff.

Overall, these answers revealed that primarily low-income African American and Latinx parents and members of their community engaged in mindfulness. They were present in the moment, intentionally sought refuge and engaged in meditation and prayer.
**Contemplative self-care.** As noted, CSC was conceived of as a proposed latent variable in buffering the relationship between Parent mACEs/Trauma and Child Traumatic Effects. It was further explored as a qualitative variable as interviewees described actual intentional and behaviorally manifested contemplative self-care practices in times of stress or trauma. Coding revealed that CSC included practicing Present Moment Awareness and Quiet. Note, present moment awareness was also coded as part of the Mindfulness Definition category. In that case, interviewees were just defining mindfulness, but not necessarily as related to their own lives (see Appendix J, Interview Protocol). Present Moment Awareness coded as part of CSC represented interviewees’ actual experiences being present in the moment.

**Present moment awareness.** When exploring how parents cared for themselves particularly during times of stress, several parents noted how they were focused on the moment, tried to control their thoughts and reactions, and tried to slow down. The following quotes reflect participants’ effort to be present in the moment:

*I don't let the thought rest in my mind, you know, because of we’re talking now, you know, like this. I don’t allow it to consume me.*

*Um. Wherever I’m at, that’s what I’m focusing on.*

One mother discussed how she worked on present moment awareness when arguing with her partner. In this example, she noticed and watched how her responses were related to different sides of herself, including her “ghosts”, how her own parents responded to similar situations:

*You know, there are sometimes that the fight and the shout is something that you can manage it from your adult part of yourself. But sometimes you're shouting like your parent, you’re in a parent’s level of yourself. And so, yes, sometimes, if I can help myself to bring back myself to adult. I can simply manage it. In the moment. I have to stay quiet. I have to stay quiet. And that is helpful, truly helpful. And, unfortunately, I can still talk with my body, with my eyes. I have to control them, and it's something that I ... Every day I am working on that. I hope I can get it because the thing that I’m telling my husband is*
now that we’re living together, we have to work on our relationship. I’m fighting for that. So, one thing that is helpful is just to stay quiet, and I’m not mastering that. I am still working on that.

Another caregiver also described how he worked to be present in the moment, worked to control his reactions and practiced empathy with his partner:

So in that state I can control what’s coming out of my mouth. I will slow down. There will be no hollering, there will not be cussin’, there will not be actually, literally, you know, having this big bad voice to intimidate because it’s gonna be in understanding, it’s gonna be in compassion, it’s gonna be in, I need to understand where you’re coming from.

The theme of controlling one’s reactions continued:

The only thing you can control is your reactions to situations and I am constantly on a daily basis working on that.

Quiet. As part of the conversation about taking care of oneself, the caregivers expressed a deeper level of awareness and self-care that included giving themselves time and space for quiet, contemplative moments as a daily practice. The theme of taking a quiet moment to regulate oneself is described here:

I always take me a moment. I tell anybody, I take a moment and just try to recalculate, if I feel like I’m being overstressed with being a single dad. It’s like it can be very stressful at times, so I understand a mother’s struggle, I take [my son] home and I say, “Let me just give me a moment,” you know. I’ll just go sit in the hallway, breathe, think, or walk down the street a block, look up to the sky, breathe, pray, come back, let’s start this over. Those are my calm moments and – and I’m trying to get my little brother into just take your walk. You ain’t got to do nothing. Just take your walk, look up, pray. You don’t have to have nothing special to say. Just do that, I see that has been very beneficial to me because I look up, I says, “There’s nobody up there, just me and the sky”.

Taking quiet moments are also part of the caregivers’ daily practice. One parent, who described her partner as very grounded, noted:

Sometimes my husband and I walk to the park in the morning. Like only we talk together. Because sometimes we want to go out for dinner, and sometimes we don’t have anybody to take care of my kids, so we have to stay with them. But in the morning sometimes like
5:30 or 6:00 A.M., we go down to the park.

Similarly, other caregivers carved out time for quiet:

_I try to get up two hours before the kids get up, before anybody in the house gets up – so I can take a shower, get ready, kind of, like, just get rid of the day before. Prepare myself in the morning for what’s to come. When I know I need quiet time, you know, I even say to [my daughter...] “I need five minutes of quiet time.” And she knows, because one day she used it on me._

In sum, the interviews revealed evidence for mindfulness and CSC in this population of African American and Latinx caregivers.

**Qualitative Constructs as Evidence for Conscious Buffering**

The interviews were an opportunity to explore some of the traumatic experiences parents reported they and their 6-year-old children experienced. As such, some of the conversations organically evolved to understanding how caregivers stopped bad things that happened to them from happening to their children, the concept of conscious buffering of IGT. Some parents were asked directly whether and how they thought about trying to stop traumas from the past from repeating.

**Intentionally stopping the past.** The subtheme of intentionally stopping the past emerged in the interviews through participants’ reflections on the past and how they worked to be different than their parents. This example shows how this parent reflected on their childhood – some of its pain – and made an intentional decision to actively stop IGT:

_I understand it, and I recognize it and I’m not going to be like that, so I have to stop the cycle. I have to stop the past...some people don’t know how, and I didn’t know how. It took a lot of learning and just trial and error. Literally doing the opposite of everything that I see. That’s the only thing. Like I love my dad to death. He’s – he will always be the greatest man in my eyes outside of Jesus, but it’s just certain things that he would – that he did I would never do...Like my dad never to this day, and I know he does, but he’s never said I love you...But for me, I’m going to be the exact opposite...every day I tell [my children] I love them, every night before they go to bed, when they wake up, just_
when I'm sitting down watching TV with them.

Relatedly, this mother reflected on her childhood with her father and decided she did not want to have some of the same experiences as an adult:

*I think part of it is like my dad was an alcoholic and a drug user for a little bit during our youth. And, you know, and I remember my mom having to kick him out. He didn’t go into rehab to try to like fix all of his problems to like get himself together. Um, and you know, and then - again, seeing all that. That was one thing where I was like, “I do not want someone like that around,” you know, like – and, um, again, just from my own experiences it was like, “Okay, I definitely don’t want to deal with that. I definitely don’t want that”. I just kind of stay away from it.*

Furthermore, this caregiver shared her struggles with her own mother who was very discouraging and demeaning. The interviewee was intentionally working not repeat caregiver behavioral patterns, a mechanism of IGT, she experienced as a child (and as an adult):

*When things didn’t go the way that she thought things would go...and uh, wasn’t nothing never gonna work out for me, or I was gonna be a little ho, I was just gonna be making babies, on drugs, you know, that's how she sold it to us. My mother wasn’t an inspire[ational] woman to make me feel like life was what I brought to myself, but only what was offered to me. She made me felt like this is just it...And like I said, I am a lost person, but I'm working on finding myself. But on top of me doing that, I'm advising my sugar to be what I didn't get a chance [to do and be].*

**Teaching child to make good decisions.** Another way in which parents worked to consciously buffer IGT was by intentionally teaching their children to make, what they classify as, good decisions, helping their children act differently, or helping their children be different in the face of adversity. One caregiver directly instructed their daughters to make good decisions. Though the quote is vague, it is related to a conversation about pregnancy and wanting to help their daughters make decisions about not getting pregnant as a teen or young adult as this caregiver experienced:

*I try to do that with my girls, instill in 'em like hey, I’m not gonna be with you forever you
know, you will make bad choices, you will make good choices, you know but just try to keep a level head about it and do what’s best for you so that’s what I try to tell ‘em, both my girls.

Other parents described how they want to be a model for their children so that their children are able to develop emotional strengths during times of trauma:

In my past, I’ve noticed that people wanna hide, “I don’t want my children to see me crying.” But they need to see this; this is how they’re gonna create their inner, you know, emotions. If they don’t see that happening, then they’re gonna think, like, “I’m supposed to be a man; or I’m supposed to be, like, young men don’t cry”.

One mother, who felt deeply embarrassed by negative experiences in school, tried to instill ways of being and ways of conducting oneself in the world to her child:

I think we were going to the cafeteria or somethin’. So I’m like, “Somethin’ stink.” And the teacher was like, “It’s probably you.” Just from, like, I be on top of my daughter, cause I am like “You are a young lady. Yes, you are 6 years old. You don’t walk out this house without washing your face. You don’t walk out this house without brushing your teeth. You make sure you go take a bath, wash good, everything. Because you are an example, a figment of me. Like, you’re a product of me. And besides that, you don’t want kids who say, like ‘Oh, you stink.’ Or, ‘Ooh…your breath stinks.” Because that’s her school. I know the pain that I felt. I don’t want my daughter to put up with that. I don’t want my kids to go through that. But you know, I’m a make sure your hair is combed. I’m gonna make sure you look pretty. I’m gonna make sure your clothes are ironed. I’m a make sure your shoes are clean. I’m a make sure you have everything that you possibly need so you don’t have to worry about that.

This caregiver wanted to make sure her child did not experience the same pain.

The parents in this study worked toward helping their children make decisions that will help prevent some of the very traumatic experiences they experienced as children. Other mechanisms of Conscious Buffering that were described in the interviews included protecting child from harm.

Protecting child from harm. Similar to the theme of helping children make good decisions, some parents expressed Conscious Buffering as protecting their children from harm.
and/or from similar pain they experienced as children. A few parents discussed how they wanted to protect their children from bullying because of their own experiences with bullying (note a bullying antidote was shared in the previous chapter). Some of the parents’ protection extended to being with and around their children at all times:

Um, by them not even being teenagers, when I leave you leave. Wherever I go – if I – if I’m going somewhere and you can’t go, I’m not going. So it – I just revolve my life around them so that they know that you don’t need outside when it come down to hanging, or needing a friend, or – I mean, I don’t stop they social life. That I don’t do. But it’s just so much going on in society today that God protecting me and I’m protecting you all, and he watching over all of us.

In a similar vein, parents discussed working to make sure their children did not witness or experience harm, including witnessing intimate partner violence, and experiencing sexual abuse. The parents described keeping their children from witnessing:

Just seeing people fight and argue, going like men, call women out their name in front of their daughters. you know, in front of their sons, and the kids – I never allowed that. My daughter, she never saw me and her father have arguments.

This parent discussed teaching their son about protecting his body from others:

I’m trying to, you know, when I talk to him about things, and I tell him “You don’t let anybody touch your property.” I was like, “And you know you can tell me.” I was like, “It’s not a bad thing, but you need to, you, it’s not good for anyone else to touch you. You’re big enough to handle your own business. There’s no reason for anyone to touch you.”

Other caregivers discussed a similar message:

But I have to let her know certain things, like, you know, making sure nobody touching you, you know. You let me know. Nobody supposed to touch you nowhere. She’s very friendly, too friendly. She like to hug and she like to – for some reason touching faces and stuff, but – I feel – I think she’s my little special angel.

But at the same time, it’s like opening doors for her to be available for these things, and me having to really install in her of how to protect herself. To not accept anything that comes your way, you know... I’m really like, really trying to push my girls to understand that. Everything is not a gift that you want to share. You know. And just know the
difference, because people will sell you anything, like your own soul.

**Helping child deal with daily stress.** When helping children deal with stress, three major themes emerged: helping child strategize, providing family support and talking to the children about the situation.

**Helping child strategize.** Parents talked about how they helped their young children strategize about finding solutions to the stressful situation. In particular, caregivers discussed how they helped their children find solutions to navigating relationships with classmates in school:

*I remember some of his friends started to like not be nice with him. And then, when he was telling me about them, I said, “Oh, let’s see what we can do next time.” And then his answer was even better than my solution. He said, “Who cares [about] that. I don’t care that he was not nice, and then oh, she was not nice to me. I just don’t play with him or her.”*

*Uh, let’s say for example in school, I know there was a situation where the children were taking toys to school. You know, and then one time she traded with a friend and she’s like, “Well the friend told me if I didn’t trade with her she wouldn’t be my friend no more.” So I said to her, “Okay, that’s okay. But in the future, you know, you’re gonna be going to first grade, and there’s gonna be other situations. If somebody tells you they don’t wanna be your friend, you let them know it’s okay; if you don’t wanna be my friend, I’ll just be somebody else’s friend.” I said, “There's so many other girls and boys that you can be friends with,” so. It's okay; you let them know, “Okay” – and then I just let her know, “Sometimes people wanna play with different friends, or they wanna talk with different friends, or share time with different friends”. It’s okay. So just letting her know it’s okay.*

Parents also advised their children to go to the teacher when they were having a stressful experience in school:

*“Do you need me to go up there [to school]?” And I'm trying to teach him to, like, tell the teacher first – before I get involved. 'Cause I have to, I have to think about it. He did tell me – about a couple times that [the kids] were bothering him and stuff. Yeah, he ended up telling the teacher, and then – like, it calmed down. She just kind of moved them away from each other and they weren't allowed to, like, interact together.*
“Uh, Mom. Somebody pulled my hair”, or they cut his hair. And I'd say, “Now, don’t let them pull you off of your square”. And I take it a step further and I said ... I know this sound crazy, but I said, “The enemy come to steal, kill and destroy, come to steal your peace or your joy,” and ... do it in the form of, of other people, other people. And I said, “don’t let them do it. Look at them and know what they’re doing, and don’t do it. ‘Cause when you go to school you go there to learn, and pay attention to the staff.”

Parents also advised their children to talk to their teachers about academic challenges:

She was telling me that they flipped through the book really fast, and that they write fast when they're copying and things like this. I said, “today, when you go to school,” I said, “you’re dealing with a situation just the same as you dealt with yesterday.” I said, “this is what you do”. I said, “You go to your teacher.” I said, “Don’t be upset, don’t be mad, don’t feel upset, don’t let nobody [make you feel] or speaking that you’re stupid, or that you're not smart as them. You just learn at a different pace than they do.” I said, “When you feel like that, tell your teacher to give you your own book, and you write and you read as much time as it take you. You got forever and a lifetime baby, of schooling. And it’s gonna be a lot of people that's gonna move faster than you. There’s gonna be people that move slower than you. But just understand, those who move slower than you and that you’re going through with people that move faster than you. So you have to understand that. You have to be more patient with them, just like, you expect someone to be patient with you.” I said, “But tell your teacher”.

**Family support.** In addition to navigating school stress, caregivers shared how they helped their children deal with other stresses with family support. Some caregivers discussed spending additional time with their children, reminding them of how much they were loved and valued.

One parent discussed how they did “any little thing” to take their child’s mind off of the family stress:

*After it’s over, um, let’s go. Let’s go to the movies. Let’s go to the park. Let’s go, let’s go do something. To get your mind off it for the moment. Yeah. So. I comb her hair. Teach her how to braid. Any little thing. Any, any little thing to take my baby’s mind off of feeling bad. To doing something, say, look what I did. Look what me and mama did. Look where I went. Any little thing. Any little thing.*

Caregivers also discussed how additional attention and love was given to their children during times of stress. One caregiver discussed how extended family spent time with the child as
the child grieved over her grandfather’s death:

She, she gets a lot of attention, her cousins and the family, you know she gets a lot of love and attention from her aunts and uncles and everybody.

Similarly, a parent helped her child with feelings of rejection from the child’s other biological parent and reminded the child of all the other love in life, especially of the love of the step-father:

I don’t want him to feel that sense of rejection, you know. And I notice that he’s gotten so much better about it because I tell him, “No matter what, you have people who love you. You know, no matter what, you have all these people who love you”. You know, my, my in-laws, we live in the same building, so I tell him, “...they love you,” you know. “[Your step-father”, he loves you”. I was like, “You didn't have to be his blood son.” I was like, “That, that’s still your dad”.

One parent discussed all of the tactics—homework help, exercise, favorite foods and additional family time—she used to help her child deal with stress:

So his father does speak, um, Spanish, so his father’s been helping him with the homework. Which is going really good. Um, and then I’m just kind of being more patient with him because – if I get worked up, then he gets worked up and then this energy just is all over the place. And so, um, we have been walking more. Um, it seems to help. I’m making food that he likes to eat, his favorite dishes. Um, I let him spend the night at Grandma’s because that’s where he loves to be on the weekends.

Note this parents also acknowledged how their energy impacts their child’s energy.

Talking about the situation. Another strategy parents used was talking with their children directly about the situation. One parent expressed their philosophy on talking with their children:

...we can’t hide things from the children; we’ve gotta let them know what’s happening, but in a different way, you know, they can tell the information. So it’s a matter of not hiding it from children, but, you know, having – finding the right moment to talk to them. Not just saying, “Oh this” – you know, just walk away. No, no, you have to, you know, see them, and see their reaction and, you know.

To that end, other interviewees discussed their strategy for talking with their children:
If they’re getting frustrated or angry, I will try to gently but firmly get down to their level and say, you know, “Let’s take a deep breath. Tell me what’s wrong. Use your words. It’s okay. You don’t need to worry. You can tell me anything. I’m not gonna get mad. Even when I get frustrated, we’ll work it out together.”

I mean I just try to be very open with, you know, like, “Hey, I, I noticed that you have a sour look on your face. What’s going on? What are you thinking? What are you doing?” And I mean, and it takes some poking and prodding and eventually she’ll open up. Um, which has been driving me nuts because I’m like, “I’m asking you what’s wrong, I know something is wrong. Don’t lie to me.” But you know, it doesn’t work that easily.

…I ask, so what was the problem? What was wrong? Why you was feeling like that? Um, you feel okay? How you feeling? What’s wrong? And I, then when I get it out of her, we conquer it head it on.

Ah, definitely we do a lot of talking. Um, I mean I try to like tell her, you know, I’m open as much as – you know, she knows that if she has any questions she can come to me, like about anything no matter how random it is. Um, so like definitely give her that option, like, “Hey, if you need to talk, talk to me”.

A few parents in the study spoke about specific difficult situations in which they had to talk with their children. Parents were direct about the difficulty while also having had feelings of sadness or stress. One parent discussed not having money for her child to attend a cultural event:

I just told her well I didn’t have the money. Um, you know, the bills was due, and, you know, she gave me that little look. Made me feel some type of way, so I had to start [asking] around. Actually, I was going to put something aside just on the strength of that. But when I had told her, you know, she was kind of like, “Well.” She just gave me that look and hunched her shoulders like, “Well”.

An example of a stressful situation in which a parent described the difficult situation with their children and prepared them for the event is noted below:

…when I explained to my kids it’s like, “I don’t know what’s going on, but somebody called DCFS on me saying that I don’t feed you, so just act normal. You know what I’m saying? Act y’all usual way, you know. Don’t be scared when she come over here.” So my son was playing his game, and [my daughter] as usual, she was right there running around with – you know, in the kitchen and just, like, talking to the lady or whatever.

Q3 revealed that this group of African American and Latinx caregivers engaged in CSC
consciously buffered IGT, and strategized about ways to help their children deal with stress.

Results Summary

Overall, the current mixed methods study found high prevalence of IGT in this population of African American and Latinx caregivers and their 6-year-old children. The most prevalent IGT type was sociocultural context trauma, with some indication that the sociocultural context, such as neighborhood safety, may have gotten worse over time and more severely affected the second generation. The findings also suggested that Parent Self-Efficacy partially mediates the relationship between Child mACEs/Trauma and Child Negative Behavior. While there was no evidence of buffering in the full sample, the qualitative component of this study found promising evidence for an alternate, more direct and intentional route to breaking the cycle of IGT, Conscious Buffering. There was also indication of CSC in the qualitative sample. Finally, the study found that this population of African American and Latinx families engaged in mindfulness and mindful-like practices and ways of being. The findings will be explored further in the next chapter.
CHAPTER FIVE
DISCUSSION

This chapter begins with a summary and discussion of the findings, and implications for further research. This will be followed by study limitations and a reflection about the dissertation and its methodological approach. Areas for future research will conclude the discussion.

Summary of Findings

This study had several interesting findings. First, a high prevalence of IGT in this population of African American and Latinx parent-child dyads was confirmed as indicated by a high correlation between adult and child trauma, as well as a 38% overlap in specific childhood traumatic experiences. Next, the primary study hypothesis was not supported with the survey data, as none of the three parent strength variables (trait mindfulness, self-care, or self-efficacy) played a buffering or moderating role in IGT. Exploratory analyses of the path coefficients among the primary study variables indicated that Parent Self-Efficacy was a significant mediator through which children’s own trauma may come to manifest as negative behavior. This suggests that child trauma may impact parents’ feelings of efficaciousness, which may in turn impact children’s behavior concerns. Third, qualitative interviews with a sub-sample were analyzed both to explore the constructs in the survey data at a deeper level, and to look for possible explanations of any unexpected findings in the quantitative data. It was anticipated that the interviews would be important as most of the survey measures were validated on predominantly White, middle-class samples, and therefore might not appropriately capture the constructs of
interest in this sample. While CSC as measured by the surveys was not found to buffer IGT, the qualitative data revealed a potentially different pathway to break the cycle of IGT dubbed, “Conscious Buffering,” which was caregivers stating an open intention to not repeat the traumas of the past in their child. In partial support of the central study hypothesis, Conscious Buffering was indeed significantly correlated with a reduction of IGT in the interviewed sub-sample, $r(23) = 0.48, p<.05$, suggesting a potentially more intentional route to protecting children from IGT and/or its consequences than I had originally anticipated. Lastly, the qualitative component of the study also found that this population of African American and Latinx families engaged in mindfulness and mindful-like practices and ways of being, and that they use these strategies to cope with stress and trauma for themselves and their children. These findings have research, policy and practice implications that can help shape the next generation of trauma and mindfulness research.

**Q1: Prevalence of Intergenerational Trauma**

IGT is the experience and transfer of trauma and traumatic experiences across generations. Defined using terms including intergenerational cycles of abuse, multigenerational trauma, transgenerational trauma, and intergenerational cycles of poverty, among many others, IGT and a suggestion that it exists to a substantial degree, is well-documented in the literature (Bandura, 1971, 1977, 1986; Black et al., 2010; Hines & Saudino, 2002; Kaufman & Zigler, 1987; Kaufman & Zigler, 1989; Kernsmith, 2006; Kim, 2009; Osofsky, 2003; Putallaz et al., 1998). One of the first studies documenting IGT quantitatively, the present study found a high prevalence, or occurrence, of IGT in this sample of primarily low-income African American and Latinx parents and their 6-year-old children. Notably, most of the IGT was found to fall within
the category of sociocultural trauma followed by witnessing or experiencing trauma. The IGT prevalence findings will be discussed further in the context of the IGT framework presented in Chapter Two, and in the context of the ACEs to increase understanding about this study’s results. The significant contribution of adding sociocultural context trauma to fully understand traumatic experiences of non-White middle-class populations in the United States will follow.

**Intergenerational trauma.** While IGT has been well cited in the literature, the literature lacks a general definition for the term or a framework for understanding its dimensions (J.D. Osofsky, personal communication, January 27, 2016; C. H. Zeanah, personal communication, January 26, 2016; M. Graham, personal communication, January 27, 2016; C. Ghosh Ippen, personal communication, January 26, 2016). Furthermore there is a need for clear articulation and a quantitative approach to measuring IGT. Table 1 summarizes the framework presented in Chapter Two; it includes IGT’s mechanism, theoretical underpinning, medium and process of transmission. Recall that not all aspects of IGT are fully explored in this dissertation (e.g., biological). What has been specifically explored is experiencing or witnessing trauma and sociocultural context trauma, as captured by the mACEs survey and qualitative interviews.

The first quantitative analysis of IGT demonstrated a statistically significant moderate to strong positive correlation ($r=0.62$) between Parent mACEs/Trauma and Child mACEs/Trauma, confirming existence of IGT and that parents’ and their children’s childhood trauma experiences co-vary in the expected direction. This finding of a strong relationship between parent trauma and child trauma mirrors the research literature theoretically as IGT has been most studied via qualitative interviews (Danieli, 1998; Davidson, 1992; Felsen, 1998; Felsen & Erlich, 1990; Frazier et al., 2009; Krysinska & Lester, 2006; Lev-Wiesel, 2007; Sun et al., 2017; Weiss &
Weiss, 2000). Although the theoretical literature is in agreement that IGT is prevalent, this may be the first study to examine the question empirically, asking parents to respond to the ACEs survey for both generations simultaneously.

As further hypothesized by the research literature, this study found a significant though small relationship ($r=0.29$) between Parent mACEs/Trauma and Child Negative Behavior, a possible manifestation of child trauma or parent trauma via parenting. Caregiver trauma, which may be displayed via sustained emotional dysregulation, as a result of trauma, is both a risk factor for IGT in children as well as a predictor of (non-trauma) poor child emotional and behavior outcomes (Holden & Ritchie, 1991; Laor et al., 2001; Schechter et al., 2007; Yehuda et al., 2001). This finding is further evidence of IGT in this group of parent-child dyads.

**IGT in the context of the Original ACEs.** As noted, IGT was measured using the mACEs questionnaire, a questionnaire modified from the extant ACEs literature that measures the Original ACEs, the PHL ACEs, and additional questions I added to further understand families’ experiences of sociocultural context trauma not measured by the other items. As noted, the adults in this sample experienced more Original ACEs than the Kaiser sample and Philadelphia sample, indicating higher risk for long-term health and life outcomes. Furthermore, the average mACEs score of 7 indicates that the Chicago adults experienced more adverse experiences in childhood than what was captured by the Original ACEs questions, indicating that pre-existing ACEs measures do not include the full range of trauma experienced by this population of parents.

The younger generation in this study, children age 6, are currently at risk for health and other negative outcomes as they have experienced more Original ACEs than children ages 0-17
in national samples. The limited ACEs studies done on children ages 0-17 suggest that the prevalence of experiencing at least one ACE is approximately 48%, and for African American and Latinx children that statistic rises to 61% and 51%, respectively (Bethell et al., 2014; Sacks & Murphey, 2018). In this current sample of children, 43% of children have experienced at least one ACE by age 6, suggesting that by the age of 18 they will have likely experienced more than the national average of childhood ACEs (Bethell et al., 2014). This confirms a high level of ACEs in this population of young children and the likelihood that they will experience additional ACEs between the ages of 7-17.

**Prevalence of sociocultural context trauma.** In addition to examining the degree of quantitative overlap between parent and child trauma overall, this study further broke new ground by conducting an item-by-item analysis of specific trauma experiences to understand trauma type match and mismatch across generations. Of the 26-item mACEs questionnaire, parent trauma matched the exact type of trauma in their 6-year-old children 38% of the time, on average. Said differently, when a parent endorsed experiencing a trauma by age 18 in the past, their child had a greater than one in three chance of experiencing that same trauma by age 6. It should be noted that one of the challenges of this data and its interpretation was that the Parent Trauma/mACEs was a reflection of the caregiver’s entire childhood experience, while the children in this sample were age 6.

Building upon a social-ecological framework and cultural trauma theory, sociocultural trauma reflects experiences of trauma shaped by government policy, systems and/or the sociocultural context that occur in schools, neighborhoods and community contexts. Looking at the generations separately, sociocultural context trauma types were reported as three of the top
five ACEs for parents and four out of five top ACEs for their children (see Tables 5 and 6) suggesting a high prevalence of sociocultural context trauma in each generation separately.

Of the highest endorsed *shared* items across both generations, sociocultural context trauma matched across parent and child 50% of the time. The highest endorsed sociocultural context trauma types were bullying by a classmate (63%), living with an undocumented household member (60%) and bullying by school adult (50%). In addition, neighborhood violence was in the top five mACEs for both parents and their children individually, and it was shared 29% of the time.

Historically, IGT has been explored understanding the psychodynamic effects of trauma transfer (Boszormenyi-Nagy & Spark, 1973; Bowen, 1978; Dekel & Goldblatt, 2008; Fraiberg et al., 1975; Framo, 1981; Holden & Ritchie, 1991; Laor et al., 2001; Main & Solomon, 1990; Schechter et al., 2007). However, this study underscores the critical importance of needing to adapt and integrate a broader definition of trauma and ACEs to include trauma related to the sociocultural context as traditional measures of trauma, trauma related to caregiver behavioral patterns and/or witnessing or experiencing violence are limited in scope (Dekel & Goldblatt, 2008). For example, when considering the issue of neighborhood violence, it is far less plausible that this trauma would be passed down via psychodynamic factors than that it would be via continuing features of the sociocultural context.

Furthermore, measuring sociocultural context trauma strengthens the cross-cultural validity of measurement instruments as some adversities such as racism and xenophobia are unequally distributed in society (Mersky et al., 2017). Studies that omit certain adversities such as neighborhood violence, racism, and colorism underestimate disparities in cumulative adversity
between individuals and groups (Mersky et al., 2017). This study made a significant contribution to the nascent and growing literature on ACEs that reflects the fuller experience of African American, Latinx and other marginalized communities (Cronholm et al., 2015; Finkelhor, Shattuck, Turner, & Hamby, 2015; Mersky et al., 2017; Mersky, Topitzes, & Reynolds, 2013; Purewal et al., 2016).

**IGT: Transmitted or shared?** The experiences of sociocultural context trauma in both generations suggest that IGT is a complex, multidimensional, and dynamic phenomenon of experiences. What this study and other expanded ACEs questionnaires (i.e., Cronholm et al., 2015; National Center for Health Statistics, 2014; Purewal et al., 2016; Wade, Shea, Rubin, & Wood, 2010). Frequently asked questions: 2011-2012 National Survey of Children’s Health, 2014) suggest is that sociocultural context traumas are central adverse experiences, especially in the lives of marginalized, and historically and contemporarily oppressed populations in the United States. Given that sociocultural context trauma is experienced because of the social structures that exist, how does the IGT literature account for the experiences of *shared* trauma – trauma that is not transmitted via psychodynamic mechanisms, but rather, is experienced due to sociocultural mechanisms? Restated, is IGT transmitted from parent to child, or simply shared by two generations who grew up/are growing up in similar contexts, or both?

This question adds a level of complexity in the dialogue about IGT. Psychodynamic, attachment and infant mental health theory has undoubtedly provided numerous insights about conscious and unconscious caregiving behavioral patterns that may be shaped by IGT. To that end, parents who experience trauma provide caregiving experiences shaped by impaired mentalization and emotional dysregulation which result in poor caregiving behavioral patterns
that can lead to dysregulation in children. However, the assumption in sociocultural context trauma is that traumatic experiences are also shaped by interactions with other individuals and/or with social systems created by societal oppressive patterns. For instance, the experience of racism of families in this study is historically rooted in the global systems of enslavement and colonialism, and experienced in an ongoing fashion in the lived experiences of the families in this study. As a framework delineated from trauma theory itself, IGT holds value as it demonstrates that the paradigmatic model of trauma does not fit for all groups. Trauma theory adheres to the definition of trauma as “a frightening event outside of ordinary experience” (Substance Abuse and Mental Health Services Administration, 2019; van der Kolk & van der Hart, 1995; Zero to Six Collaborative Group, National Child Traumatic Stress Network, 2010), however, as implied by this and other studies, the event-based definition of trauma does not account for the “sustained and long-term account of trauma from colonialism…with its repeated and cumulative stressor events” (Visser, 2015, p. 9). I argue that IGT is both transmitted and shared. This perspective both reflects the theoretical foundations of trauma and IGT and centers the experiences of marginalized communities in this framework. In turn, considering an expansion of trauma theory and therefore the mechanisms of trauma transmission, may have implications for expanding approaches to buffering or ameliorating IGT.

Q2: Buffering IGT

Evidence suggests that culturally-informed dyadic interventions, such as Infant-Parent Psychotherapy (Lieberman & Pawl, 1993), Child-Parent Psychotherapy (Lieberman & Van Horn, 2004), Cognitive Behavior Therapy (Follette et al., 2006) and/or Parent-Child Interaction Therapy (Eyberg & Robinson, 1982), can help mitigate or buffer IGT in parent-child dyads.
However, not all families have access to clinical treatment. Moreover, some families may not be aware of formalized treatment services, may not engage in formalized services, or when engaged there may be poor uptake and low retention (Ghosh Ippen & Lewis, 2011). This is especially true for families that have been historically ignored by or negatively impacted by systems of care. As such, I developed interest in understanding how parents’ pre-existing strengths in terms of mindfulness characteristics or traits, self-care strategies, or parenting self-efficacy may be conditions that would reduce IGT and potentially improve the effectiveness of interventions.

Why might it be that there was little evidence these constructs played a buffering or moderating role in reducing IGT in this sample of African American and Latinx parent-child dyads?

**Mindfulness and self-care may not be enough.** Mindfulness is commonly known as a state of being present and attentive to what is happening in the moment without judgment and with compassion. This research study suggests that although these behaviors are present in high levels in this group of families, these are not the qualities to buffer IGT, especially the trauma experienced by this population of families – sociocultural context trauma and witnessing and experiencing trauma. As such, a parent may be highly attentive to the experience of an event like a neighborhood shooting in which their children hears gunshots and are visibly upset about the occurrence. However, said parent may be unable to prevent their children’s witnessing or experiencing trauma, as the event was beyond the parent’s control. Similarly, a parent may be attuned to his/her child’s experience of bullying – the moment-to-moment experience of harassment and feelings of unsafety in school, the playground or on the street – but cannot change those experiences. In both examples, while a parent may be highly attuned to their child (at least enough to be able to report the experiences), this conscious awareness or trait
mindfulness cannot stop or buffer their children’s experiences. Rather, it is possible that the parents’ active awareness and attunement may reflect their ability to help their child deal with stress or trauma rather than buffer or stop the trauma. There are several examples in the interviews of parents discussing ways in which they were attuned to their children’s experiences of stress and trauma and helped their children cope.

Relatedly, it is possible that mindfulness would have buffered IGT, if the most prevalent IGT in this sample had been Caregiver Behavioral Patterns, a noted IGT transmission mechanism as described in Chapter Two and discussed in Table 1. One would assume that if parents were more present in the moment and consciously aware of all that is happening around them, they would ruminate less on negative feelings or behaviors (Brown & Ryan, 2003) and may be less likely to directly cause harm to their child. In short, it is still possible that mindfulness could buffer IGT under certain types of parent trauma that might be more malleable to such traits and practices, but those types of trauma were not predominant here. Similarly, although there is some evidence of the existence of the predicted relationship between Parent Self-Care and Child Negative Behavior, i.e., \( r = -0.29 \), that association may have been stronger under the existence of more malleable trauma types. It was logical to assume that a parent who engaged in self-care activities and presumably felt more balanced was also less likely to enact negative caregiving behavioral patterns. Many of the parenting magazines and websites espouse this theory (Black, 2015; George, 2015; Hateley, 2017; Lite, 2018), but they were likely assuming a predominance of more conventional trauma types, such as physical or emotional abuse.
There is potentially another reason why CSC, or trait mindfulness and/or self-care did not buffer IGT. Perhaps the effects of trauma are too profound or intractable to buffer in a single generation. Studies looking at IGT of third generation Jewish families who survived the Holocaust, families’ placement in a transit camp following immigration, and families experiencing forced relocation and war demonstrate that the traumatic experiences were perpetuated across three generations (Danieli, 1998; Dekel & Goldblatt, 2008; Lev-Wiesel, 2007). While these studies looked at the impact of the trauma on the second and third generation and took a slightly different stance than this research study, these findings suggest that trauma can have lasting effects and reoccur in subsequent generations. Furthermore, as noted, given that many of the traumas experienced in both generations in this study are sociocultural context trauma, rooted in the operations of structural oppression, buffering of sociocultural context trauma may take generations of progress on social justice.

**Role of parent self-efficacy.** The present study extends the resilience research with its examination of parent characteristics and ways of being as potential buffers. Given the weak relationships between IGT, trait mindfulness, self-care, and self-efficacy, it was decided to explore Parent Self-Efficacy, originally conceived of as just a co-variate, for its role in possibly “carrying” the effects of children’s traumatic experiences to their actual behavior. Indeed, the data showed that Parent Self-Efficacy partially mediated the relationship between child trauma and child negative behavior. Interestingly, although Child mACEs/Trauma and Child Negative Behavior were not highly correlated enough to justify combining them into CTE (compound construct child traumatic effects), this unexpected finding with Parent Self-Efficacy suggests a logical, sequential “narrative” between the child variables. In short, while I originally conceived
of the two child variables as parts of a unified construct, it appears instead that one (trauma) may lead to the other (negative behavior), which results at least partially from the fact that children’s trauma is damaging to parents’ sense of self-efficacy.

Recall that Parent Self-Efficacy describes parents’ beliefs in their ability to perform the parenting role successfully and competently to positively influence the development of their children (Bandura, 1989; Coleman & Karraker, 2003; Wittkowski et al., 2017). The current finding that Parent Self-Efficacy acts as a partial mediator of the relationship between Child mACEs/Trauma and Child Negative Behavior is consistent with several research studies and theoretical analyses suggesting that parenting self-efficacy and child behavior are transactionally related (Bandura, 1977; Bugental & Shennum, 1984; Coleman & Karraker, 2001; Gecas, 1989; Meunier & Roskam, 2009). Knowing that in this sample sociocultural trauma predominated in children, a reasonable interpretation of the transactions suggested in the mediation model is that parents may feel defeated by their child’s repeated exposure to negative experiences that are beyond their control, such as a lack of neighborhood safety. Furthermore, given the high level of shared trauma shown here, an additional level of negative intensity may surround a parent’s sensation that they could not “create a better life for my child”. However, the fact that the quantitative characteristical strengths did not buffer IGT, and the fact that the manifestation of child trauma in Child Negative Behavior was only partly mediated by parenting self-efficacy, suggest there are other factors that may reduce the intergenerational reverberations of trauma. It is the work of ongoing research to uncover those factors.

This study also shows further evidence of a small significant inverse relationship between Parent Self-Care and Child Negative Behavior ($r=-0.26$). Given the high levels of trait
mindfulness in this study, this finding suggests that one could be aware of themselves, or
essentially mindful, as the FFMQ results demonstrated, however, reducing IGT may require
active engagement to care for oneself as well as active parenting competencies. Taken together,
the findings of Parent Self-Efficacy partially mediating the relationship between Child
mACEs/Trauma and Child Negative Behavior and Parent Self-Care being negatively correlated
with Child Negative Behavior further suggest that more positive parenting behaviors and frames
of mind did play a role in the reduced manifestation of behavioral concerns in their children.

**Promising buffers of IGT - Conscious buffering.** This population of parents
consciously buffered IGT by intentionally working to not repeat what they experienced or saw in
the past, modeling and teaching their children to make different decisions and working to protect
their children from harm. Conscious Buffering suggested a deep level of awareness and insight.
It demonstrated reflection about their own childhood, consideration about how they want to
parent and intentionally act to do things differently. The qualitative data provides examples of
parents working to make sure that their children were not exposed to substance using family
members, were not exposed to negative caregiving behavioral patterns, and working to
intentionally stop the cycle. This finding demonstrated further strengths in this population of
parents.

As noted in Chapter Four, and consistent with the mixed methods design of this study,
the qualitative findings sparked further interest in exploring whether Conscious Buffering might
(quantitatively) reduce IGT. It was found that indeed Conscious Buffering was significantly
correlated with the parent-child trauma difference score in this sample, (r=0.48) suggesting that
the more parents intentionally try to stop trauma from repeating, the greater reduction of trauma
from one generation to the next. The size of this correlation is impressive considering that, unlike the survey analyses, these two data collection procedures were separated in time.

In summary, the findings for Q2 suggest that while trait mindfulness and self-care did not explicitly buffer or moderate IGT, the parents in this study had other strengths and strategies for buffering IGT. Overall, the Conscious Buffering finding debunks the narrative in the literature about parents, especially low-income African American and Latinx parents, having a low level of agency and not protecting their children from harm (Hymowitz, 2005; Roberts, 2002).

**Q3: Contemplative Self-Care**

The final goal of this study was to understand how primarily low-income African American and Latinx caregivers sought mindfulness and/or engaged in mindful-like activities. Contemplative practice, the practice of thinking, questioning and concentrating on the self for an expanded level of awareness (McGarrigle & Walsh, 2011), was at the core of this group of parents’ mindfulness and mindful ways of being. While the qualitative sample was unfamiliar with the term mindfulness as well as contemplative practices like tai chi, chi gong, and yoga (Ospina et al., 2007) that lead to mindfulness, the qualitative results demonstrated that this group of parents were highly mindful (as demonstrated by the mean FFMQ of 3.64 (SD=.533)) and in fact engaged in the construct CSC. One hypothesis about why the qualitative sample was mindful but unfamiliar with the term mindfulness is that it is likely that mindfulness and contemplative practices are inherently embedded in cultural and religious practices (de Caussade, 2008; Kamenetz, 2007; Lawrence, 1982; Lykins, 2014; Selby, 2003; Thomas, Furber, & Grey, 2018). However, the contemporary focus and meaning of mindfulness has taken a deeply rooted
familial or community experience and broadened it into a self-care mechanism and fad for the upper middle class.

As discussed earlier in this chapter, CSC was a construct developed to test the relationship between Parent Self-Care and Parent Trait Mindfulness. There was found to be a small, but significant relationship between the two variables ($r=0.34$) and therefore the construct was not used to analyze the quantitative data but is a relevant finding overall. However, CSC was also found as a qualitative coding category. CSC is defined in the qualitative data as a method of taking care of oneself with increased and intentional attention to being present in the moment. Evidence of CSC in the data demonstrated that CSC fostered resilience by helping parents find peace and seek quiet to deal with daily life and respond to adverse circumstances without reacting in automatic ways (Bajaj & Pande, 2015).

**Spirituality and religion as demonstration of mindfulness.** Central to this group of parent’s CSC was religion and spirituality. Prayer brought the parents quiet, helped regulate their behavior and helped bring clarity. These findings are in alignment with a study that sought to understand the cultural relevance of mindfulness mediation for African Americans (Woods-Giscombé & Gaylord, 2014). They found that prayer was the most commonly mentioned cultural practice that had similarities to mindfulness meditation (Woods-Giscombé & Gaylord, 2014). That sample also noted that prayer and mindfulness mediation seemed to provide similar benefits of mental clarity and tranquility, centering and contemplative prayer (Woods-Giscombé & Gaylord, 2014). Relatedly, there are other examples in the existing literature (i.e., Caplan, Escobar, & Paris, 2013; Finch & Vega, 2003; Krause & Bastida, 2011) that demonstrated the central role of religion and spirituality to help with coping with adversity in the African
American and Latinx community. As cited by Jones (2007), in their 1993 study of African Americans, Littlejohn-Blake and Darling found that spirituality was noted to “provide a sense of empowerment and purpose greater than self that assists African Americans in coping with challenges and environmental stressors” (p. 131). Campesino and Schwartz’s (2006) study indicated that spirituality and religiosity were interwoven in the daily lives of Latinxs serving as foundations of strength and coping with life’s struggles. Furthermore, Pargament and Nielsen (as cited in Bradley, Schwartz, & Kaslow, 2005, p. 686) coined the term ‘religious coping’ to help define how religion was used to mediate stress. Religious coping is defined as “the use of religion or behaviors (i.e., prayer, seeking strength from God) to facilitate problem solving and prevent or alleviate the negative emotional consequences of stressful life circumstances” (Bradley et al., 2005, p. 686). Religion and spirituality are protective factors that foster mindfulness practice such as quiet and peace.

Community self-care. As indicated, to further gauge mindfulness and mindful-like practices, interviewees were probed about how members of their communities care for themselves. Surprisingly, few interviewees were able to answer this question directly, as many said they were unsure. Of the few that answered, they noted partying and/or smoking. I was expecting to hear similar self-care strategies as church and social support. Relatedly, given the significantly strong negative correlation between Child mACEs and Community Self-Care ($r=-0.46$), parents in the study who reported greater levels of mACEs for their children saw this as being due in part to a lack of self-care in the community. Given that the more frequently endorsed mACEs items for children are sociocultural context trauma, these findings indicate there is a moderate to strong relationship between children’s experiences in their neighborhood
and community self-care. In summary, while there was little evidence of community self-care, overall, the qualitative findings supports one of the study’s hypothesis that this community of African American and Latinx caregivers engaged in mindful-like ways of being, primarily CSC.

**Study Implications**

The implications of this study for reducing the prevalence of IGT point to a multipronged approach across research, policy and systems change. As implied by this study, the research community needs to adopt a broader perspective on trauma and adverse experiences. It is known that the Original ACEs indices were not selected based on a systemic process of measurement theory and testing, thus there is an increased need and interest in revisiting its measurement conventions (Cronholm et al., 2015; Finkelhor et al., 2015). Adapting a more culturally relevant and diversity-informed theoretical approach to trauma would ensure that trauma extends beyond the Eurocentric model as a single overwhelming event (Andermahr, 2016) to include the scope of the environment and systemic forces like racism, poverty and xenophobia (Danzer, 2012).

Additionally, a more concerted effort to understand and address systemic barriers that perpetuate IGT is needed. Though understanding ACEs and its impact on long-term health outcomes has been a priority of government agencies (such as the Substance Abuse and Mental Health Services Administration), private foundations (i.e., Robert Wood Johnson Foundation) and hospitals and health care providers (i.e., Purewal et al., 2016), collectively these entities have done little to address systems-level factors that contribute to IGT. One solution to address racism, colorism and xenophobia would be to train schools, governments and private organizations in diversity-informed practice (St. John, Thomas, & Noroña, 2012; Thomas, Noroña, & St. John, 2019) and implicit bias (Devine, Forscher, Austin, & Cox, 2012) to
potentially reduce discrimination and bias. These types of opportunities should also be offered to neighborhoods and communities to ensure that a cross section of society is developing the tools to reverse the effects of systemic racism and bias.

Systems of care that work with children and families can begin to enact trauma-informed policies and procedures that would help reduce the prevalence of IGT and its potential consequences. One example of how state systems have worked to understand the impact of ACEs and trauma on child behavior is the impressive efforts by Connecticut (SB01053, 2015), California (AB420, 2014) and Illinois (HB2663) to ban suspension and/or expulsion for behavioral problems attributable to ACEs (Metzler et al., 2017). Relatedly, given the mACEs results demonstrating the salience of neighborhood violence in young children’s experience, enacting policies that encourage public and private investment in African American and Latinx neighborhoods and that decrease segregation and concentrated poverty may reduce the conditions in which neighborhood violence occurs, and in turn improve the life experiences and outcomes of children and families.

The findings of Parent Self-Efficacy and Conscious Buffering of IGT as potentially important factors in trauma manifestation in children provide fodder for research, policy and practice. There is a research opportunity to continue to explore Parent Self-Efficacy and its related constructs and measures to reach consensus about which would be most helpful in accurately determining capability to parent. Accurate measures may also ensure that parents with lower levels of self-efficacy are better identified and supported to improve their skills (Witkowski et al., 2017). The Conscious Buffering of IGT finding reveals that caregivers in this study employ a level of agency and competency in family and community context with a
prevalence of IGT. While it has been proven difficult to buffer children from sociocultural context trauma and from witnessing trauma, future research in this area should look into ways in which interventions can help parents deepen or develop self-efficacy skills, as well as work with parents to expand contemplative practices of reflection, awareness, insight and other ways of being to help protect their children from harm.

To further cultivate CSC, one would argue a natural step would be to integrate mindfulness meditation and other self-care practices into caregivers’ routines. Given the evidence of the centrality of spirituality and religion in the lives of African American and Latinx parents, mindfulness-interventions should be tailored by cultural practices of both communities. Incorporating cultural practices such as music and dance may help with recruitment and retention of African American and Latinx participants in mindfulness based interventions.

Additionally, mindfulness-based groups or interventions should incorporate philosophical approaches that would include the sociocultural context trauma this population experienced. As noted in Chapter Two mindfulness-based or mindfulness-informed interventions have a theoretical underpinning of helping people increase their acceptance of what is. This includes the willingness to experience emotional stress, and adapting behavior ‘skillfully’ to address challenges or issues (Follette et al., 2006). Stated differently, mindfulness allows a sense of ‘calm abiding’ with current experiences (Follette et al., 2006). This is contrary to critical analysis, social justice, diversity-informed approaches, and critical inquiry and analysis. Accepting ‘what is’ runs the risk of fostering a belief that the problem is how one thinks about their experience of sociocultural context trauma instead of the sociocultural context trauma itself. To be useful in addressing sociocultural context trauma perhaps mindfulness practice can be
tailored as a pathway for deepening connection through vulnerability and authenticity and to uncover issues of power and privilege including racism and other forms of sociocultural context trauma and oppression (Cannon, 2016). Overall, the first step in making mindfulness interventions accessible for the populations of parents and caregivers in this study is to ensure accessibility by providing childcare and meals (Blum, 2014; Woods-Giscombe & Gaylord, 2014).

**Study Limitations**

This study was the first to use a quantitative index to explore the prevalence of IGT and its possible buffers in African American and Latinx parents and their 6-year-old children. Overall, this dissertation adhered to the goals and expectations outlined in its proposal, however there remain a few limitations that should be acknowledged.

**Sampling**

The study’s design included purposeful recruitment of African American and Latinx caregivers from Chicago to explore the construct of IGT and its potential buffers. The power analysis determined a minimum sample size of 84 to detect a moderate effect size and determine the strength of key variables (Padgett, 2008). To allow for buffering range, the study over-recruited and reached a sample size of 109. While the study exceeded minimum power, the fact that the sample was drawn from one school district may limit the study’s generalizability.

Relatedly, because of financial limitations, the number of Latinx interview participants (22% or 5 people) was less than desired thereby limiting the generalizability of the study results further. It had been originally proposed the interview sample would be about evenly divided between African Americans and Latinx. However, more than half of the Latinx sample was
Spanish speaking. I am not fluent in reading or speaking Spanish and therefore could not interview this group. Due to funding constraints (all costs were covered by the Dissertation Chair/Principal Investigator of the noted RCT or by dissertation student) limited dollars were available to hire Spanish speaking interviewers, and to cover the cost for transcribing and translating Spanish interviews. This did allow for oversampling African Americans which painted a rich picture of African American caregiver experiences. With additional and external funding, a study similar to this one could have increased the number of participants overall, and interview primarily Spanish speaking populations.

This study is also limited in terms of its sampling technique. As the study sought to explore theoretical constructs of IGT, mindfulness and CSC, convenience and purposive sampling techniques were used. This type of sampling prevents statistical generalization (Corbin & Strauss, 2008) and therefore likely decreased the ability to infer from this sample to a larger population of African American and Latinx parent-child dyads.

**Data Collection**

A second limitation of this study was the single reporter in the form of one parent/caregiver and therefore potential bias when reporting on children’s experiences. Measures in the study relied on self-report instruments and parent perceptions of their children’s traumatic experiences (Child mACEs/Trauma) and behavior (Child Negative Behavior), without parallel objective measures. Ideally, for those families in which there was more than one primary caregiver, gathering data from a co-parent would have provided an additional perspective on the child’s traumatic experiences and/or negative behavior. Teacher report would have added yet another perspective on the Child Negative Behavior measure. However, collecting data from a
teacher would have called for additional resources that were not available in this study. While this poses a question as to the internal validity of the research, this study adds a unique perspective of African American and Latinx caregivers’ first-person perspectives on trauma (their own and their children’s), mindfulness and self-care, all of which are rarely captured in research.

So what impact might the single-reporter bias have had on the results found here? Specifically related to the mACEs Questionnaire, parent report could have been especially limiting and led to under-reporting of trauma because as noted, parents may not be fully aware of all of their children’s trauma experiences. One example of a potential case of under-reporting observed in the data was parent report of their children’s ACEs related to sexual abuse. As noted, 22% of parents reported experiencing sexual abuse in their childhood. However, none (including parents that did not experience sexual abuse) reported any sexual abuse experienced by their children, thereby leaving the section of the survey blank. The qualitative data, however, revealed that some children had experienced some level of sexual abuse. The heightened level of sensitivity of the subject matter may have created the potential for misreporting to prevent discomfort and/or embarrassment (Tourangeau, Rips, & Rasinski, 2000). There is also some concern for social desirability bias in Latinx respondents given some families’ vulnerable position in society (Harkness & Schoua-Glusberg, 1998; Ponce et al., 2007) as having undocumented members. While parent report was a limitation in this study, parent report is consistently used for studies with young children (Bethell et al., 2014) and with ACEs and trauma-screenings (McKelvey et al., 2016; Sacks & Murphey, 2018).
On the other hand, parents might have also over-reported their child’s trauma, or over-reported their overlap with their child’s experiences. For example, if parents experienced racism or colorism as a child, they may assume that their child also experienced it without necessarily having seen it firsthand. Another place where single reporter bias may have had an impact on the data is revealed with the relationship between Parent Self-Efficacy and Child Negative Behavior. It is possible that parents who reported higher levels of self-efficacy were less likely to report high levels of Child Negative Behavior, signifying a potential reporting bias. Finally, the mACEs Questionnaire, which asked caregivers about ACEs in childhood (age 0-18), was retrospective, and therefore relied on parent memory and recall, which are prone to inaccuracy (Tourangeau et al., 2000).

Despite these limitations, this study has theoretical and research value. The study was designed to explore the prevalence of IGT and its potential buffers with an understudied population of primarily low-income African American and Latinx families. Such explorations provided new insights into the construct of IGT, CSC and Conscious Buffering. Insights can be extended to future research on all constructs. Given that measurement techniques were the same or comparable to the existing literature in terms of methods (i.e., parent report) and ethical concerns (i.e., the inability to ask children directly about trauma), over- or under-reporting concerns due to single-reporter bias are likely also comparable to those existing in previous research.
Dissertation and Methodological Reflections

Quantitative Data Reflection

Exploring new research constructs and relationships requires the use of previously existing measures to understand how variables fit together. This study used five surveys to understand IGT, trait mindfulness, self-care and self-efficacy. When piloted with a sample similar to the study sample, it took an average of approximately 20 minutes to complete the survey packet. However, for caregivers in this study, the average time required was somewhat higher. For some caregivers it took nearly 45 minutes; this was especially true for caregivers for whom English was their second or third language. Further, there were two instances when older caregivers were having a hard time completing the survey packet. In those cases, I paired those participants with Research Assistants from the larger CCK2 study (both of whom were familiar with the survey instruments and research measures), to verbally interview the participant. Some of this was due to the number of surveys, differing survey formats and varying types.

After some reflection, I would have liked to make some revisions to the Self-Care Measure “Caring for Myself” to include items that were relevant to urban African American and Latinx families. Artistic categories would have been added such as dancing, crocheting, and knitting. I would have added cooking and baking to that measure as well. However, while the addition of such items might have made the measure feel more familiar and applicable to the participants, it is unlikely that these changes would have made any substantive changes to the findings.
Qualitative Data Reflection

As expected, the interviews were an opportunity to further understand what type of stress and trauma families experienced, how they cared for themselves, and the extent to which they were mindful and/or engaged in mindful-like activities. There are several reflections from conducting the interviews including my building relationships with the potential sample, the use of quantitative data to gather further information, and the use of a mindfulness tool.

Role of researcher. In many ways, I can be defined as a ‘practitioner-researcher’. I was a CCK2 Calm Community Facilitator and led the project’s parent engagement work. As indicated in Chapter Three, I worked to integrate mindfulness practices into kindergarten thru second grade classrooms and facilitated Family Engagement Nights in which CCK2 and mindfulness were introduced to families, many of whom who are in this current study. At the same time, I worked in the field of early childhood mental health as a grantmaker, policy maker and systems builder. All of these roles informed my work on this dissertation. In my capacity as the CCK2 Parent Engagement lead, I helped to recruit parents to the ‘Parent Study’. My efforts to familiarize myself with the potential Parent Study participants prior to the study did appear to facilitate parents’ comfort with interviewing and sharing their experiences. In several cases participants reported that interviewing was “like talking to a friend”.

Use of quantitative data to support qualitative interviews. As important as it was to have some sort of relationship with the participants, I do not believe that my familiarity with the sample biased the data. The interviews were purposely timed to allow me to review the quantitative data prior to the interview to highlight some of the experiences reported in the quantitative packet. There were some instances in which the interviewee was open to talking
about his/her traumatic experiences and self-care and did not need any prompting to discuss what was reported in the quantitative interviews. There were other instances, however, where I used the quantitative data to prompt the interviewee about some of the information shared. There were approximately four instances where interviewees reported something in the quantitative data that I sought to clarify in the interview. In all of those cases, the interviewee asked to make an amendment to the quantitative data.

**Mindfulness.** As noted, though the sample had average to above average trait mindfulness (FFMQ) level, mindfulness, as a construct and a practice, was unfamiliar to the interviewees. As I was trying to understand if any of the interviewees had any familiarity with mindfulness and/or if their families or communities engaged in similar practices, I realized that set of questions outlined in the Interview Protocol were garnering little to no information. After the fourth interview, at the suggestion of my Dissertation Chair, I used a common tool and handout “Mindful or Mind full?” (see Appendix Q) to illustrate the meaning of mindfulness. I found mixed results using the tool. I am unsure if the handout was unhelpful or if the qualitative sample had so little familiarity with mindfulness that the handout was not a helpful resource. Nevertheless, initial concerns that the sample might have over-emphasized the role of mindfulness in their lives due to having been familiar with the CCK2 project, were not borne out in these data.

**Mixed methodology approach.** Employing mixed methods was a very helpful approach in working to understand the complexity of IGT and parent strengths. Triangular mixed methods fostered an opportunity for deeper analysis of some of the quantitative findings and clarified questions that emerged from the quantitative data (as exemplified by the above note about sexual
abuse). Mixed methods provided a more balanced perspective of the data (Morse & Chung, 2003) and added a level of breadth, depth and richness to quantitative data (Schulze, 2003) such as CSC, and allowed for the discovery of Conscious Buffering. Engaging in a mixed methods study accelerated my quantitative and qualitative research skills simultaneously!

**Biography.** In the spirit of the practice of reflective research (Etherington, 2007), I am aware of how the personal, social and cultural context in which I live shaped my conduct, interpretations and representations of this research endeavor. Mindfulness and self-care have always been a part of my own practice long before my understanding of IGT and its relevance in my own life. My own Original ACEs score is 3, similar to the adult sample mean Original ACE score, and my mACEs score is 5 (whereas the average mACEs for the adult sample is 7). I am sure that Conscious Buffering in my own mother led to me not having a higher ACE score and my own Contemplative Self-Care practices help me navigate sociocultural context trauma and other stress and/or trauma I experience daily. While engaging in my dissertation studies, integrating meditation into my community felt critically important. I became involved in Insight Chicago Meditation Community (www.insightchicago.org) and started a twice-monthly vipassana meditation sitting group. The group is not officially considered a practice group for people of color, however, the location of the sitting group is on the Southside of Chicago and therefore the group is 90% low-middle income African American. In short, my experiences have shaped this dissertation, and this dissertation has in turn shaped further experiences.

**Conclusion – Prevalence of IGT and Evidence of Some Strengths**

This study’s three research questions were explored using a triangular mixed methods design which employed surveys and 60-minute interviews to explore the hypotheses. The study
confirmed the prevalence of IGT in this sample of primarily low-income African American and Latinx parents and their 6-year-old children. Quantitative analyses that represented the index of IGT were employed and the trauma measure included sociocultural context items that did not exist in previous measures. Because of the evidence that trait mindfulness, self-efficacy and self-care help parents cope with stress, this study explored the possibility of these strengths as buffers of IGT. This hypothesis was not supported with these data. However, an exploratory analysis of the variable Parent Self-Efficacy found it to be a significant mediator of the relationship between Child mACEs/Trauma and Child Negative Behavior, partially explaining the underlying mechanism of the relationship between the two variables. Finally, this study also explored African American and Latinx parents’ mindful-like behavior that helped reduce stress and trauma in their families. The qualitative interviews found evidence for CSC and Conscious Buffering of IGT as strengths. Conscious Buffering was indeed significantly correlated with the parent-child trauma difference score in this sample, \((r=0.48)\) suggesting that the more parents intentionally try to stop trauma from repeating, the greater reduction of trauma from one generation to the next. This finding also suggests that there are alternative pathways of buffering IGT, at least in the interviewed sample.

The qualitative findings of CSC and the high rates of Parent Trait Mindfulness in this sample suggest that although these pre-existing strengths were not buffers of IGT, an intervention that made a more explicit effort to build on CSC and Parent Trait Mindfulness, may nevertheless be helpful. Furthermore, the significant, though small, relationship between Parent Trait Mindfulness and Child Negative Behavior \((r=-0.21)\) demonstrates that perhaps with a formalized mindfulness practice, may be able to help reduce negative behavioral patterns (a
potential manifestation of trauma) in their 6-year-old children. The Conscious Buffering finding also indicated that parents knew exactly what they needed to do to reduce IGT – consciously and intentionally employ action to protect their children. Parent characteristical strengths are important, of course, but their influence on reducing IGT may not be seen unless accompanied by conscious action. Given that this finding was only able to be analyzed with the interviewed sub-sample, an important next step in this research would be to examine it in a larger and representative sample.

This study broke new ground as one of the first to describe the prevalence of IGT in terms of the quantity of overlap in trauma across parents and children, and in terms of the specific types of trauma that overlapped or were new in the second generation. Future studies should seek to confirm and/or expand the prevalence findings as well as the quantitative approach to evaluating IGT that was developed here. Given that Parent Self-Efficacy accounts for some but not all of the transference from Child mACEs/Trauma to Child Negative Behavior, future research should explore additional potential mediators. This study found there to be both a prevalence of IGT and evidence of strengths in helping to limit trauma across generations. Future studies may be able to replicate the idea that when sociocultural context traumas are prevalent in the sample, there may be some other type of intervention or prevention needed as parent character strengths were found to not buffer societal-influenced IGT. This sample was characterized mostly by sociocultural context trauma which were likely more intractable making buffering a more difficult process. These results also speak to the need for intentional social justice, anti-bias, and diversity-informed practice to address and change sociocultural context trauma which go beyond the parent-child dyad and reach deep into societal institutions and
overall culture. In short, the results found here underscore the presence and importance of parental strengths in protecting their children, but they also underscore that within-dyad protective factors are necessary but insufficient conditions for breaking the cycle of trauma transmission across generations, especially when the types of trauma that are experienced are largely beyond a parent’s control.
APPENDIX A

FAMILY STRESSFUL EXPERIENCES SURVEY
We all live with stress and have stressful experiences. This survey helps us to understand some of the stress you experienced as a child (when you were under the age of 18), the stress your child experiences and/or witnesses, and stress people of your same race/ethnicity experience.

Instructions: Read the experience statement and circle whether or not the statement happened to you as a child, if it happened to your involved in the Calm Classroom K-2\textsuperscript{nd} grade program, and if the experience has caused trouble for other people of your same race or ethnicity.

<table>
<thead>
<tr>
<th>Experiences</th>
<th>Did this happen to you as a child (under age 18)?</th>
<th>Do you believe this experience has caused a lot of trouble in the lives of other people of your same race/ethnicity?</th>
<th>Has this happened to your son or daughter or did he or she witness it?</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Feel unsafe in the neighborhood</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>PHL ACE Survey</td>
</tr>
<tr>
<td>2  People in the neighborhood do not look out for each other</td>
<td>Yes  No</td>
<td>No</td>
<td>Yes  No</td>
<td>PHL ACE Survey</td>
</tr>
<tr>
<td>3  There are no opportunities for jobs and/or services in the neighborhood</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>No</td>
<td>Created by author</td>
</tr>
<tr>
<td>4  Bullied by a peer or a classmate</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>PHL ACE Survey</td>
</tr>
<tr>
<td>5  Bullied by a teacher or another adult in school</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Created by author</td>
</tr>
<tr>
<td>6  Had bad experiences at school (for example: asked for help and never received it, labeled as a troublemaker or talent/smarts never recognized)</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Created by author</td>
</tr>
<tr>
<td>7  See or hear someone beaten up, stabbed or shot in the neighborhood or school</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>PHL ACE Survey</td>
</tr>
<tr>
<td>8  The family cut the size or skipped meals because there was not enough money for food</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>PHL ACE Survey</td>
</tr>
<tr>
<td>9  People treated differently because of race or ethnicity</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>Yes  No</td>
<td>PHL ACE Survey</td>
</tr>
<tr>
<td></td>
<td>People treated differently because of immigration status</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>-----</td>
</tr>
<tr>
<td>10</td>
<td>People treated differently because of the color of skin, and/or hair texture</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>11</td>
<td>Hide immigration status from friends, neighbors and peers</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>12</td>
<td>Live with anyone who was depressed or mentally ill</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>13</td>
<td>Live with anyone who was suicidal</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>14</td>
<td>Live with anyone who was a problem drinker or alcoholic</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>15</td>
<td>Live with anyone who used illegal drugs or abused prescription medications</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>16</td>
<td>Live with anyone who serve time or sentenced to serve time in a prison, jail or other correctional facility</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>17</td>
<td>Live with anyone who does not have legal immigration status and is/was undocumented</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>18</td>
<td>Live in foster home(s)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>19</td>
<td>If yes, please indicate how many foster homes</td>
<td>Yes</td>
<td>No</td>
<td>If yes, how many foster homes? ___</td>
</tr>
<tr>
<td>20</td>
<td>See or hear parent, step parent or other adult at home being yelled at, screamed at, sworn at, insulted or humiliated</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>21</td>
<td>See or hear parent, step parent or another adult at home being slapped, kicked, punched or beaten</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>22</td>
<td>Experience parent, step parent or another adult at home swearing at you, insulting you, putting you down</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Experience parent, step parent, or another adult at home push, grab, shove, slap or beat you</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>-----</td>
</tr>
<tr>
<td>23</td>
<td>Experience parent, step parent or another adult at home act in a way that made you afraid of being physically hurt</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>24</td>
<td>Experience an adult family, friend or stranger touch or fondle you in a sexual way or have you touch their body in a sexual way</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>25</td>
<td>Experience an adult family, friend or stranger attempt to have or have any type of sexual intercourse (oral, anal or vaginal) with you</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
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<td>26</td>
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</tbody>
</table>

Sources:


APPENDIX B

CALM CLASSROOM K-2ND GRADE FAMILY LIAISON OVERVIEW
What is the role of the Family Liaison?
Family Liaisons help Calm Classroom maintain relationships with K-2nd grade families. Family Liaisons help collect contact information and share information with families. They attend their school’s Calm Classroom Family Event and stays in contact with Calm Classroom staff for any updates.

What is Calm Classroom?
Calm Classroom is the new social and emotional program at your child’s school. Calm Classroom incorporates mindfulness and mindful awareness to help reduce stress, increase calmness and improve behavior in school and at home. While the whole school is involved in the program, students in K-2nd grade are receiving extra resources. Calm Classroom has been implemented in more than 125 Chicago Public Schools.

What happens in each classroom?
- Each Calm Classroom does a Calm Classroom exercise 2-3 times per day. Exercises include breathing, stretching, relaxation and focusing techniques.
- Each classroom has a “Calm Spot,” a tablet that displays relaxing and highly engaging nature videos for two minutes to help children refocus and be calm.
- Every week, Calm Community facilitators visit each class to provide extra support to the class.

For more information contact: Adenia Linker; Project Director alinker@erikson.edu or (312) 893-7126
Kandace Thomas; k.thomas@erikson.edu or (773) 272-5597
APPENDIX C

POWER ANALYSIS JUSTIFICATION
An a priori power analysis was conducted using G*Power 3.1 (Faul, Erdfelder, Buchner, & Lang, 2009) to determine an appropriate sample size. Using Cohen’s (1988) criteria, a medium effect size of 0.3 was estimated. With power $(1 - \beta)$ set at 0.80 and $\alpha = .05$, two-tailed, the projected sample size needed with this effect size is approximately $N=84$ for this correlation analysis ($r$).

**Test**

Bivariate Normal Model (Pearson r for two continuous variables)

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<thead>
<tr>
<th>Model</th>
<th>Two-tailed, small association (.20)</th>
<th>Two-tailed, small association (.25)</th>
<th>Two-tailed, moderate association (.30)</th>
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<tr>
<td>Power</td>
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<tr>
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<tr>
<td>N</td>
<td>193</td>
<td>123</td>
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</table>
APPENDIX D

PARENT INFORMATION FORM
UNDERSTANDING HOW MINDFULNESS CAN REDUCE STRESS IN FAMILIES

Study to be completed by: Kandace Thomas, Doctoral Student
Faculty Advisor: Amanda Moreno

PARTICIPANT INFORMATION FORM

Thank you for agreeing to participate in my study. This study will be completed in two parts – surveys and interviews with selected parents/guardians. To participate in the surveys, please complete the information below and review and sign the following consent form. One parent will be eligible to win a $100 gift card for your participation.

Parent/Guardian Name: ________________________________

Parent/Guardian Age: _______

Child Name: _________________________________________

Child’s Age: _______

Child’s Grade: _______

Are you interested in participating in the interview portion of the study?

☐ Yes

If yes, when is the best day and time for a one-hour interview?

_____________________________________________________

☐ No

If yes, please provide your contact information:

Phone Number: _________________________________________

When is the best time to call you?_____________________

Email Address: _________________________________________

To protect your and your child’s confidentiality, this cover sheet will be removed once all of the data is entered into the computer.
APPENDIX E

DEMOGRAPHIC INFORMATION FORM
UNDERSTANDING HOW MINDFULNESS CAN REDUCE STRESS IN FAMILIES

Study to be completed by: Kandace Thomas, Doctoral Student
Faculty Advisor: Amanda Moreno

DEMOGRAPHIC INFORMATION FORM

This questionnaire provides some background information about you for the research project. Do not put your name on this form. Please keep in mind your child involved in the Calm Classroom K-2nd grade program.

1. What is your role in the child’s life:
   □ Parent
   □ Grandparent
   □ Foster Parent
   ◦ If you are a foster parent, how long have you been fostering this child?
   __________
   □ Aunt/Uncle
   □ Other: ______________

2. How many children do you have? ________________
   a. How many are living at home with you? _________

3. How many children do you have involved in the Calm Classroom K-2nd grade program? __________

4. How old is/are the child(ren) involved in the Calm Classroom K-2nd grade program? ________________

5. What is the gender of the child(ren) involved in the Calm Classroom K-2nd grade program?
   ____________________________________________________________________________________

6. How old are you? _____________

7. What is your racial/ethnic background?
   □ African American or Black
   □ Hispanic or Latino
   □ Asian or Pacific Islander
   □ White or European American
   □ Native American
   □ Bi-racial or multiracial
5. Where you born in the United States?  Yes  No

6. Where your parents born in the United States?  Yes  No

7. What is your relationship status?
   - Married
   - Single
   - Divorced
   - Living with a partner
   - Have partner, living separately
   - Separated
   - Widowed
   - Other: ____________________________

8. What is your employment status?
   - Employed full-time
   - Unemployed
   - Employed part-time
   - Homemaker
   - Student/job training
   - Disabled
   - Retired
   - Other: ____________________________

9. How much schooling do you have?
   - Graduated high school
   - Some college courses
     - college degree
   - GED or vocational certificate
   - Post college degree

10. What is your religious preference?
    - Christian
    - Muslim
    - Non religious
    - Agnostic or Atheist
    - Jewish
    - Buddhist
    - Other
APPENDIX F

BRIEF PROBLEM MONITOR - PARENT
Figure 1. The BPM-P. Superscripts indicate the items scored on the INT, ATT, and EXT scales, which are summed to yield the TOT score. (Superscripts are not printed on the actual form.)
APPENDIX G

FIVE FACET MINDFULNESS QUESTIONNAIRE
Below is a collection of statements about your everyday experience. Using the 1–5 scale below, please indicate how frequently or infrequently you have had each experience in the last month (or other agreed time period). Please circle the answer according to what really reflects your experience rather than what you think your experience should be.

1. I perceive my feelings and emotions without having to react to them

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<th>never or very rarely true</th>
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2. When I’m walking, I deliberately notice the sensations of my body moving

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3. I find it difficult to stay focused on what’s happening in the present

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4. I’m good at finding the words to describe my feelings

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5. I criticize myself for having irrational or inappropriate emotions

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6. I watch my feelings without getting lost in them

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7. When I take a shower or bath, I stay alert to the sensations of water on my body

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8. It seems I’m “running on automatic” without much awareness of what I’m doing

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9. I can easily put my beliefs, opinions, and expectations into words

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10. I tell myself that I shouldn’t be feeling the way I’m feeling

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11. In difficult situations, I can pause without immediate reacting

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12. I notice how foods and drinks affect my thoughts, bodily sensations and emotions

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13. I rush through activities without being really attentive to them

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14. It’s hard for me to find the words to describe what I’m thinking

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<th>never or very rarely true</th>
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15. I believe some of my thoughts are abnormal or bad and I shouldn’t think that way

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<th>never or very rarely true</th>
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16. When I have distressing thoughts or images, I am able just to notice them without reacting

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17. I pay attention to sensations, such as the wind in my hair or sun on my face

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<th>never or very rarely true</th>
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18. I do jobs or tasks automatically without being aware of what I’m doing

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19. I have trouble thinking of the right words to express how I feel about things

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20. I make judgments about whether my thoughts are good or bad

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21. When I have distressing thoughts or images, I feel calm soon after

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<th>sometimes not true</th>
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22. I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing

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23. I find myself doing things without paying attention

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24. When I have a sensation in my body, it’s hard for me to describe it because I can’t find the right words

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25. I tell myself I shouldn’t be thinking the way I’m thinking

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26. When I have distressing thoughts or images, I “step back” and am aware of the thought or image without getting taken over by it

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<th>never or very rarely true</th>
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27. I notice the smell and aromas of things

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28. When I do things, my mind wanders off and I’m easily distracted

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29. Even when I’m feeling terribly upset, I can find a way to put it into words

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30. I think some of my emotions are bad or inappropriate and I shouldn’t feel them

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31. When I have distressing thoughts or images, I just notice them and let them go

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32. I notice visual elements in art or nature, such as colors, shapes, textures, or patterns of light and shadow

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33. I don’t pay attention to what I’m doing because I’m daydreaming, worrying or otherwise distracted

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34. My natural tendency is to put my experiences into words

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35. I disapprove of myself when I have irrational ideas

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<th>sometimes not true</th>
<th>often true</th>
<th>very often or always true</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

36. I pay attention to how my emotions affect my thoughts and behavior

<table>
<thead>
<tr>
<th>never or very rarely true</th>
<th>not often true</th>
<th>sometimes not true</th>
<th>often true</th>
<th>very often or always true</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

37. I am easily distracted

<table>
<thead>
<tr>
<th>never or very rarely true</th>
<th>not often true</th>
<th>sometimes not true</th>
<th>often true</th>
<th>very often or always true</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

38. I can usually describe how I feel at the moment in considerable detail

<table>
<thead>
<tr>
<th>never or very rarely true</th>
<th>not often true</th>
<th>sometimes not true</th>
<th>often true</th>
<th>very often or always true</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

39. When I have distressing thoughts or images, I judge myself as good or bad, depending what the thought/image is about

<table>
<thead>
<tr>
<th>never or very rarely true</th>
<th>not often true</th>
<th>sometimes not true</th>
<th>often true</th>
<th>very often or always true</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

APPENDIX H

CARING FOR MYSELF QUESTIONNAIRE
The following questionnaire asks you about how you take care of yourself in day-to-day life. Please rate the following areas according to how well you think you are doing based on the scale below.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>I do this frequently</td>
</tr>
<tr>
<td>2</td>
<td>I do this occasionally</td>
</tr>
<tr>
<td>1</td>
<td>I do this rarely</td>
</tr>
<tr>
<td>0</td>
<td>I never do this</td>
</tr>
<tr>
<td>N/A</td>
<td>This does not pertain to me</td>
</tr>
</tbody>
</table>

Physical Self-Care
- Eat regularly (e.g. breakfast, lunch, and dinner)
- Eat healthily
- Exercise
- Get regular medical care for prevention
- Get medical care when needed
- Take time off when sick
- Get massages
- Take baths
- Dance, swim, walk, run, play sports, sing, or do some other fun physical activity
- Take time to be sexual - with myself, with a partner
- Get enough sleep
- Wear clothes I like
- Take vacations
- Other ways I take care of myself physically: ________________________________

Psychological Self-Care
- Take day trips or mini-vacations
- Make time away from telephones, email, and the Internet
- Make time for self-reflection
- Notice my inner experience - listen to my thoughts, beliefs, attitudes, feelings
- Have my own personal psychotherapy
- Write in a journal
- Read literature that is unrelated to work
- Do something at which I am not expert or in charge
- Attend to minimizing stress in my life
- Engage my intelligence in a new area, e.g., go to an art show, sports event, theatre
- Be curious
- Say no to extra responsibilities sometimes
- Other ways I take care of myself psychologically: ________________________________
Emotional Self-Care

- Spend time with others whose company I enjoy
- Stay in contact with important people in my life
- Give myself affirmations, praise myself
- Love myself
- Re-read favorite books, re-view favorite movies
- Identify comforting activities, objects, people, places and seek them out
- Allow myself to cry
- Find things that make me laugh
- Express myself through arts
- Express my outrage in social action, letters, donations, marches, protests
- Other ways I take care of myself emotionally: ________________________________

Spiritual Self-Care

- Make time for reflection
- Spend time in nature
- Find a spiritual connection or community
- Open to inspiration
- Cherish my optimism and hope
- Be aware of non-material aspects of life
- Try at times not to be in charge or the expert
- Be open to not knowing
- Identify what is meaningful to me and notice its place in my life
- Meditate
- Pray
- Sing
- Have experiences of awe
- Contribute to causes in which I believe
- Read inspirational literature or listen to inspirational talks, music
- Other ways I take care of myself spiritually: ________________________________

Relationship Self-Care

- Schedule regular dates with my partner or spouse
- Schedule regular activities with my children
- Make time to see friends
- Call, check on, or see my relatives
- Spend time with my companion animals
- Stay in contact with faraway friends
- Make time to reply to personal emails and letters; send holiday cards
- Allow others to do things for me
____ Enlarge my social circle
____ Ask for help when I need it
____ Share a fear, hope, or secret with someone I trust
____ Other ways I take care of myself in my relationships: ____________________________

Workplace or Professional Self-Care (please skip this section if you do not work outside of the home)
____ Take a break during the workday (e.g., lunch)
____ Take time to chat with co-workers
____ Make quiet time to complete tasks
____ Identify projects or tasks that are exciting and rewarding
____ Set limits with clients and colleagues
____ Balance my caseload so that no one day or part of a day is “too much”
____ Arrange work space so it is comfortable and comforting
____ Get regular supervision or consultation
____ Negotiate for my needs (benefits, pay raise)
____ Have a peer support group
____ Strive for balance within my work-life and work day
____ Strive for balance among work, family, relationships, play, and rest

Other ways you care for yourself that is not included in this survey:
________________________________________________
_________________________________________________________________________________
___________________________________________

APPENDIX I

PARENT SELF-AGENCY MEASURE
Please read each statement below, and circle the number that corresponds to your feelings about parenting your child(ren) involved in the Calm Classroom K-2nd grade program.

1. I feel sure of myself as a mother/father.
   1 2 3 4 5 6 7
   Never Always

2. No matter what I try, my child will not do what I want.
   1 2 3 4 5 6 7
   Never Always

3. When something goes wrong between, me and my child, there is little I can do to correct it.
   1 2 3 4 5 6 7
   Never Always

4. I know I am doing a good job as a mother/father.
   1 2 3 4 5 6 7
   Never Always

5. I feel useless as a mother/father.
   1 2 3 4 5 6 7
   Never Always

6. My child usually ends up getting his/her way.
   1 2 3 4 5 6 7
   Never Always

7. I know things about being a mother/father that would be helpful to other parents.
   1 2 3 4 5 6 7
   Never Always

8. When my child gets upset with me, I usually give in.
   1 2 3 4 5 6 7
   Never Always

9. I can solve most problems between my child and me.
   1 2 3 4 5 6 7
   Never Always

10. When things are going badly between my child and me, I keep trying until things begin to change.
    1 2 3 4 5 6 7
    Never Always

APPENDIX J

INTERVIEW PROTOCOL
Opening Statement
Thank you for agreeing to participate in this research study. You may remember that your child is involved in a program called Calm Classroom K-2nd grade, a mindfulness program in school. For this project, we are interested in learning about your experiences with stress and how you care for yourself and your child, how you relax, and what you learned from your child(ren) based on Calm Classroom K-2 (I’ll refer to it going forward as CCK2).

This interview will be recorded and notes will be taken. Everything you say is confidential and this interview is completely voluntary. I will use the interview for my dissertation study. It will be analyzed with other interviews. If I quote anything you say, I will not use your name. As a thank you for your time, you will be given a $25 gift card to Target at the end of our interview. Do you have any questions before we begin?

Mindfulness in School
- Describe how your child has brought aspects of the CCK2 program home. Give me some examples.
  - Is your child talking more about breathing or taking breaths, his/her emotions, being calm?
  - How has your child talked about CCK2 at home?
  - How has your child practiced any of the techniques with you or anyone else at home?
  - How has the Calm Classroom program helped to make school a better place for your child(ren)? Please explain.
- How do you think the CCK2 program helps make school a better place for your child(ren)?
  - How has your child talked about the difference in his/her school or classroom since CCK2 has been implemented?
  - Does the teacher or school administration talk about how CCK2 changed the school or classroom environment?

Moderating Stress in Children
- What is stressful for your child?
  - Sometimes it is difficult to think about our children being stressed out but we all know there are things or situations in our lives that can be stressful for children. What are some of those things for your child?
    - How is school stressful for your child?
      - What was school like for you? What were some of the best parts of your education? What was some of the more difficult parts?
Did you ever feel rejected or ignored when you were in school? Or feel disrespected by teachers?

- Have there been any changes in your family or family situation that may be stressful for your child?
- What about any situations or challenges in the neighborhood? Or in your home?

- Describe a time when your child was upset and what do you do to help him/her?
  - How do you think you are able to make him/her feel better?
  - How are you able to protect him/her from difficult situations?
  - How are you able to talk with him/her about things to help deal with the situation?

- Often when things are hard for children, they are hard for adults.
  - Give me an example of a time when your child was stressed and how you took care of yourself?

- Describe how stress impacts your relationship with your child?
  - Does it impact your interactions? The way you behave toward your child?

Other than the experiences we’ve talked about, have you had any experiences that you would consider traumatic? I mean, any experiences that were overwhelming and/or immediately terrifying.

**Mindfulness as Relevant and Acceptable Practice**

- Now, I want to ask you about mindfulness. Had you heard of the term mindfulness before your child’s involvement with the CCK2 program? Have you heard of meditation, yoga, tai chi? (Show picture if needed)

- What are some ways that you are mindful day-to-day?
  - What puts you in the “relaxation zone”? If you think about your entire community what would you say puts people in the “relaxation zone”? Please give me examples.
  - How do you find a sanctuary or a refuge? What is the sanctuary or refuge for people in your community? Please give me examples.
  - Give me an example of how you calm yourself when you are upset.
    - Do you do any breathing techniques at home? Calming techniques?
  - What are some of the lessons or instructions from parents or elders in the community about ways to behave?
  - Can you think of a time when you wanted to react or lash out but did not? What did you do to make that happen?

- How would you define mindfulness?
Have you heard of the term mindfulness before your child’s involvement in the CCK2 program? What was its definition? How would you define mindfulness today?

- What aspect of mindfulness feels most relevant to you?

**Conclusion**

- What are the other things you are thinking about you want to share? Did anything come up during the interview that you might want to share information?
- What questions can I answer for you?

Remind participants that the interview will be kept confidential. We will transcribe it and will summarize the data. All of the data will be stored in a locked cabinet at Chapin Hall. I will share the results once finalized.

Thank you very much for your time and sharing your experiences with me. I appreciate the opportunity to talk with you and I look forward to sharing the results of this study with you.
APPENDIX K

CALM CLASSROOM FAMILY DINNER AND MEETING INVITATION FLYER
calm classroom family meeting & Dinner
K-2\textsuperscript{nd} grade families Only

Day, Date
Time
School

Learn about Calm Classroom
the social and emotional program at _____ school

Practice mindfulness and talk about ways
to be mindful at home

Opportunity to participate in research study about mindfulness,
family stress, and ways you care for yourself.

Sign up to be chosen for an interview.

One family will win $100 gift card for participating in research study.

Please RSVP by _______ to __________, or
Lisa Wartemberg at lwartemberg@erikson.edu or (312) ____

Each family will receive dinner, CTA card and book
Child Care provided

For information or questions about research study,
please contact Kandace Thomas at (773) 272-5597 or Stephen Baker (773) 256-5113
APPENDIX L

CALM CLASSROOM FAMILY DINNER AND MEETING INVITATION LETTER
Dear _______ parents/guardians of K-2nd graders:

Please join us for a meeting and dinner on ______ social and emotional learning program, Calm Classroom. As you may know, Calm Classroom uses mindfulness to help your child lower stress, increase calmness and improve behavior in school and at home. While the whole school is involved in the program, students in K-2nd grade are receiving extra support because they are part of a research program. Please join us to learn more about CCK2. 

Practice mindfulness and talk about ways to be mindful at home.

You will also be able to participate in a research study about mindfulness, family stress and ways to care for yourself. You can sign up to be chosen for an interview. One family will win a $100 gift card for participating in the research study.

Calm Classroom K-2 Family Meeting and Dinner
Day, Date, Time
School
Dinner for the whole family will be provided
Each family will receive a CTA card and a book. Child Care provided!

Please RSVP by Day, Date to ______________ or call or email Lisa Wartemberg at lwartemberg@erikson.edu or (312) 893-7126. When you RSVP, please give your name, your child’s grade and the number that will attend. We look forward to seeing you!

Sincerely,
Calm Community staff
Calm Classroom K-2 is supported by a grant from the U.S. Department of Education.

For information or questions about the research study please contact Kandace Thomas at (773) 272-5597 or Stephen Baker (773) 256-5113

Calm Classroom Family Engagement Event RSVP by Day, Date (please rip off at the line and give to ______________)

Parent or Guardian Name(s): ___________________________ Child’s Name:

__________________________

Your child’s room number: ________ Number of adults attending: ________

Number of children attending: ________ Your phone number and email:

__________________________
APPENDIX M

CALM CLASSROOM ENEWSLETTER INVITATION CONTENT
Recruitment Content for April/May and June/July CCK2 Mindful E-Newsletter

Newsletter Section: FAMILY ENGAGEMENT EVENTS

CCK2 Family Engagement Events are happening at your child’s school this spring. Come learn more about CCK2. Practice mindfulness. Talk about ways to be mindful at home.

You will be able to participate in a research surveys about mindfulness, family stress and ways you care for yourself. Sign up to be chosen for an interview. One family will win a $100 gift card for taking the surveys.

Dinner and childcare will be available for all. Each family will receive a book and a CTA pass.

Flyers and letters will be sent home with your child.

If you have questions about the research project, please contact Kandace Thomas at k.thomas@erikson.edu or (773) 272-5597, or Stephen Baker at (773) 256-5113 or sbaker@uchicago.edu.
APPENDIX N

PHONESCRIPT CONTENT
Phone script to attend CCK2 Spring 2017 Event/Participation in Research

Hello, is this _________? Hi, ___________. This is Kandace Thomas from Erikson and the Calm Classroom K-2nd grade program. We met at ________ (school name) CCK2 family engagement event in _______ (month and year).

I’m calling to invite you at attend your child’s school’s spring Calm Classroom family event and dinner. Is now a good time to talk? If yes: The CCK2 family engagement event will be on ________ from ________ pm. We will practice mindfulness activities, discuss updates about CCK2 and talk about how you can be more mindful at home. We also have/will send your child(ren) home with invitation flyers and letters for our events. How many people do you think will attend?

If no: when is a good time to call you back?

If yes, continue here:
As you may remember, I am a graduate student at Erikson Institute/Loyola University Chicago and am working on my dissertation. As part of the event, I will ask each family to participate in my research study on mindfulness and stress by completing anonymous surveys and volunteering to be interviewed.

At the event, we will raffle off a $25 gift card for participating. Dinner and childcare will be provided for all families. And, each family will receive a CTA card and book. I look forward to seeing you there.

If he/she is unable or unavailable to attend the event:
Even though you are not able or available to attend the event, would you be interested in participating in the study?

If he/she says yes: Thank you so much. Can I tell you more about the research now or should I call you back at another time?

If now is a good time: As you may remember, I am interested in understanding stress and how mindfulness and caring for oneself can be helpful. The research includes filling-out surveys. In addition to the surveys, some families will be selected to be interviewed. We have to select families because we do not have enough interview slots for everyone to participate. Both the surveys and the interview are anonymous to protect your privacy. The surveys should take about 20 minutes.

If you are selected for an interview, the interview will be 60 minutes and will be recorded. For your participation and your time, you are eligible for a $20 gift card. I am inviting you to participate because of your child’s participation in the CCK2 program. Are you interested?

If yes: Do you have access to the internet? I can send you the link to take the survey online?

If the participant does not have access to the internet: I can meet you at your child’s school to administer the survey. When is best to meet at school? Here is my phone number and email address just in case you need it. I will give you a call the day before to confirm our meeting. Thank you so much for your time. I look forward to talking with you.

If no: thank you for your time.
APPENDIX O

BUDGET FOR PARTICIPANT INCENTIVES
<table>
<thead>
<tr>
<th>Qualitative Data</th>
<th>Per Person</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviewee thank you</td>
<td>$25</td>
<td>$575</td>
</tr>
<tr>
<td>Travel reimbursement</td>
<td>$8</td>
<td>$32</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quantitative Data</th>
<th>Per School/Person</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>School incentive</td>
<td>$100</td>
<td>$1500</td>
</tr>
<tr>
<td>Online incentive</td>
<td>$100</td>
<td>$100</td>
</tr>
</tbody>
</table>

**Total Participant Incentives** $2,207
APPENDIX P

CONSENT TO PARTICIPATE FORM
Consent to Participate in Research Study
University of Chicago

Study Title: Trait mindfulness and self-care as moderating variables of intergenerational trauma transmission: A mixed methods study

Principal Investigator: Stephen Baker

You are being asked to participate in a research study. You are being asked because of your child’s participation in the Calm Classroom K-2nd grade (CCK2) social and emotional program in school. This form gives you information about the study, what will be asked of you and for your consent. You will be given a copy.

The research study includes surveys and interviews. The surveys will ask about mindfulness, family stress, your child’s behavior, and how you care for yourself. The interviews will ask more questions about the same topics.

What do I have to do to participate?
If you agree to participate you will complete this consent form, an overview form and five surveys. It will take you 15 - 20 minutes. If you agree to give your name to be selected for an interview you will receive an email or phone call. The interview will be 60-minutes and will be recorded and later transcribed.

What information will be kept confidential?
All naming information will be kept confidential. Completed surveys and interview transcripts will be locked in a file cabinet at Chapin Hall. Once all of the data is collected and analyzed, the survey forms will be destroyed. Interview recording will be stored on the researchers computer and will be protected with a password. Recording will be destroyed when the research is complete. Data will only be seen by the researcher. If this study is published or presented, no naming information will be used. All data will be destroyed five years from the end of the study.

How could participating in this study cause me harm?
There are no known risks to participating in this research project.

How will I benefit from participating in this study?
There are no benefits to you. The results of this study will be used to help others understand how mindfulness may help lower stress in families.

How much will this cost me?
Your participation is free. There is no cost to you. One person will win a $100 gift card for participating in the study. If you are interviewed, you will receive a $25 gift card.
Is this voluntary?
Participation is voluntary. If you do not want to participate, you do not have to. You do not have to answer any questions you do not want to. Or you can stop participation at any time without any consequences. Participating or not participating in this study will not affect your or your child’s involvement in the CCK2 program.

Who do I contact if I have any questions?
If you have any questions about this research study, please contact Kandace Thomas at (773) 272-5597 or k.thomas@erikson.edu; or Dr. Stephen Baker at sbaker@uchicago.edu or (773) 256-5113. If you have any questions about your rights as a research participant, please contact Kari Walsh at kewalsh@uchicago.edu or (773) 834-0402.

Agreement to Participate
I have read this form and the research study has been explained to me. I have been given the opportunity to ask questions and they have been answered. If I have additional questions, I know who to contact.

Please check which part of the research you agree to participate:

☐ I do not consent to participate in this study.

☐ I consent to participate in the survey only.

☐ I consent to participate in the survey and interview. I understand I will be called if I am chosen to interview.

____________________________________
Participant’s Name

____________________________________  ___________________________
Participant’s Signature                        Date

____________________________________  ___________________________
Researcher Signature                         Date
APPENDIX Q

‘MIND FULL OR MINDFUL’ IMAGE
Mind Full, or Mindful?
REFERENCE LIST


Bishop, S. R. (2002). What do we really know about Mindfulness-Based Stress Reduction? Psychosomatic Medicine, 64, 71-84.


Chicago Public Schools Tiers. http://cpstiers.opencityapps.org


Cronholm, P. F., Forke, C. M., Wade, R., Bair-Merritt, M. H., Davis, M., Harkins-Schwarz, M.,


University of San Diego Health System Center for Mindfulness. Mindfulness.ucsd.edu


VITA

Dr. Kandace Thomas was born and raised in Bronx, New York. She was an A Better Chance scholar at Mt. Greylock Regional High School in Williamstown, Massachusetts. She earned a Bachelor of Arts degree from Wesleyan University in 1999 and a Master of Public Policy degree in 2004 from the Harris School of Public Policy at the University of Chicago. Prior to enrolling at Loyola University Chicago and Erikson Institute, she worked in the areas of child and family policy, and government and non-profit management. Dr. Thomas works as a Senior Program Officer at the Irving Harris Foundation integrating early childhood mental health best practices into systems serving young children and their families. She is also a leader in the creation of the ‘Diversity-Informed Tenets for Work with Infants, Children and Families,’ integrating diversity-informed practice into social service fields and facilitating workshops and trainings to infuse diversity and inclusion practices into organizations and systems. As a Loyola/Erikson student, Dr. Thomas re-established Erikson Institute’s Doctoral Student Association and served as co-chair for two years, and was a Doctoral Fellow for the Calm Classroom K-2nd Grade Project. Dr. Thomas lives in Chicago, Illinois.