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Generational Trauma Effect on Paranoia in the Clinical Population

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ABSTRACT

Generational trauma, also known as intergenerational or transgenerational trauma, implies the transmission of psychological distress and emotional patterns from one generation to the next, arising from events like war, displacement, abuse, and systemic oppression. This study examines how generational trauma results in paranoia among clinical populations. A quantitative research design was used, using purposive sampling. The sample included aged 18-40 years old male and female participants who were selected with clinically diagnosed Anxiety Disorders, Panic Disorders, and Paranoid Disorders. Data were collected in the hospital and private clinic settings of Lahore and Islamabad, which were analyzed using correlation and regression. Prior the findings revealed a non-significant relationship between Generational Trauma and Paranoia. The growing awareness of generational trauma, the relationship with paranoia, remains understudied, particularly in South Asian clinical populations.

Introduction and Literature Review

A study by Roberts et al. (2021) described Trauma as experienced in childhood and teenage years leaves a huge impact on a person's personality, emotions, beliefs, and behaviours that lead to psychological disturbance. The interpersonal trauma, such as abuse or neglect, can also lead to the development of positive psychotic symptoms: hallucinations and delusions. Reese et al.(2022). Intergenerational trauma, also referred to as transgenerational trauma, is the psychological effects

of traumatic experiences that are passed down from parents to their children. The parents who experience any traumatic experience have a strong negative effect on family health, which results in adverse family experiences. In comparison, parents who had a pleasant childhood have a positive impact on the health of their family. Paranoia can be defined as the heightened beliefs of others trying to harm, control, or mislead the person, ranging from mild deception to extreme persecutory delusions, without any evidence (Freeman et al., 2020). Paranoia reflects self-referential misinterpretations (ideas of reference) and persecutory beliefs (ideas of persecution), spanning mild suspicion to unfounded conviction that others intend personal harm (Freeman et al., 2019).

Ullah et al. (2023) described Intergenerational trauma, also known as transgenerational trauma, as the psychological and emotional consequence of trauma that is passed from one generation to another. It not only impacts the person who has experienced the traumatic event, such as war, but also their children, grandchildren, and so forth. They may have inherited the behavior and distress, as well as coping mechanisms. Kagoyire, Kangabe, and Ingabire (2023) conducted a study to explore the trauma of the 1994 genocide against the Tutsis that is transmitted to the children of the survivors in Rwanda. The research consisted of 19 participants who were individually interviewed, and six focus group discussions were conducted. The trauma had limited the interactions, and day-to-day Engagements have led to the transmission of trauma in the children. Elahi et al. (2022) examined the relationship between perceived discrimination, ethnic identity, and paranoia among university students of Pakistani heritage in England. 119 participants were given assessments about paranoia and discrimination. Students with more love for the Pakistani heritage felt more discriminated against and had paranoid thoughts. While others who don't associate much with Pakistani heritage felt less paranoid about the experiences.

Humphrey et al. (2022) used path analysis to exhibit that disorderly attachment and negative "other-beliefs" fully mediated the relationship between childhood interpersonal trauma and paranoia in adults, setting forth psychosis. The mediation persisted significantly even after adjusting for depression and hallucinations, illustrating the role of trauma-related beliefs in paranoia emergence. This shows that trauma affects paranoia mainly through its impact on how a person relates to and perceives others. Dauvermann et al. (2021) found that Childhood trauma significantly indicates paranoid ideation, with emotional neglect and abuse emerging as the most influential predictors, supporting the perspective that trauma is a primary antecedent of paranoia. Ni and Wang (2022) examined the relationship between negative parenting practices, childhood trauma, and the development of Paranoid Personality Disorder (PPD). It emphasizes how insecure attachment patterns and maltreatment during childhood can result in the emergence of paranoid traits and PPD in adolescence and adulthood. The negative parenting and trauma effects greatly on the onset of paranoid traits through mechanisms such as insecure attachment and negative cognitive schemas about others.

Bird et al. (2021) study examines the prevalence, persistence, and clinical correlates of paranoia in young people attending child and adolescent mental health services. Results revealed that paranoia is common, associated with distress, and frequently are comorbid with other disorders such as depression and anxiety. De Albornoz et al.'s (2021) study shows that individuals who have a traumatic experience, like childhood abuse or stressful life events, are more likely to have paranoia and thoughts of suicide. Early life trauma can have a long-lasting effect on a person's thinking and feelings, especially their fear, trust, and mental health. Schlier et al. (2024)study compared the R-GPTS and B-CAP in UK and US adolescents aged 14–17. Both scales showed strong factorial validity and high intercorrelations with distress. However, R-GPTS identified more cases of

paranoia, while B-CAP was highly correlated with bullying, risking confounding. Paranoid ideation, particularly persecutory thoughts, is relatively common during adolescence but remains under-researched about overall psychological well-being and daily functioning.

Thompson et al. (2025) studied a large, nonclinical sample of adolescents from the UK and US. Persecutory ideation was found to be negatively associated with well-being, social functioning (e.g., interpersonal relationships), and role functioning (e.g., school/home responsibilities). Regression analyses indicated that even after controlling for depression, bullying, and adverse life events, paranoia significantly forecasted impaired social functioning. Interestingly, well-being moderated this relationship, with paranoia impacting social functioning only when well-being was low. These outcomes suggest that fostering psychological well-being may serve as a protective factor, buffering the negative social effects of adolescent paranoia.

Theoretical framework

Intergenerational Transmission of Trauma

The Intergenerational Transmission of Trauma theory was first formally suggested by Yael Danieli in 1998. This theory describes how trauma experienced by one generation, specifically, parents, can affect the physical and mental well-being and experiences of the next generation, their children. According to this theory, the trauma is passed down through several ways, such as Emotional Availability and Parenting Styles. The parents who have experienced trauma have struggled to manage their emotions, especially being emotionally available to their children. As a result, this affects the child's sense of attachment and safety. The parenting style of trauma-affected parents can be overprotective, avoidant, inconsistent, and harsh, which can confuse the child and lead them to adopt maladaptive coping strategies.

Furthermore, this theory suggests one of the ways the trauma gets passed down is through the silence that children feel something is wrong, which creates hypervigilance and anxiety. The trauma leads the parents to come up with unhealthy ways to cope with the stress that the children can learn for their own lives. Another way to transfer the trauma is through genes (Barnes et al., 2022).

Cognitive Model of Paranoia

The Cognitive Model of Paranoia was first introduced by Daniel Freeman and colleagues, including Philippa Garety and Emily Holmes, in the 1970s. According to the Cognitive Model of Paranoia, the individual thinking under stress or any sort of emotional pain can result in the development of false beliefs about a certain threat or persecution. The paranoia is shaped by emotional states such as anxiety or loneliness, or it can be because of a past trauma that the person is unable to deal with. Moreover, the paranoia can influence the cognitive distortions or the biases of the person. The paranoia can also form negative core beliefs about the person himself or herself, others, or the world. The Cognitive model of Paranoia also suggests how paranoia is formed. Firstly, the person comes across a situation that can be neutral or ambiguous, such as two people looking in their direction and talking in hushed tones. The person might already be feeling anxious and sad, which would lead them to interpret the situation differently. The emotions of that person would heighten the threat response. This would lead to Maladaptive Cognitive Processing, that is, the biased way of thinking, such as jumping to conclusions. Further leading to the development of negative core beliefs, which develop into paranoia. The people raised in trauma-affected families would internalise the beliefs and have paranoid ideation (Barnby et al., 2024).

Research objective

To investigate whether intergenerational trauma significantly predicts levels of paranoia in individuals with clinical diagnoses.

Hypothesis

H1: Individuals with a family history of generational trauma will exhibit significantly higher levels of paranoia than individuals without such a history.

Methodology

Research Design

The research design would be a Cross-Sectional Survey.

Participants

The study employed a stratified random sampling technique to recruit 150 participants between the ages of 18 and 40 from various clinical settings across Lahore. Stratification was based on participants 'clinical and psychosocial profiles, particularly the presence or absence of generational trauma, and diagnoses such as Trauma, Anxiety Disorders, Panic Disorder, and Paranoid Personality Disorder.

Inclusion Criteria

- Adults aged 18–40 years
- Diagnosed with Depression, Anxiety Disorders, Panic Disorder, or Paranoid Personality Disorder.
- Self-reported or clinically confirmed generational trauma.
- Willing to provide informed consent

Exclusion Criteria

- Diagnosed with schizophrenia or active psychosis
- Severe cognitive impairment or intellectual disability
- Individuals who refuse or are unable to complete the questionnaire

Procedure

After taking consent from the university, the hospitals and private clinics were approached. The hospitals and private clinics were approached for permission to collect data from the patients of the respective departments. After getting permission, the participants were approached in the clinical setting and asked for their consent and explained the study. Participants were given printed questionnaires after giving consent to sign, and questions were asked from the questionnaire. Depending on convenience and access, the participants were given approximately 15–20 minutes. Ethical considerations were kept, and the right to withdraw at any point in the study. Further, the data collected was analysed by SPSS, and the results were reported.

Ethical considerations

Ethical considerations were followed throughout the study to ensure the confidentiality, dignity, and well-being of the participants. Before using the questionnaire, permission was taken from the respective authors. The approval for data collection was obtained beforehand from the relevant hospitals and private clinics. The participants were selected from a clinical setting and provided informed consent before their participation. The participants were fully informed about the study, the purpose of the study, the nature of the questions, and their right to withdraw at any point during the study. To ensure the anonymity of the participants, the personal identities were kept confidential. Given the sensitive nature of topics, the participants were approached respectfully. The study was conducted following the ethical guidelines outlined by the American Psychological Association APA.

Results

Table 1: Reliability Analysis

Variables	No of items	Cronbach's Alpha
Generational Trauma	98	0.868
Paranoia	18	0.716

Analysis

The table shows Cronbach's alpha coefficients for Generational Trauma and Paranoia. The scale used for Generational Trauma was the Historical Intergenerational Trauma Transmission Questionnaire (HITT-Q), which contained 98 items and exhibited an excellent reliability of 0.858, as measured by Cronbach's alpha, indicating strong internal consistency in assessing Generational Trauma. The Paranoid Thoughts Scale (R-GPTS) contains 18 items that show 0.716, indicating good reliability.

Table 2: Correlation Analysis

		R Square	B	Std. Error	Beta		
1	(Constant)	0.006	2.174	0.415		5.240	0.000
	HITTQ		0.120	0.128	0.076	9.33	0.353

Analysis

The correlation table shows the relationship between Generational Trauma and paranoia. The Historical Intergenerational Trauma Transmission Questionnaire (HITTQ) was used along with paranoia, measured through the Revised Green Paranoid Thoughts Scale (R-GPTS). The Pearson correlation coefficient between HITTQ and R-GPTS was found to be $r = 0.076$, exhibiting a very weak positive correlation between generational trauma and paranoid thoughts. Moreover, the significance value ($p = 0.353$) outdoes the conventional threshold of 0.05, recommending that the relationship is not statistically significant.

Table 3: Regression

Variable	M	SD	1	2
1. HITT-Q	3.22	0.33	—	0.076
2. R-GPTS	2.56	0.51	0.076	—

Analysis

The results of the regression table revealed that intergenerational trauma, as measured by the HITTQ, did not significantly predict levels of paranoia (R-GPTS) among participants. The R Square value was 0.006, indicating that only 0.6% of the variance in paranoia symptoms could be explained by intergenerational trauma. The standardized beta coefficient ($\beta = 0.076$) suggested a very weak positive relationship between the two variables, and the corresponding p-value of 0.353 indicated that this relationship was not statistically significant. Furthermore, the unstandardized coefficient (B = 0.120) means that for every one-point increase in HITTQ scores, paranoia scores increased by only 0.120 units, which is not a meaningful result.

Discussion

The study examined the relationship between Generational Trauma and paranoia (in a clinical population. The Generational Trauma was measured through the Historical Intergenerational Trauma Transmission Questionnaire HITT-Q and Paranoia was measured through the Revised Green Paranoid Thoughts Scale R-GPTS. The outcome of the study revealed that the Generational Trauma did not significantly predict paranoia, as shown by a non-significant regression coefficient ($\beta = 0.076$, $p = 0.353$) and a negligible R^2 value of 0.006. The results were further supported by correlational analysis, which showed a weak and non-significant positive correlation ($r = 0.076$, $p = 0.353$) between intergenerational trauma and paranoia. El-Khalil et al.'s (2025) systematic review exhibited the effects of Generational Trauma on offspring, showing a high level of stress, while other shows resilience or neutral effects, depending on mediating variables such as coping mechanisms, socio-cultural context, and personal meaning-making. Luo et al. (2022**)** revealed through neuroimaging that children of trauma-exposed mothers had smaller amygdala volumes, indicating changes in threat-processing areas of the brain. These biological modifications did not universally translate into paranoid ideation, recommending that structural vulnerability may predispose but not establish results. Variables like emotion regulation, **c**ognitive schemas, and trauma-related appraisals can be examined that can shape a connection between Generational Trauma and paranoia.

Limitation

One of the main limitations was that the data was collected in urban settings, which can impact the generalisability of the study. The self-report may contain biases among the participants in answering the questions.

Recommendations

1. A longitudinal study would be more effective in observing the Generational Trauma effects on the generation.

2. Incorporating qualitative methods (e.g., interviews or case studies) alongside quantitative tools as a mixed method could provide deeper insight into the personal and familial experiences that shape paranoia and vigilance patterns.

Implementations

The study underscores the critical need to incorporate intergenerational trauma awareness into clinical assessments, especially for individuals exhibiting paranoid symptoms. The findings advocate for trauma-informed therapeutic approaches that consider inherited psychological patterns, focusing on the use of culturally sensitive care and tailored interventions. Clinicians and policymakers should prioritize education, prevention, and treatment programs that address trauma passed down through generations, ultimately improving diagnostic accuracy and therapeutic outcomes in clinical populations affected by paranoia.

Conclusion

The main purpose was to examine the influence of Generational Trauma on paranoia in clinical populations. The results showed that no significant relationship was found between generational trauma and paranoia, which indicates that Generational Trauma alone cannot anticipate paranoia. There is a high chance that the other psychological mechanisms, such as cognitive distortions or maladaptive beliefs, can act as a bridge from trauma to paranoia. The social and environmental factors can also have an impact on paranoia.

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