**Supplemental Material for**

A Multi-Cohort Examination of the Independent Contributions of Maternal Childhood Adversity and Pregnancy Stressors to the Prediction of Children’s Anxiety and Depression

**Supplemental Method**

**Pregnancy stressful life events (PSLE) measure.** The PSLE survey was comprised of the following 14 items. Mothers reported whether they had experienced each event during pregnancy.

1. A family member was hospitalized
2. Death of a close friend/family member
3. Moving to a new address
4. Loss of job/employment
5. Partner lost their job
6. Participant/partner had a reduction in work hours or pay
7. Problems paying the rent/mortgage or other bills
8. Separation/divorce from partner
9. Was apart from partner due to military deployment or extended work-related travel
10. Argued with partner more than usual
11. Partner did not want participant to be pregnant
12. Close friend/family member had a problem with drinking/drugs
13. Participant/partner was incarcerated
14. Participant was homeless.

**Regression Model Covariate Details**

A series of three regression models included three additive sets of covariates. Model 1 included methodological variables that might serve as confounders. Model 2 included those and potentially confounding variables at the family-, parent-, and child-level. Models 2a included all covariates from Models 1 and 2, and additional variables potentially on the mechanistic path between maternal stress exposure and child mental health.

Model 1 (minimally-adjusted model): Given the multi-site nature of the total study sample, a variable capturing site was comprised of the following categories: Memphis, TN (CANDLE), San Francisco, CA (TIDES), Minneapolis, MN (TIDES), Rochester, NY (TIDES), Seattle, WA (TIDES), Seattle, WA (GAPPS), Yakima, WA (GAPPS).

Model 2 (fully-adjusted model): Added covariates included a measure of family income, adjusted for household size, region of the country, and inflation. Covaried maternal factors were age, parity (number of previous pregnancies), pre-pregnancy body mass index, level of education (Less than high school, High school diploma or GED, Vocational or Technical school after high school, some College [no degree] or Associate Degree, College Graduate or Baccalaureate degree, Masters Degree, Doctoral-level/professional degree). Covaried child factors were age at outcome, year of birth, biological sex assigned at birth, race/ethnicity[[1]](#footnote-1) (White, Black/African American, Hispanic/Latinx, or other).

Model 2a (fully-adjusted + possible mechanisms model): Additional covariates added in Model 2a were variables potentially on the mechanistic path between maternal stress exposures and child internalizing problems. Potential mechanisms adjusted for in Model 2a were: maternal cigarette smoking during pregnancy (yes/no), child gestational age at birth (days), whether the child was breastfed (yes/no), and maternal self-reported depression at the child age 8 visit. Maternal depression was assessed with the Patient Reported Outcome Measurement Information System (PROMIS) Depression Short Form (PROMIS-D-8) in the TIDES and GAPPS cohorts, which was developed by the National Institutes of Health to measure patient-reported depression symptoms relevant to a range of chronic diseases (Cella et al., 2010; Teresi et al., 2010). This 8-item measure inquires about the frequency of depression symptoms (e.g., sadness, worthlessness, anhedonia) in the previous week. In the CANDLE cohort, maternal depression was assessed with the 6-item depression subscale of the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983), which has been linked to the PROMIS-D-8 via empirical work (Kaat et al., 2017). A crosswalk table has been developed to harmonize these two measures, converting a BSI-depression subscale score to a PROMIS-D-8 t-score. The PROMIS-D-8 has demonstrated good inter-item reliability (range .74-.84) and convergent validity with other established measures of depression (e.g., CES-D and PHQ-9 (Amtmann et al., 2014).

**Supplemental References**

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1. Race is a political and social construct that often serves as a proxy for the impact of racist practices and structural inequality, it is not a biological construct (Bryant et al., 2022) and thus is examined in the current paper with this premise in mind. [↑](#footnote-ref-1)