Prevalence of Adverse Childhood Experiences in Latino Immigrant Children

Hilda Loria, MD1 and Margaret Caughy, ScD2

1Fellow, University of Texas Southwestern Medical Center and Children’s Health, Dallas, TX; 2University of Georgia, Athens, GA

BACKGROUND

Adverse childhood experiences (ACEs) are chronic or severely stressful experiences that occur before 18 years of age, such as abuse, neglect, and violence within the home. 1,2 Increased exposure to ACEs is associated with poor physical, mental, and psychosocial health outcomes across the lifespan. 1 In a nationally representative sample of US children, the 2011-2012 National Survey of Children’s Health estimated the prevalence of having two or more ACEs to be 23%. 1 Data regarding the prevalence of ACEs among Latino immigrant children, however, appears to be limited.

OBJECTIVES

To use data from the 2011-2012 National Survey of Children’s Health to:
1. Estimate the prevalence of ACEs in Latino immigrant children in the US
2. Identify the types of ACEs most commonly faced by this population
3. Examine differences in the prevalence of ACEs by immigrant generation status

METHODS

• Secondary data analysis of the 2011-2012 National Survey of Children’s Health, a telephone survey of parents/caregivers of a nationally representative sample of US children born to age 17
• Survey included nine-item inventory of ACEs
• To remove confounding effect of poverty, study sample limited to Latino immigrant children in households ≥200% of federal poverty level
• Primary outcome: prevalence of ACEs, determined by positive responses to any of nine ACE items
• Primary predictor: immigrant generation status
• Descriptive statistics used to determine prevalence of ACEs and examine differences in ACE prevalence by immigrant generation status

RESULTS

Of 22,297 children, 29% (n = 6,483) were Latino (9%, first generation; 57%, second generation; and 30%, third or higher-generation).

• Twenty-five percent (n = 1,692) of Latino immigrant children experienced ≥ 2 ACEs.

The prevalence of ACEs was highest among third or higher-generation children, particularly adolescents. The lowest prevalence was among second-generation children. These differences persisted when ACE prevalence was stratified by age.

• The most common ACEs faced by all Latino immigrant children were financial hardship and divorce.

• Total and mean number of ACEs differed by child generation status [χ²(12) = 685.6, p < .01 among all groups; χ²(6) = 413.9, p < .01 among Latinos only].

Of Latino immigrant children, 1.3% vs. second-generation, 0.81% vs. third-or higher-generation, 1.60); F (2, 6312) = 225.01, p = <.01.

The prevalence of ACEs was highest among third (US born child with ≥1 parent born outside US or foreign-born child with 1 foreign-born parent and 1 US-born parent), third or higher-generation (US-born or foreign-born child born with both parents born in the US), and second-generation (foreign-born parent and 1 US-born parent) children. These differences persisted when ACE prevalence was stratified by child generation, particularly adolescents. The lowest prevalence was among second-generation immigrant children. These differences persisted when ACE prevalence was stratified by age.

CONCLUSIONS

• The prevalence of ACEs in Latino immigrant children is similar to the national prevalence for all US children; however, the prevalence of ACEs is significantly higher in later generation immigrant children.

• The particularly high prevalence among later generation Latino immigrant children is concerning given the known association of ACEs with poor health and developmental outcomes.

• These findings are consistent with the parallel paradox.

IMPLICATIONS

• Further research is needed to understand what accounts for the gender differences in ACE prevalence and how best to care for at-risk Latino immigrant children.

• In particular, targeted ACE screening and guidance regarding care practices for Latino immigrant children with increased exposure to ACEs is needed.

REFERENCES


ACKNOWLEDGEMENTS

The authors would like to acknowledge the Data Resource Center for Child and Adolescent Health (Child and Adolescent Health Measurement Initiative) for their preparation of the National Survey of Children’s Health Indicators Data Set and their assistance with the use of the data for this study.