Adverse and Positive Childhood Experiences and General Health among Asian American Emerging Adults

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Aim/Purpose/Objective: The purpose of this study was to (1) investigate whether disparities in ACE and PCE exposures exist in a diverse Asian American population of emerging adults (i.e., Asian Indian, Chinese, Hmong American) differing in their US immigration histories, cultures, language, and countries of origin and (2) describe the relationships among ACEs, PCEs, and self-reported general health among Asian American emerging adults.

Sample: A total of 814 Asian American emerging adults (18 - 25 years) self-identified as Asian Indian, Chinese, or Hmong Americans were recruited from 46 U.S. states and the District of Columbia, with approximately 20.0% of participants from California. The sample consisted of 27.2% Asian Indian (n = 221), 30.6% Chinese (n = 249), and 42.3% Hmong (n = 344).

Setting: The cross-sectional survey study used Research Electronic Data Capture (REDCap), a secure HIPAA-compliant web-based application (REDCap Project, n.d.), to design and distribute the study survey. This study recruited Asian American emerging adults from various sources, including U.S.-based community organizations, university student groups, ResearchMatch.org, and Facebook groups.

Methodology: Quantitative, Surveys
Participants completed online surveys measuring ACEs (Philadelphia ACEs Survey), PCEs (Benevolent Childhood Experiences Scale), general health (PROMIS Adult Global Health Scale v1.2), and childhood socioeconomic position (CSEP).

Results: Differences in ACEs and PCEs exposures were observed between Hmong and Asian Indian (ACEs: $p < .001$; PCEs: $p = .005$) and Hmong and Chinese (ACEs: $p < .001$; PCEs: $p < .001$). CSEP variables partially explain the observed disparities. ACE score was negatively associated with general health score ($\beta = -1.16$, $p < .001$). The interaction term of ACEs x PCEs was significant ($\beta = -0.06$, $p = .009$).

Conclusions: Significant differences in ACEs and PCEs exposures were observed between Hmong, Asian Indian, and Chinese participants. CSEP factors accounted for some variations in the disparities of ACEs and PCEs. Higher cumulative ACE score was significantly associated with poorer general health; PCEs moderated the relationship between ACEs and general health in this sample of Asian American emerging adult.

Implications: Nurses and other health care professionals should be aware of and routinely screen for both ACEs and PCEs. Individuals from lower socioeconomic backgrounds may be more susceptible to ACEs and their negative impacts. Future policy initiatives should target support towards these vulnerable groups to prevent ACEs and mitigate the negative impact of ACEs on health.

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