

Article

Adverse Childhood Experiences in Latinx Families: A Comparison between Intraracial and Interracial Families

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Abstract: Racial/ethnic minorities are prone to adverse childhood experiences (ACEs), posing a concern over social justice. However, the influence of interracial family structure has been rarely discussed. Considering that 26% of Hispanic individuals form interracial marriages in the U.S., we need to examine whether interracial family structure matters for ACEs disparities in Latinx families. We hypothesized that there were differences in ACEs between intraracial and interracial families in the Latinx population. A Latinx sample was collected from the Fragile Family and Child Well-being Studies with 1113 children of two Latinx parents and 397 children of interracial parents (e.g., White mother/Latinx father, Black mother/Latinx father, Latinx mother/White father, Latinx mother/Black father). Negative binomial models revealed a higher overall ACEs score among children in interracial families ($\beta = 0.54$, $p < 0.05$). Compared to children with two Latinx parents, children in each interracial family group were prone to higher risks of different ACEs. For example, children with Latinx mothers and Black fathers were more likely to experience parental separation ($OR = 2.33$), household material hardship ($OR = 1.64$), physical abuse ($OR = 6.01$), and psychological abuse ($OR = 3.49$) than children in intraracial Latinx families. Based on our findings, we call for culturally responsive ACEs prevention and intervention that consider the unique stressors of interracial families, to promote the health and well-being of racial/ethnic minorities.

Keywords: Latinx families; adverse childhood experiences; interracial families



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1. Introduction

Following the ground-breaking Adverse Childhood Experiences (ACEs) Study [1], research has suggested profound impacts of ACEs on children and adolescents' developmental outcomes, including self-harm [2], suicidality [3], internalizing problems [4–6], delinquency [7,8], poor school performance [9], and compromised functioning and overall mental health and wellbeing [10–13]. ACEs can have immediate impacts on young children's health and behavioral health outcomes, such as increased internalizing and externalizing symptoms [14], compromised cognitive skills and increased attention and social problems [15], as well as poor health outcomes [16]. Some types of ACEs exposure, such as child maltreatment, can also result in intergenerational effects that harmfully impact the next generation [17]. Therefore, ACEs prevention and intervention is a crucial public health mission [18]. Early childhood marks a critical period when stressful events can shape physical and psychological health [19], which makes it essential to address ACEs in early childhood before detrimental impacts become irrevocable for later adult development.

However, childhood adversity among different races and ethnicities is under-investigated. Even less attention has been paid to the influence of interracial family structure on a child's exposure to ACEs. Over the past 50 years, U.S. families have experienced fundamental shifts

in patterns of union formation and dissolution. The rate of interracial marriage is increasing with Latinx individuals being the racial group with the most interracial marriages at 27% among newlyweds [20]. Considering the dire consequences of ACEs on child development, there is an urgent need to examine the association between interracial family structure and ACEs to inform targeted ACEs prevention and intervention for families in need.

1.1. ACEs in Different Racial/Ethnic Groups and Intersectionality

Critical race theory [21,22] informs research to examine how the current structural inequalities normalize and perpetuate racism, thereby creating disadvantaged conditions for people of color. Exposure to ACEs in early childhood should be viewed as a structural inequality because it causes profound developmental consequences on human development [14], which later deprives children who experience ACEs a myriad of life opportunities and perpetuate them in a disadvantaged social status [23]. From a social justice perspective, preventing and intervening ACEs among racial and ethnic minority groups is critical because those actions may help break the cycle of inequalities.

Despite growing interest in ACEs, there has been limited research on racial and ethnic differences in ACEs rates and results are mixed. The few studies that assess racial and ethnic differences consistently indicate that Non-Hispanic Blacks and Hispanics are more likely to be exposed to more ACEs compared with non-Hispanic Whites [24–26]. Multiracial individuals had significantly higher ACEs than all other races/ethnicities [27].

In a study of 1523 women with low income in the Midwest, American Indians reported comparable ACEs scores to non-Hispanic Whites, which were significantly higher than the ACEs scores of non-Hispanic Blacks and Hispanics [28]. Similarly, Kinney and Singh [29] examined ACEs according to parents' reports from the 2011–2012 National Survey of Children's Health (NSCH) and provided evidence that Native American children were two to three times more likely to experience multiple ACEs compared to non-Hispanic White children. In addition, Mersky & Janczewski [28] examined the distribution of ACEs in the sample of 1523 low-income women and revealed that Hispanics were more likely to report physical neglect, but less likely to report physical abuse, emotional abuse, and emotional neglect than Whites.

The intersecting dimensions of race/ethnicity, socioeconomic status (SES), education levels, and immigration status add more complexity to ACEs. When intersecting race/ethnic and SES disparities, White children with low SES were significantly more likely to experience multiple ACEs than Black and Hispanic children with low SES [25,28]. With regard to education, having a college degree was significantly associated with the lowest rate of ACEs compared to individuals with high school degrees and some college degrees [27]. Additionally, children of immigrant parents experienced fewer adverse experiences compared with children of U.S.-born parents [25]. Further analysis of the intersectionality between race/ethnicity and family structure would allow the field to reach a more comprehensive understanding of ACEs disparities and social injustice among different racial groups.

1.2. The Complexity of Interracial Families

Interracial coupling has become more prevalent in recent decades in the U.S. Interracial marriage was forbidden in most U.S. areas until the 1960s. Shortly after interracial marriage was allowed by U.S. law in 1970, interracial marriages saw an increase of more than 5 times, accounting for 8.4% of all marriages [20]. As of 2015 in the U.S., 10% of married people had a spouse of a different race or ethnicity, with Hispanic individuals being the racial group with the most interracial marriages at 27% among newlyweds [20]. Intermarriage is even more prevalent among U.S.-born Hispanic newlyweds with a 39% rate, where Hispanic-White couples account for the largest share of interracial marriages [20]. Societal norms have shifted significantly towards accepting interracial marriages, with 77% of individuals approving of such unions in 2010 [30]. However, interracial marriage can be complicated by not only the union of two individuals, but also the navigation of unique

identities, cultures, and values. As demonstrated in recent studies, interracial couples encounter unique experiences and challenges arising from a variety of interpersonal and contextual factors while exploring their relationships [31].

According to the homogamy hypothesis [32], growing up in families with different cultural backgrounds may increase the likelihood to hold conflicting values and expectations among interracial partners and families. Interracial couples continue to report experiencing disapproval from their families and diminished social support, which in turn create more challenges to sustaining their relationships [33]. Family opposition leads couples to limit their connections with their immediate family and creates more emotional distress to handle family disapproval [31]. For example, Bratter & Eschbach [34] compared the levels of distress between interracial married/cohabiting adults and their same-race counterparts using a five-year pool of data from the National Health Interview Survey (NHIS). They found that intermarried Asians and African Americans had similar distress to those in same-race unions. On the other hand, intermarried Hispanics who married to non-Whites experienced more than twice as high as those in marriages with other Hispanics.

Interracial couples consistently report lower relationship qualities, which may put them at a higher risk of getting a divorce or separation than same-race couples. However, Hispanic-White couples were more likely to report the highest levels of relationship quality, whereas Black-Hispanic couples were more likely to report the lowest level of relationship quality [33]. Marriages between Whites and Hispanic-Whites are less likely to be perceived as interracial and may not experience as many social stigmas as other interracial groups [35]. Brown, William, and Durtschi [36] through a longitudinal study across 8 years examined potential differences in relationship quality trajectories with 1336 couples and indicated that Black-Hispanic interracial couples were twice as likely to separate across 8 years than same-race couples.

Gender may also intersect with the already complex interracial relationships. Though Latinx families and communities support dating and marrying Whites more so than Blacks [37], in the case of Latino/Black interracial dating, parents expressed explicit sanctioning and disapproval of Latinas than Latino men [38], suggesting the racialized and gendered boundaries between Latinx and Blacks. Therefore, it is speculated that the life experiences of Black mother/Latinx father and Black father/Latinx mother families would be different.

1.3. Children in Interracial Families

Stigmas against interracial unions and challenges faced by intermarried couples may create risks for multiracial children's exposure to greater ACEs relative to their monoracial peers. Children of intermarriage still experience discrimination and stigmatization. For example, the "one-drop rule" has traditionally specified that children from Black-White intermarriage are considered Black [39]. Research has provided evidence that this "one-drop rule" is still prevalent among biracial adults in recent decades [40]. Developing racial identities can be complex and challenging, especially for multiracial children, who are more prone to developing social and emotional concerns than monoracial children, such as anti-social behaviors, depression, and marginalization in two or more cultures [41].

Children from interracial unions may be more likely to be exposed to family instability, such as the result of parental separation or divorce. Choi & Goldberg [42] drew data from the 2006–2019 National Survey of Family Growth, which included 15,369 children born in first marriages and 8612 children born in first cohabitations to non-Hispanic White, non-Hispanic Black, and Hispanic parents. Their results indicated that children born to Hispanic-Hispanic married parents were less likely than other monoracial children to experience family transitions. Meanwhile, White-Black and White-Hispanic biracial children were more likely to experience parental separation or divorce than Black, White, and Hispanic monoracial children. More recently, Weller et al. [43] examined the association between household dysfunction (e.g., caregiver divorce/separation, caregiver in jail, domestic violence, mental health at home, and substance use at home) and mental health conditions

among adolescents from interracial families and indicated that household dysfunction significantly impacted multiracial adolescents' mental health, including depression, anxiety, behavioral problems, and ADHD. Although Weller and her colleagues constructed family dysfunction as a latent variable and conducted structural equation modeling analysis, not addressing the differences among each multiracial group did not fully capture the complexity of interracial unions.

Taken together, the literature consistently supports the significance of studying racial disparities of ACEs, while exposing a few gaps: (a) there has been no attention to the influences of family racial composition (interracial vs. intraracial) on child ACEs exposure; (b) most research studies on interracial families have been conducted on the union between an African American and a White, which actually is the least common type of interracial marriage in the U.S. [44]; (c) rarely have studies broken down the racial pairs and revealed the nuanced differences among interracial couples with different racial composition. Given the soaring Latinx population in the U.S., and the changing patterns of interracial marriage [45], we should study Latinx family structure and understand its impact on child well-being.

1.4. This study

Our study moves the field forward by examining how the racial composition in Latinx families is associated with ACEs disparities, as the Latinx population constitutes the highest proportion of interracial marriage. This research goal is aligned with the National Institutes of Health Minority Health and Health Disparities Strategic plan 2021–2025 [46], which emphasizes the essential role of research that can unravel social determinants of health and health disparities. Our findings can deepen our understanding of Latinx families and contribute to developing culturally sensitive early ACEs prevention and intervention for racial/ethnic minority populations.

In this study, we hypothesized that: (1) children in intra-racial Latinx families experienced fewer ACEs than children in inter-racial families with one Latinx parent; (2) ACEs exposure was different for children in interracial families with different parental racial composition (e.g., White mother/Latinx father, Black mother/Latinx father; Latinx mother/White father; Latinx mother/Black father).

2. Methods

2.1. Sample

We conducted a secondary data analysis based on 1510 young children who have at least one parent from a Latinx background. Our study sample is a sub-sample from the Fragile Family and Child Well-being Studies (FFCWS), which recruited racially diverse birth cohort participants of children and their parents [47]. FFCWS used a stratified, multistage sampling strategy to recruit 4898 children born in large U.S. cities between 1998 and 2000. For those children, births to unmarried mothers were oversampled by a ratio of 3 to 1. Therefore, FFCWS included a large number of Black, Hispanic, and low-income families. FFCWS collected information when children were at birth, ages 1, 3, 5, 9, 15, and 22 (ongoing). We only used the data from the wave of age 3 for focusing on early ACEs, because early traumatic experiences cause profound influences on child development.

Table 1 shows that 48.5% of the study sample were girls. The average age of mothers giving birth to the focal child was 24.7, and over half of the mothers had high school and above high school degrees. For this study sample, 1113 (74%) children had two Latinx parents, while 397 (26%) children were in interracial families. Families with a White mom and Latinx dad had the highest percentage (7.9%), followed by households with a Latinx mother and Black father (7.6%), Black mother and Latinx father (6.2%), and Latinx mother and White father (4.5%). Close to 50% of the children's families lived under the poverty line. On average, a participant's household had 2.14 adults and 2.41 children living together.

Table 1. Sample characteristics.

	N	%	M (SD)	Range
Child Characteristics				
Sex (female)	732	48.5		
Parent/Family Characteristics				
Age of mother giving birth	1509		24.7 (5.72)	15–43
Mothers' Education level				
Less than High School	735	48.7		
High School and equivalence	401	26.6		
Some college	305	20.2		
College or graduate school	67	4.4		
Family racial composition				
Two Hispanic parents	1113	73.7		
White mother Hispanic dad	120	7.9		
Black mother Hispanic dad	94	6.2		
Hispanic mother White dad	68	4.5		
Hispanic mother Black dad	115	7.6		
Family income				
0–49% of poverty line	266	21.6		
50–99% of poverty line	272	22.1		
100–199% of poverty line	387	31.4		
200–299% of poverty line	152	12.3		
300%+ of poverty line	156	12.7		
Numbers of adults living in house	1226		2.14 (0.96)	1–9
Numbers of children living in house	1226		2.41 (1.25)	0–10
Overall ACEs score	1262		1.89 (1.52)	0–7
Two Hispanic parents	918		1.75 (1.46)	0–7
White mother Hispanic father	105		2.46 (1.60)	0–7
Black mother Hispanic father	81		2.26 (1.66)	0–7
Hispanic mother White father	60		1.83 (1.61)	0–6
Hispanic mother Black father	98		2.56 (1.63)	0–7

2.2. Measures

Adverse Childhood Experiences (ACEs). The outcome variable is early ACEs, measured as a cumulative ACEs score by summing nine dichotomized indicators of childhood adversity (Yes = 1; No = 0) the focal child experienced at age three. Guided by Felitti's [1] and other fellow researchers' ACEs study, we included indicators of witnessing mothers experiencing domestic violence, experiencing parental involvement with criminal justice, parental separation, parental mental health issues, parental substance abuse, material hardship, physical abuse, psychological abuse, and neglect. Due to the nature of the secondary analysis, we could not access sufficient information related to child sexual abuse. Therefore, child sexual abuse was not included despite its significance. Below are nine indicators of ACEs examined in this study.

Physical abuse. Physical abuse was measured from a proxy variable of physical assault assessed by five questions from the Parent–Child Conflict Tactics Scale [48]. Mothers reported the frequencies of behaviors such as “slapped child on the hand, arm, or leg” in the past year, with responses ranging from “never happened” to “more than 20 times”. As recommended by the scale developer [48], we used the midpoint of each response to denote the level of physical assault, with higher scores suggesting more aggravated physical assault (i.e., physical abuse). We then created a sum-score based on the raw scores from the five questions of physical assault. Following other researchers' practice of constructing physical abuse variables using the FFCWS dataset [49], we assigned the value of 1 for the indicator of physical abuse to those participants high in the top 10th percentile of the sum-scores among the entire sample, meaning the focal child had experienced physical abuse at age 3. The reliability was 0.61 for the measure of physical abuse.

Psychological abuse. Psychological abuse was also measured from a proxy variable of psychological aggression assessed by five questions from the Parent–Child Conflict Tactics

Scale [48]. Mothers reported the frequencies of behaviors such as “swore or cursed at child” in the past year, with responses ranging from “never happened” to “more than 20 times”. Similar to physical abuse, we assigned the value of 1 for the indicator of psychological abuse to those participants high in the top 10th percentile of the scores among the entire sample, meaning the focal child had experienced psychological abuse at age 3. The reliability was 0.52 for the measure of psychological abuse.

Neglect. The indicator of neglect was measured by five questions from Parent–Child Conflict Tactics Scale [48] about mothers’ behaviors of physical, emotional, and medical neglect such as “were not able to make sure child got the food he/she needed”. If any of the five questions was confirmed by the mother, the indicator of neglect was coded as 1. The reliability was 0.54 for the measure of neglect.

The remaining six ACEs indicators were non-maltreatment ACEs. *Witnessing mothers experiencing domestic violence* was assessed by mothers’ reports of being physical, sexual, and emotional hurt by the child’s biological father or her current partner. Sample questions included: “He slaps or kicks you?” “He tries to keep you from going to work or school?” and “He tries to make you have sex or do sexual things?” We coded the indicator of witnessing mothers experiencing domestic violence as 1 if mothers suggested that they experienced any type of domestic violence. *Parental involvement with criminal justice* was coded as 1 if mothers reported that they had any pending charges or that the child’s father was incarcerated. *Parental separation* was coded as 1 if mothers indicated that they did not live with the child’s biological father. *Parents’ mental health issues* were measured by the Composite International Diagnostic Interview (CIDI) [50], which provided information on whether the child’s parents met the criteria of depression and anxiety. We coded parents’ mental health issues as 1 if mothers suggested that either her or child’s father met the CIDI’s criteria. *Parents’ substance abuse* issues were measured by mothers’ responses to CIDI, as well as mothers’ confirmation of substance use problems of the father or the mother’s current partner. Parents’ substance abuse was coded as 1 if either of them had the issue. Finally, we included *material hardship* as an additional ACE, though it was not a traditional ACE, given that convincing evidence showing its negative neurobiological and psychosocial consequences on child development [51]. was assessed by eight questions related to the family’s unmet needs of food, house, and electricity from the Survey of Income and Program Participation [52]. Mothers were asked questions such as: “In the past year, were you evicted from home?” and “In the past year, was your electricity ever turned off?”. If any of the eight items were indicated as ever happened, the indicator of household financial difficulties was coded as 1.

Family Racial Composition. Focal children’s family racial composition is defined by their parents’ race. Based on the mothers’ and fathers’ racial backgrounds, we divided children into two categories: living in intraracial families (e.g., two Latinx parents) and living in interracial families (one parent from other racial groups such as White or Black). Interracial families could be further divided into families with (1) White mother/Latinx father; (2) Black mother/Latinx father; (3) Latinx mother/White father; (4) Latinx mother/Black father. The original dataset included parents who reported their races as “Other race”, but the numbers were too small for comparison. Therefore, we only examined three racial groups: Latinx, White, and Black.

Covariates. To make more accurate estimates, we included covariates that can potentially be associated with a child’s early ACEs exposures, such as the child’s sex, mother’s age when giving birth, mother’s education, number of adults living at home, number of children living at home, and family income.

2.3. Analytic Strategies

Descriptive statistics were used to show the demographics and the ACEs distributions among the participants. Using children with two Latinx parents as a reference group, we built a negative binomial model to examine whether family racial composition is a predictor of focal children’s overall ACEs scores. Given that our outcome variable (i.e., overall ACEs

score) is a count variable with variances larger than its mean, the negative binomial model is the most appropriate estimation model. Further, logistic regression models were built to examine the risks of children in different interracial family groups experiencing each type of ACE. We used SPSS 26 for data management and *Mplus*-8 for data analysis.

Little's MCAR test showed that data were not missing completely at random, $\chi^2(595) = 696.953$, $p = 0.002$. Therefore, we conducted an analysis on the missingness pattern of the nine indicators of ACEs (e.g., our outcome variable). We only found that the missingness of witnessing mothers experiencing domestic violence was negatively associated with higher education and positively associated with intraracial families, but other eight indicators of ACEs were not statistically correlated with other demographic variables. Therefore, missing data were handled by Full Information Maximum Likelihood in *Mplus* as recommended [53].

3. Results

Table 1 shows higher average ACEs scores for children in interracial families than children in intraracial families ($M = 1.75$, $SD = 1.46$). Children with Latinx mothers and Black fathers had the highest ACEs score ($M = 2.56$, $SD = 1.63$), followed by children with White mothers and Latinx fathers ($M = 2.46$, $SD = 1.60$), children with Black mothers and Latinx fathers ($M = 2.26$, $SD = 1.66$), and children with Latinx mothers and White fathers ($M = 1.83$, $SD = 1.61$). Breaking down the number of ACEs, Table 2 suggests that close to 90% of the children in intraracial Latinx families experienced 3 and fewer than 3 ACEs, while there were higher percentages of children from interracial families experiencing over 4 ACEs. It should be noted that experiencing over 4 ACEs suggests a high risk of developing compromised life-long health and behavioral health outcomes [1]. For children in interracial families, the percentage of experiencing 4 and over 4 ACEs was highest (24.8%) among children living with White mother and Hispanic father while most children in this group experienced 4 or 5 ACEs. Though the percentage of experiencing 4 and over 4 ACEs was not so high among children with Hispanic mother and Black father (21.4%), the percentage of experiencing 6 and over 6 ACEs was high among this group.

Table 2. ACEs breakdown among different family racial composition groups.

ACEs	Number (Percent)				
	Two Hispanic Parents	White Mother Hispanic Father	Black Mother Hispanic Father	Hispanic Mother White Father	Hispanic Mother Black Father
0 ACE	209 (22.8%)	13 (12.4%)	14 (17.3%)	14 (23.3%)	11 (11.2%)
1 ACE	236 (25.7%)	16 (15.2%)	14 (17.3%)	18 (30.0%)	19 (19.4%)
2 ACEs	220 (24.0%)	29 (27.6%)	19 (23.5%)	9 (15.0%)	30 (30.6%)
3 ACEs	143 (15.6%)	21 (20.0%)	18 (22.2%)	6 (10.0%)	17 (17.3%)
4 ACEs	67 (7.3%)	13 (12.4%)	6 (7.4%)	10 (16.7%)	12 (12.2%)
5 ACEs	29 (3.2%)	10 (9.5%)	8 (9.9%)	2 (3.3%)	3 (3.1%)
6 ACEs	10 (1.1%)	2 (1.9%)	1 (1.2%)	1 (1.7%)	4 (4.1%)
7 ACEs	4 (0.4%)	1 (1.0%)	1 (1.2%)	0 (0%)	2 (2.0%)

Results in Table 3 from negative binomial model 1 indicated that, after controlling covariates, living in interracial families was positively associated with a higher ACEs score ($\beta = 0.54$, [0.37, 0.70], $p < 0.001$). Model 2 elaborated the effects of different family racial compositions and showed that all racial groups were positively associated with higher ACEs exposures: White mother and Latinx father ($\beta = 0.42$, [0.26, 0.57], $p < 0.001$), Black mother and Latinx father ($\beta = 0.18$, [0.002, 0.37], $p = 0.047$), Latinx mother and White father ($\beta = 0.21$, [0.003, 0.41], $p = 0.047$), Latinx mother and Black father ($\beta = 0.34$, [0.19, 0.50], $p < 0.001$).

Table 3. Negative binomial models for predicting overall ACEs score.

Predictors	Model 1 Intra vs. Inter β (CI)	Model 2 Family Racial Composition β (CI)
Mother's age when giving birth	−0.34 ** [−0.55, −0.12]	−0.34 ** [−0.55, −0.12]
Child sex	0.08 [−0.11, 0.27]	0.08 [−0.11, 0.27]
Mothers' education	0.13 [−0.10, 0.35]	0.14 [−0.08, 0.37]
# of adults living at home	−0.28 * [−0.49, −0.07]	−0.28 * [−0.48, −0.07]
# of children living at home	−0.29 ** [−0.50, −0.08]	−0.29 ** [−0.50, −0.09]
family income	−0.78 *** [−0.96, −0.59]	−0.77 *** [−0.96, −0.59]
Interracial family	0.54 *** [0.37, 0.70]	
White mother Latinx father		0.42 *** [0.26, 0.57]
Black mother Latinx father		0.18 * [0.002, 0.37]
Latinx mother White father		0.21 * [0.003, 0.41]
Latinx mother Black father		0.34 *** [0.19, 0.50]

Note. For model 1 and 2, the reference group = Intraracial Latinx family, i.e., Two Latinx parents' family. * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

Table 4 shows risks of children in interracial families in terms of each indicator of ACEs. Compared to children with two Latinx parents, children with White mothers and Latinx fathers had higher risks of experiencing parents' mental health issues (adjusted OR = 2.92 [1.80, 4.73], $p < 0.001$), parents' substance abuse issues (adjusted OR = 3.99 [2.15, 4.73], $p < 0.001$), material hardship (adjusted OR = 2.01 [1.28, 3.14], $p = 0.002$); children with Black mothers and Latinx fathers were more prone to adversities of parental involvement with criminal justice (adjusted OR = 4.19 [1.81, 9.70], $p = 0.001$) and parental separation (adjusted OR = 3.92 [2.24, 6.84], $p = 0.009$); children with Latinx mothers and White fathers were more likely to experience parents' substance abuse issues (adjusted OR = 3.25 [1.30, 8.13], $p = 0.01$). Finally, children with Latinx mothers and black fathers faced higher risks for parental separation (adjusted OR = 2.33 [1.44, 3.77], $p = 0.021$), material hardship (adjusted OR = 1.64 [1.03, 2.61], $p = 0.036$), physical abuse (adjusted OR = 6.01 [2.65, 13.66], $p = 0.046$), and psychological abuse (adjusted OR = 3.49 [1.88, 6.49], $p = 0.024$).

Table 4. Logistic regression models for predicting each ACEs.

ACEs	White Mother Latinx Father Adjusted OR	Black Mother Latinx Father Adjusted OR	Latinx Mother White Father Adjusted OR	Latinx Mother Black Father Adjusted OR
Witnessing mothers experiencing domestic violence	1.56 [0.99, 2.48]	0.84 [0.51, 1.39]	1.69 [0.94, 3.03]	1.00 [0.63, 1.60]
Parental involvement with criminal justice	1.48 [0.49, 4.50]	4.19 ** [1.81, 9.70]	0 * [0, 0]	2.42 [0.99, 5.95]
Parental separation	1.48 [0.94, 2.36]	3.92 ** [2.24, 6.84]	1.49 [0.80, 2.74]	2.33 * [1.44, 3.77]
Parents' mental health issues	2.92 *** [1.80, 4.73]	1 [0.53, 1.88]	1.63 [0.79, 3.39]	1.14 [0.64, 2.02]
Parents' substance abuse issues	3.99 *** [2.15, 7.45]	1.01 [0.38, 2.68]	3.25 ** [1.30, 8.13]	1.57 [0.70, 3.48]
Material hardship	2.01 ** [1.28, 3.14]	1.05 [0.63, 1.73]	0.84 [0.45, 1.55]	1.64 * [1.03, 2.61]
Physical abuse	2.01 [0.71, 5.70]	2.37 [0.74, 7.61]	2.80 [0.84, 9.35]	6.01 * [2.65, 13.66]
Psychological abuse	1.46 [0.73, 2.90]	1.97 [0.91, 4.25]	1.42 [0.58, 3.50]	3.49 * [1.88, 6.49]
Neglect	0.63 [0.26, 1.52]	0.59 [0.22, 1.56]	0.91 [0.30, 2.77]	0.94 [0.42, 2.08]

Note. The reference group = Two Latinx parents' family. * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

4. Discussion

Overall, we found higher levels of early ACEs exposure of children living in interracial families with one Latinx parent compared to children with monoracial Latinx parents. Our findings are consistent with prior studies. In Bratter & Eschbach's study [34], they found elevated distress experienced by Latinx men and women married to non-white spouses, compared to the endogamous Latinx couples. Additionally, Wong and Penner [54] found that Latinx women's depressive symptoms increased after entering interracial relationships. Given that family is the primary institution for early child development, stress and worsening psychological health of parents are significant adversities for children.

We further examined the risks of ACEs among different parental racial composition groups. First, compared to monoracial Latinx children, children with White mothers and Latinx fathers had a higher likelihood of experiencing parents' mental health issues, parents' substance abuse issues, and material hardship. Having mental health and substance issues could be the reflection of experiencing marital distress in an interracial relationship. In the context of the relationships between Whites and non-Whites, it is not uncommon that a White partner did not understand their partner's experience such as racism [55], which may contribute to the challenges in communication and intimacy. For Latinx families, White partners may minimize or misunderstand the Latinx people's experience of racism, discrimination, or acculturation stress and difficulties. Therefore, parents in interracial relationships may develop mental health issues and seek substances to cope with marital stress. At the same time, the finding that children living with White mothers and Latinx fathers were more likely to experience material hardship was consistent with Fusco's finding [55] on White mothers of biracial children that they were more likely to live in poverty and held a lower status job. Even worse, White mothers in interracial relationships may receive less support from extended families [56]. Taken together, the lower SES of White mothers and limited social support could contribute to higher risks of children experiencing material hardship in White mother Latinx father families.

Second, compared to children in monoracial Latinx families, children living with Black mothers and Latinx fathers were more likely to experience parental criminal justice system involvement, which well reflected the reality that people of color are disproportionately represented in the criminal justice system [57]. Children with Black mothers and Latinx fathers also experienced higher parental separation compared to monoracial Latinx children, which may be related to the prevalent disapproval of Latinx/Black relationships in Latinx families and communities [37] that was constructed by the racism embedded in U.S. society. Vasquez showed that anti-Black prejudice and Latinx people's needs to "stay in the racial middle" were strong forces for the Latinx population to oppose the Latinx/Black relationship [37] (pp. 466–467). Morales [38] also showed that Latinx parents' disapproval of Latinx/Black dating was related to the concern about Black people's racial hierarchy. It is possible that Latinx/Black couples experienced higher familial and societal opposition that cripple their capacity to maintain relationship stability.

Children with Latinx mothers and White fathers only experienced a higher likelihood of parental substance abuse, which could be explained by the same reason for parental substance abuse in White mother/Latinx father families. However, children living with Latinx mothers and White fathers also experienced a lower likelihood of parental involvement with criminal justice compared with monoracial Latinx children.

Children with Latinx mothers and Black fathers seem to be in the most disadvantaged conditions as indicated by higher risks of four types of ACEs. Similar to children in Black mother/Latinx father families, children living with Latinx mothers and Black fathers were also more likely to experience parental separation. In addition, the fact that Latinx mother/Black father families were at a higher risk of material hardship could be an indicator of the scarcity of social support for this kind of family. It should be noted that comparing to intraracial Latinx families, Black mother/Latinx father families did not demonstrate significant differences regarding material hardship, while Latinx mother/Black father families showed increased risks of material hardship. We speculate that the gender effect intersects

the likelihood of Latinx mother/Black father families experiencing material hardship partly through the social support provided to those families. According to Morales [38], compared to Latino men, Latinas experience more sanctions in dating Blacks because Latinx parents hold women accountable for the creation and rearing of children to preserve the racial hierarchy. Therefore, Latinx mother/Black father families may experience more severe punishment than Black mother/Latinx father ones, such as being ostracized from and receiving very little support from their families and communities. Finally, Latinx mother/Black father families exhibited severely higher risks of physical abuse and psychological abuse. Higher risks of child abuse might be explained by cumulative stress effects. Research suggests that experiencing material hardship and being a single parent are both sources of parenting stress, and parenting stress is subsequently a significant risk factor for child abuse [58].

Study limitations should be acknowledged. First, this study was an exploratory study showing the ACEs disparities among monoracial Latinx children and biracial children with one Latinx parent. Our study was not able to build causal mechanisms to explain those disparities (e.g., parental immigration status may be related to the child's ACEs exposure). We also could not reveal all selection biases that lead people into interracial union formation. However, we believe this exploratory study is still worthwhile because we presented an evidential fact that family structure (e.g., parental racial composition) is a social determinant of health (i.e., children living in interracial families were more likely to be exposed to early ACEs, which in turn can profoundly compromise their health outcomes). Second, though this study used the term "adverse childhood experiences", we did not 100% follow the indicators of the original ACEs study [1]. We constructed ACEs indicators of physical abuse, psychological abuse, and neglect from the Parent-Child Conflict Tactics Scale, but the reliability scores of these measures were not high (lower than 0.7). Further, due to the nature of secondary data analysis, we were not able to include sexual abuse as one important ACE; however, we included material hardship as an ACE. An increasing number of studies suggest that experiencing poverty should be deemed as an ACE because it causes profound influences on child development [59]. It should be noted that more expanded ACEs, such as separation from primary caregivers due to immigration, deportation, and death of primary caregivers, should be included as critical ACEs for future studies examining Latinx children. Finally, we relied on mothers' self-report data for all variables, which can cause estimation biases due to social disability and inflated variances. Future studies could consider multi-informants for data collection.

5. Conclusions and Implications

As people are increasingly aware of the profound influences of ACEs on health development, a sizable body of research has contributed to understanding various factors associated with ACEs exposure. This study filled the research gap by calling attention to the association between family racial composition and ACEs exposure. Interracial marriages are increasingly acceptable in the U.S., with the Latinx population leading the highest proportion of interracial marriages. However, the fact that children in interracial families experiencing significantly higher ACEs than intraracial families is concerning, considering that ACEs exposure is associated with compromised individual health [18], behavioral health [60], and other developmental outcomes [7,9]. Therefore, developing culturally responsive ACEs prevention and intervention strategies to break the cycle of trauma are urgently needed to improve the population's health and well-being.

Research implications. More future research on interracial families, particularly the ones to explore the unique family process of and structural influences on interracial families, are needed to inform our practice and policy interventions. For example, in addition to factors such as systematic racism and discrimination towards minority populations, future research may need to explore whether parents' immigration and deportation would contribute to Latinx children's ACEs. At the same time, it would be necessary to consider expanded ACEs (such as poverty, neighborhood violence that disproportionately affect people of color) because the original ACEs study was mainly focused on White middle

class individuals' experiences. When researchers collect enough sample size for each racial group ($N \sim 100$ for each group), it would also be interesting to examine gender differences in the association between racial composition and child ACEs. Finally, future research should explore the trajectories of the relationship between racial compositions and ACEs over time using longitudinal analysis.

Practice implications. Given that mental health providers play an essential role in preventing ACEs and providing trauma-informed care [61], they should be culturally competent when working with racial/ethnic minority populations. It may be helpful to conduct ACEs assessment and clinical interviews among interracial families to identify unique risk factors, so mental health providers can work with families to specifically address these concerns, such as revealing hidden racism, increasing trust in communication, developing coping skills, and extending social support [62,63]. A systems collaboration approach among different mental health providers is also urgently needed to provide trauma-informed care for populations experiencing ACEs, including case management, behavioral health, medical care, supplemental nutrition assistance programs, housing, legal services, and early care and education programs and providers. The role of early care and education providers is particularly important because they would be the first persons to identify child trauma exposure. Additionally, more family-oriented community programs should be built to support interracial couples and families. Ultimately, to improve the racial/ethnic minority population's health and well-being, we need a social change to acknowledge and address social injustice, historical oppression, and health disparities that are intertwined with ACEs among racial/ethnic minorities.

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